

Ashgrove Care Home Limited

Ashgrove Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Ashgrove Nursing Home is a nursing home with a residential unit on site, providing personal and nursing care to up to 57 people. The service provides support to older people, younger adults and people living with dementia. At the time of our inspection there were 45 people using the service.

The home accommodates people across 2 separate areas, each of which has separate adapted facilities. One of the areas specialises in providing care to people living with dementia and the other specialises in nursing care and offers support to people leaving hospital.

People's experience of using this service and what we found

People did not always receive their medicines as prescribed. There were gaps in medicine administration records and staff were unable to confirm if people had received their medicines. Some people did not receive their medicines consistently.

There was an on-going improvement plan to address environmental concerns in relation to infection prevention and control. Governance systems were not always effective in identifying the concerns we found during the inspection in relation to medicines.

People felt safe. Staff knew how to identify and report concerns for people's safety and wellbeing. Risks were assessed and managed by staff who knew people's needs. There were enough staff to support people safely and staff had been safely recruited. Where things had gone wrong the management team responded and took learning from events to improve future care.

People's needs had been assessed and plans developed to ensure staff understood how to support them as individuals. Staff received training relevant to their role and felt supported by the management team. People were supported with eating and drinking to maintain their health and staff worked in partnership with healthcare professionals to ensure people's needs were met.

Staff sought people's consent before providing care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were treated with kindness and compassion by a staff team who knew them well. Staff promoted people's independence and encouraged them to make decisions for themselves.

People's care was responsive to their changing needs. Information about changes to people's care was shared with staff so they could provide consistent, timely care and support. People's communication needs were considered and they were supported to spend time both alone and with others enjoying activities and interests. People and relatives knew how to raise concerns about their care and there was a system in place

for the management of complaints.

With the exception of medicines, audits used to monitor the quality of care provided were effective and identified areas of improvement. These were then actioned to ensure lessons were learned and improvements were made. People, relatives and staff felt able to offer feedback about their experiences and spoke positively about the management team. The staff team worked in partnership with other professionals to meet people's needs and improve the quality of care people received.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for the service under the previous provider was good, published on 24 March 2022.

Why we inspected

The inspection was prompted in part due to concerns received about poor quality care and the home environment. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We have identified breaches in relation to the safe management of medicines at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective.

Details are in our effective findings below.

Good ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Ashgrove Nursing Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was conducted by 1 inspector, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Ashgrove Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ashgrove Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. Management of the home was overseen by the area manager. However, a new manager had been in post for 1 day and planned to submit an application to register.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 7 people who used the service and 3 relatives about their experience of the care provided. 2 visiting professionals also shared their feedback with us. We also spoke with 6 staff, the deputy manager, the new manager, the area manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records, these included 7 people's care records, medicines administration records and governance and quality assurance records. We also looked at 3 staff recruitment files.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Systems used for the management of medicines were not always safe. We identified a number of occasions where staff had not signed to confirm if a person had received their medicines as prescribed and there were gaps in the Medication Administration Records (MAR). Staff were unable to confirm whether or not people had received their medicines.
- We identified 1 person whose medicine had been out of stock for a period of 5 days. Although nursing staff were aware of this, it was not clear what action had been taken to get the medicines back in stock. Following the inspection, the area manager sent us evidence to confirm that action had been taken to try and get the medicine back in stock. For other people, we could not be sure if they had received their medicines as prescribed as the instructions for staff to follow were not clear. For example, records did not state where creams should be applied, which meant staff may not act consistently when applying these medicines.
- MAR charts showed some people had not received their medicines consistently. For example, one person had missed 11 doses of medicines prescribed to help manage their dementia, as they were sleeping at the time the medicines were offered to them. No action had been taken by staff to ask healthcare professionals to review the time the medicines should be administered, and the repeated missed doses had not been escalated to the area manager. This placed people at risk of not receiving their medicines as prescribed.

We found no evidence people had been harmed, however systems were not in place to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The area manager and manager took immediate action in response to our concerns. They arranged for the timing of people's medicines to be reviewed to ensure they had the best opportunity to ensure they received them. They also introduced a daily checking sheet to monitor the amount of stock in place to reduce the risk of medicines not being available.

Preventing and controlling infection

- We identified some concerns with the home environment which may contribute toward poor infection control. These included some damage to the home environment, worn furniture or equipment which could not be cleaned in accordance with infection control guidance. The area manager was aware of these concerns and was working towards an action plan following a visit from the local infection control team. A full refurbishment plan was underway to make environmental improvements to the home.
- We were assured that the provider was preventing visitors from catching and spreading infections.

- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes

The area manager was aware of their responsibilities in relation to supporting people's rights to have visitors at the home. Visitors could access the home freely.

