Regal Care Trading Ltd

Ashcroft Nursing Home

Inspection report

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Tel: 01843296626

Date of inspection visit:
29 July 2019
30 July 2019

Date of publication:
09 October 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Ashcroft Nursing Home is a residential care home that is registered to provide 88 people with nursing and/or residential care. In practice, the service does not provide nursing care. It can accommodate older people and people who live with dementia. It can also provide care for people who have physical and/or sensory adaptive needs.

At the time of this inspection there were 52 people living in the service. All the people only required residential care. Most of the people lived with dementia some of whom had special communication needs.

People's experience of using this service and what we found
People and their relatives were positive about the service. A person said, "The staff here are good to me and as I'm okay here." Another person smiled and pointed in the direction of a passing member of staff when we used signed-assisted language to ask them about their home. A relative said, "I'm happy with the care provided here as the staff are very attentive." A health and social care professional wrote to us saying they considered the service to provide 'commendable' care.

We found there were four breaches of regulations three of which had continued since our inspection in June 2018. People did not always receive safe care and treatment to reduce risks to their health and safety. Some parts of the accommodation did not meet people's needs and expectations. Care was not always provided in a person-centred way to promote people's dignity. The registered persons did not have all the necessary systems and processes to enable them to effectively supervise the running of the service.

Our other findings were as follows
Although care staff had received training and guidance they did not always have the skills and competencies they needed to care for people in the right way. We have made a recommendation about ensuring care staff have the competencies they need.

People were safeguarded from the risk of abuse. There were enough care staff on duty and safe recruitment practices were in place.

People received coordinated care when they moved between services. People had been helped to quickly receive medical attention when necessary. People were supported to have maximum choice and control of their lives and care 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 given information in an accessible way so it was easier for them to understand. People were supported to pursue their hobbies and interests. There were arrangements to quickly investigate and resolve complaints. People were treated with compassion at the end of their lives so they had a dignified death.

People had been consulted about the development of the service. There was good team work and joint working was promoted.

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

Rating at last inspection (and update)
The last comprehensive inspection was completed on 18 June 2018 and 19 June 2018. The inspection report was published on 1 August 2018. The rating for the service was Requires Improvement.

The registered persons completed an action plan after the inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained and the registered persons were still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified three continuing breaches of regulations. People did not always receive care and treatment that was safe and person-centred. The service was not consistently well-led. There was a new breach of regulations. This was because some parts of the accommodation were not designed, adapted and decorated to meet people's needs and expectations.

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

Follow up
We will meet with the registered persons following this inspection report being published to discuss how they will make changes to ensure they improve their rating to at least Good. We will work with the local authority to monitor progress. We will return to visit the service in line with our inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Ashcroft 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 as part of our regulatory functions. This inspection checked whether the registered persons were meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the service on 29 July 2019 and 30 July 2019.

Inspection team:
The inspection was completed by two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Service and service type:
Ashcroft Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided. Both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. In this inspection report when we speak about both the registered manager and the provider we refer to them as being, the 'registered persons'.

Notice of inspection:
The first day of the inspection was unannounced and the second day was announced.

What we did before the inspection:
We used information the registered persons sent us in their Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This information helps support our inspections.

We reviewed other information we held about the service. This included notifications of incidents that the registered persons had sent us since our inspection in June 2018. These are events that happened in the service that the registered persons are required to tell us about.

We invited feedback from the commissioning bodies who contributed to purchasing some of the care provided by the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes. We used all this information to plan our inspection.

During the inspection:
We spoke with 12 people living in the service using sign-assisted language when necessary. We met with six relatives.

We spoke with five care staff, two senior members of care staff called team leaders, two activities coordinators, the maintenance manager and the chef.

We also spoke with the service manager who was based in the service and ran it on a day to day basis. The service manager reported to the operations manager. The operations manager was the registered manager for Ashcroft Nursing Home. However, the operations manager planned to give up this role because they were no longer based in the service. In their place, the service manager had applied to us to become the registered manager.

We reviewed documents and records that described how care had been planned, delivered and evaluated for eight people.