Systems and processes to safeguard people from the risk of abuse

- People and their relatives told us they felt safe. One relative said, "I feel my wife is safe here, I go home happy knowing she is well looked after." Staff had received training in safeguarding, they could identify possible signs of abuse and knew how to escalate concerns for people's safety.
- The area manager understood their responsibilities in relation to keeping people safe. Where safeguarding incidents had occurred, they had made appropriate referrals to local authority safeguarding teams, and had notified us, as required by law.

Assessing risk, safety monitoring and management

- Risks to people's safety, health and wellbeing had been assessed and guidance was available for staff to follow to ensure people were safely supported. Some improvements were required to the detail contained in people care plan's relating to the management of distressed behaviours. The area manager told us these would be reviewed following the inspection.
- Staff were knowledgeable about where people were at risk and supported them safely following guidance in care plans. Where people required support to protect their skin integrity, or with mobility support they were safely supported by staff.
- People's risks were regularly reviewed and any changes were shared with staff in handover meetings or the daily flash meeting. This ensured people received up to date care which met their current needs.

Staffing and recruitment

- There were enough staff to safely support people. With the exception of one person, all people and relatives we spoke with felt staff responded to them in a timely way and were confident staff were available when needed. One person felt they sometimes had to wait longer than they would like when using their call bell, however felt this had not made them feel unsafe.
- Most of the staff we spoke with were positive about staffing levels. One staff member told us, "I think there are enough of us (staff), I have no concerns." The area manager used a clinical risk register to assess how many staff were needed to support people.
- Staff were safely recruited. The provider had carried out pre-employment checks, including DBS checks, to ensure staff were safe to work with people. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong

- Systems had been established to ensure learning took place following incidents and events. Staff told us they were aware of plans to drive improvement and learning was shared with them when things went wrong.
- Records relating to accidents and incidents reflected changes to people's care and support that had been made to reduce the risk of reoccurrence and keep people safe from avoidable harm.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Initial assessments were carried out when people moved into the home and these gathered information about protected characteristics, such as people's cultural needs and how they expressed their sexuality.
- People's health and support needs were recorded in care plans which enabled staff to provide personalised care. People's needs were regularly reviewed so care provided reflected their current needs.
- Information about people's life histories were included in their care plans as well as details of their likes and dislikes and personal preferences.

Staff support: induction, training, skills and experience

- Staff had the skills and knowledge required to support people. Relatives told us they felt staff had a good understanding of their family members needs and knew what was important to them. One relative commented, "I think the staff are well trained, I feel confident when they use the hoist with [person's name]."
- Staff received an induction and on-going training and support which helped them carry out their roles effectively. One staff member told us, "My training has been good. The induction included role plays which made you think about how you would use your training when caring for people. It helped me."

Supporting people to eat and drink enough to maintain a balanced diet

- People received support with food and drink. Staff were aware of people's dietary needs and were able to share with us how people's food was modified to support their nutrition. Staff members responsible for the preparation of food received information about people's dietary and hydration needs and ensured appropriate food was available.
- Risk assessments were in place to ensure people received food and drink safely. For example, where people were at risk of choking, clear plans were in place for staff to follow to ensure people's safety. Where people were at risk of malnutrition or dehydration staff monitored their dietary intake and shared any concerns with healthcare professionals.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff worked with healthcare professionals to ensure people's health needs were met. Where changes in people's needs had been identified, referrals were made to healthcare professionals. These included referrals to GP's, district nursing teams, physiotherapists and speech and language therapists.
- Information about people's health needs was shared with staff at the start of each shift and in daily flash meetings. This included where staff needed to undertake additional monitoring, or what action had been taken where a decline in a person's health had been observed.

- People and relatives told us they felt staff acted promptly when people became unwell. One person told us, 'I requested to see my GP and that was arranged, I have also had a visit by the optician.'