We examined documents and records relating to how the service was run. This included health and safety, the management of medicines and staff training and recruitment. We also looked at documents relating to learning lessons when things had gone wrong, obtaining consent and the management of complaints. In addition, we looked at various parts of the accommodation and grounds.

We reviewed the systems and processes used by the registered persons to assess, monitor and evaluate the service.

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

After the inspection visit:
We continued to seek clarification from the registered persons to add to the evidence we found. This included examining documents and records sent to us by the registered persons.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question remains as 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.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection; Learning lessons when things go wrong
At the last inspection the registered persons had failed to consistently provide people with safe care and treatment. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements had been made to address each of the shortfalls we identified at the last inspection in relation to regulation 12. Previously, care staff had not been provided with enough written guidance about how to safely assist people who experienced reduced mobility and/or who lived with epilepsy. In addition, sufficient guidance had not been provided when caring for people who had a catheter. Some hot water taps had not been temperature-controlled to reduce the risk of scalding. Although all these matters had been put right, at this inspection there were additional shortfalls that meant the registered persons were still in breach of regulation 12.

• Risks to some people's safety had not been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. There were shortfalls in the steps taken to protect some people from the risk of fire. Although there was a modern fire safety system to detect and contain fire, records showed one member of care who worked at night had not taken part in fire drills in line with the recommendations of the local fire and rescue service. Fire drills are necessary so that care staff know what action to take if the fire alarm sounds.
• We highlighted these shortfalls to the service manager. They assured us the oversights would quickly be put right
• The registered persons said special provision was in place for some people who were at risk of not drinking enough to maintain sufficient hydration. There was a nutrition champion who provided colleagues with advice on how to support people to eat and drink enough. The registered persons said care staff were carefully checking how much these people were drinking so action could be taken if a person was not taking enough fluids. However, in practice this was poorly managed as no action had been taken even when records showed a person had drunk significantly less than the service manager said was necessary. In addition, some care staff did not know all the signs that might indicate a person was becoming dehydrated. Although there was no evidence to show that people had experienced direct harm, the shortfall had increased the risk of this occurring.
• The service manager assured us that steps would immediately be taken to address our concerns. These included providing more guidance for care staff. They also included introducing a more robust audit to check that the record of fluid taken was accurate and action had been taken when a person was not

drinking enough. Examples of the action to take were encouraging a person to drink more or seeking advice from a health care professional.
• Care staff had been given guidance and had received training in how to support people to keep their skin healthy. However, this had not always resulted in people being supported in the right way to keep their skin healthy. We noted one person had not been provided with a special airflow cushion that the person's care plan said was necessary. These cushions reduce pressure on a person's skin and make it less likely they will develop pressure ulcers. Another person was using an airflow cushion but this had not been inflated to the correct pressure. This is important so the cushion provides the right support and is comfortable to use. Although none of the people living in the service had developed sore skin, the shortfalls in question had increased the risk of this happening.
• The service had not consistently managed medicines properly and safely. An incident had occurred shortly before our inspection visit when a substantial amount of a person's controlled medicine had gone missing and could not be found. Controlled medicines need to be securely managed because they can be particularly harmful if misused. The service's records did not show if the medicine had been mislaid or administered to the person in excess of the prescribed maximum dose. Although care records showed the person had not experienced direct harm, the shortfall had increased the risk that the person had not been assisted to use the medicine safely. This had occurred because the service did not have robust systems and processes with which to safely manage the medicine in question.
• Suitable provision had not been made to prevent and control the risk of infection. Throughout the accommodation windows, window frames and window handles were dirty. This increased the risk of people acquiring infections when they touched them. In one toilet the water closet was full of excrement that was still present one hour later. In two of the bedrooms we visited the occupants' toothbrushes were stored in cupboards that were dirty. This increased the risk of the toothbrushes becoming soiled and not fit for use.
• In the ground floor dining-room the serving trolleys were dirty with pieces of food encrusted at the edges and corners. In the alcove where the trolleys were kept, the walls were heavily stained with food and drink that had been spilt. Shortly after our inspection visit the registered persons told us both these shortfalls had been addressed. The ground floor treatment room where medicines were stored had some surfaces that were damaged. As a result, they could not be cleaned to a hygienic standard and they were not clean.
• In the grounds of the building there were commercial containers used to store clinical waste. This waste is potentially hazardous and so needs to be kept locked away to reduce the risk of cross infection. At the start of the first day of our inspection the containers were overflowing with waste and so could not be locked. The service manager said that a contractor who had been due to call to empty the bins had been delayed. By the end of the first day of the inspection visit this shortfall had been resolved.
• There were shortfalls in the steps taken to prevent avoidable accidents and to learn lessons when things went wrong. There was an audit tool to analyse and respond to accidents. This was designed to identify what had occurred so steps could be taken to reduce the risk of the same thing happening again. There were also protection plans that provided guidance for staff when responding to other adverse events. These protection plans were not consistently effective in identifying and quickly resolving all significant events that occurred in the service. An example of this took place when a person who lived with dementia mistook another person's bedroom as belonging to them. The person walked into the room and sat on the bed on which the occupant of the room was resting. The occupant of the room became distressed and this increased the risk of both people responding in ways that put themselves and the other person at risk of harm.
• We raised our concerns with the service manager and operations manager. They assured us that each of the shortfalls would immediately be addressed. After the inspection visit they sent us evidence to show that a number of improvements had been made or were underway to provide safe care and treatment. However, the changes did not address all the shortfalls we had found.

Failure to provide safe care and treatment to reduce risks to people's health and safety was a continuing

breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People had been helped to avoid preventable accidents. Radiators were guarded to reduce the risk of burns. Windows were fitted with safety latches to prevent them opening too wide so they could be used safely.
• Medicines were stored in secure treatment rooms that were temperature-controlled. Medicines that required cool storage were kept in special refrigerators.
• There were additional guidelines for team leaders to follow when dispensing variable-dose medicines. These are medicines that a doctor had said can be used when necessary. An example of this was medicines used to provide pain relief. Team leaders who dispensed medicines had received training and had been assessed by the service manager to be competent to safely assist people to take medicines. We saw them dispensing medicines in the correct way so each person received the right medicine at the right time. They also completed an accurate record on each occasion to show what medicines a person had taken. When a person had declined to accept a medicine, team leaders had informed the service manager who had notified the person's doctor. A person said, "The staff give me my tablets on time every day and they always ask me if I want to have a drink to get the tablets down."
• Care staff were provided with clean uniforms and we saw them regularly washing their hands. They also wore disposable gloves and aprons when providing people with close personal care.
• There was an adequate supply of cleaning materials. Mattresses, bed linen, towels and face clothes were clean. This was also the case for tablecloths, drinking glasses and cutlery.
• The local authority's food safety department had given the service '5 stars' showing its food management arrangements were safe and reliable.

Systems and processes to support staff to keep people safe from harm and abuse
• People were safeguarded from situations in which they may be at risk of experiencing abuse. Care staff had received training and guidance. They knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. A person said, "I do feel safe here because I know the staff are on my side." A relative said, "I have no concerns about the service because I can see how kind the staff are."
• The service manager and operations manager used an electronic audit tool to list any concerns raised with them. They used the tool to ensure there was a suitable account of the action they had taken including notifying the local safeguarding authority and the Care Quality Commission. This helped to ensure that the right action was taken at the right time to keep people safe.