Adapting service, design, decoration to meet people's needs

- Refurbishment works were underway to improve the whole home environment and décor. The area manager shared the provider's plan to carry out any identified repairs and make on-going improvements to the home.
- Facilities throughout the home contained adaptations, for example in bathrooms. This enabled people to maintain their independence where possible. Some signage was in place to assist people in locating bathrooms and bedrooms.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People told us they were asked for their consent before care was provided. One person said, "Staff do ask for consent, but actually I direct my care and they respect that."
- Where people lacked capacity to make specific decisions staff had followed the principles of the MCA to ensure their rights were protected and any decisions were made in their best interests.
- Where people's rights were restricted, staff understood this, and had made applications to ensure this was done so lawfully.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People spoke positively about the care they received and felt well treated by staff. One relative told us, "I recommend this place to everyone I meet. It is homely, friendly and the staff know mom and always have time for a chat..."
- Staff knew people well and there was a relaxed atmosphere in the communal lounge areas. People felt comfortable approaching staff when they needed support and staff responded promptly and with reassurance, when required.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People were involved in decisions about their care. Where people chose to, they spent time in their bedrooms and told us they were happy to do so. Other people spent time in communal areas and were offered choices such as where they preferred to sit and which food and drink they preferred.
- People's privacy was respected. We observed staff knocking on people's bedroom doors before entering and arranging for people to meet with relatives in private or quieter parts of the home.
- Staff promoted people's independence. We observed people walking freely around the home and people were encouraged to do things for themselves where possible. One relative told us, "All the staff know [person] well, staff support them to keep safe but allow their independence, which is very important to them."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care was planned with them or their relatives where appropriate. Care plans reflected people's needs as well as their interests and preferences. Some people's care plans lacked detail about their life histories; however staff told us they were in the process of reviewing and updating these.
- Staff understood people's likes and dislikes well and understood how they liked to receive their care. For example, staff shared with us how they supported a person who became anxious by using a range of techniques learned from previous experiences. This enabled staff to support the person in a way that reduced their anxiety rather than heightened it.
- Where people's needs changed their care plans were reviewed and any changes were shared with staff to ensure people receive consistent care in line with their current needs.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were assessed and known by staff. This included where people used glasses or hearing aids, as well as their chosen language.
- Information was available throughout the home in a variety of formats to support people's communication needs. Tablet computers were used to offer pictorial communication, as well as a staff member being trained in British Sign Language (BSL). This along with visual aids to support people with dementia with time/date orientation and other visual signage supported people's communication needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported with a combination of group and one to one activities which helped to reduce social isolation and promote their wellbeing.
- We observed people taking part in interactive activities led by staff as well as listening to music and taking part in group discussions. Any concerns about people's wellbeing were shared with the activity leads who then planned to spend time with people on a one to one basis to support their mental health.

Improving care quality in response to complaints or concerns

- People were confident to raise concerns if they were unhappy with an aspect of their care. One person told

us, "I have never made a complaint, but I would complain to [name of area manager]."

- Relatives also told us they felt able to complain if they needed to. One relative commented, "I have never made a complaint, I think there is a great atmosphere."
- There was a system in place to record and monitor complaints and identify any patterns or trends. This enabled the management team to make improvements where required.

End of life care and support

- People were supported to make decisions about the care they would like to receive at the end of their lives. Where possible, staff involved people and their relatives in developing care plans. These reflected people's cultural, religious and spiritual needs as well as their preferences. Where people had chosen not to discuss their wishes, this was documented.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was, at times, inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Audit processes used by the nursing and management team were not always effective. Medicines audits had not identified the concerns we found during the inspection.
- The area manager told us nursing staff were responsible for medicines audits, and they had further oversight. Following the inspection, the management team took immediate action to address the concerns were identified.
- With the exception of medicines, effective audits were in place to monitor the quality of care and identify any areas for improvement. The area manager had implemented a range of quality audits to check on the care people received and address any areas of concern.
- Weekly director's meetings were held to review whole home activity and ensure progress was being made against any identified areas of improvement. For example, where new equipment was required, or improvements were required to the home environment.
- The area manager and new manager were experienced and understood their regulatory responsibilities. The new manager was undertaking an induction, led by the area manager, to ensure practical information about the home as well as governance arrangements were shared with them. They told us this would ensure a smooth handover to the new manager.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- People and their relatives spoke positively about the culture of the home since the new provider had taken over. One relative said, "The staff seem happy, the home is well organised and they appear to work well as a team."
- The management team had worked to develop a positive culture within the staff team. Staff we spoke with were positive about the changes that had taken place since the change of provider and felt improvements had been made which benefit the people living at the home. One staff member said, "The previous home manager left. There has been a transition and [name of area manager] has been leading, implementing new structure. I feel like they are doing a good job."
- People's support was tailored to them and staff worked together with other professionals to support people's well-being and improve their health. A visiting professional told us, "We work well with the staff and management, we make suggestions and the staff are receptive to them. They work hard to carry out any suggestions we make."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The area manager and manager were aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.
- Where things had gone wrong the management team had spoken with people and/or their relatives and explained what action they had taken to improve the quality of care people received.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People had been asked to share feedback about the home. Their responses had been reviewed and where any concerns were identified, these had been addressed.
- Visiting professionals had also been asked for their feedback and we reviewed comments that mentioned the kindness of staff and their caring approach.
- Relatives had not yet been asked for their feedback formally, however comments made by family members or discussions with staff about concerns, were documented and actioned where possible. Relatives spoke positively about the newly introduced support meetings. One relative told us, "They have set up monthly meetings for families and loved ones, we couldn't make the last one, but we definitely be attending the one in July."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure the proper and safe management of medicines.