Staffing and recruitment
• The service manager had calculated how many care staff needed to be present given the care each person needed to receive. The service did not employ any nurses as in practice it did not provide any nursing care.
• Three people told us that often there were not enough care staff on duty to quickly provide them with the care they needed. One of them said, "I have a call bell, but when I call, it takes them a long time to come, this is how they know if I need help using the toilet, it takes them ages to come, all because they are always short of staff, the carers are doing their best, I can't blame them." Most people told us they promptly received the care they needed. One of them remarked, "When I use my call bell the staff come pretty quickly most times. There seem to be enough staff but this is a big building and so they need a lot of staff."
• We concluded there were enough care staff on duty. Records showed that planned shifts were being reliably filled. On most occasions we saw people promptly being assisted to undertake a range of everyday activities. These included washing and dressing, using the bathroom and receiving care when in bed. However, we told the service manager about the reservations some people had raised about the adequacy of the number of care staff on duty. They service manager said they would consult with everyone living in the

service so that improvements could be made to respond to their concerns.
• Safe recruitment and selection procedures were in place. Applicants were required to provide a full account of previous jobs they had done. This was so the registered manager could identify what assurances needed to be obtained about applicants' previous good conduct.
• References from past employers had been obtained as had disclosures from the Disclosure and Barring Service. These disclosures establish if an applicant has a relevant criminal conviction or has been included on a barring list due to professional misconduct. All these checks helped to ensure that only trustworthy and suitable people were employed to work in the service.

Requires Improvement

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.

At the inspection in June 2018 this key question was rated as Requires Improvement. This was because suitable arrangements had not been made to ensure some people only received care that was the least restrictive possible. At this inspection this key question remains as Requires Improvement. This meant the effectiveness of people' care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs
• The accommodation was not decorated and presented to meet people's needs and expectations. At the back of the property some of the paving stones were uneven, a sunshade was torn, some bannister rails were broken and the wooden decking was discoloured with mould.
• On the inside a stair-lift leading down to a small lounge used by four people was broken. We were told that it had been out of use for six weeks. The operations manager could not provide a date by which it was due to be repaired. However, they assured us the parts necessary to complete the repair had been ordered. Three of the four people who used the lounge could not manage the stairs and so they had to walk outside the building when they wanted to go into the main part of the service. A person said, "It's just not right is it. We shouldn't have to go outside just to get about the home."
• Throughout the service a large number of double-glazed windows had failed and were misted up inside. Shortly after our inspection visit the registered persons told us all the window panes in question had been replaced. In one of the communal bathrooms a window pain was cracked and had a hole in it. In one of the hallways there was another cracked window pane. It had been crudely repaired with black insulating tape. The mechanisms used to close a number of windows were broken and so the windows could not be closed to achieve a weather-tight seal.
• There were numerous examples of decorative finishes being damaged and unsightly. These included badly chipped paintwork, stained and scuffed wall finishes and damaged ceramic wall tiles.
• All these defects detracted from the accommodation being homely and welcoming. The service manager and operations manager said the maintenance manager regularly completed minor repairs and that there was a more general development plan for the building. However, the maintenance manager's records did not list any of the defects described above for action. The development plan addressed the defects with provision for the progress made to be reviewed in 2020.
• After the inspection visit the registered persons sent us evidence showing that some of the necessary improvements were being completed.

Failure to provide premises and equipment appropriate for the purpose for which they were being used was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There was a passenger lift and the corridors were wide. There were bannister rails, toilet frames and

support rails to help people get around their home safely.
• There was enough communal space and each person occupied their own bedroom.
• The accommodation was light and airy. There was a fresh atmosphere throughout the accommodation. There were signs to advise people about the location of communal bathrooms, toilets and bedrooms.
• People had been supported to personalise their bedrooms with items of their own furniture, photographs and keepsakes.

Ensuring consent to care and treatment in line with law and guidance
At the last inspection the registered persons had failed to suitably obtain consent for the care provided for two people. Gates had been fitted to the people's bedrooms. This was so they could have their bedroom doors open while other people were prevented from entering their bedrooms by mistake. However, the arrangement restricted the ability of the two people to freely come and go from their bedrooms. Suitable consideration had not been given to see if there was a less restrictive arrangement available. This was a breach of regulation 11 (Consent to Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the gates had been removed. They had been replaced with brightly coloured curtains. These left the bedrooms' occupants free to come and go while helping other people not to go in by mistake.

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 Act 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 make 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 with appropriate legal authority. In care homes and some hospitals this is usually through the Act's application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the Act and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• People had been supported to make everyday decisions for themselves whenever possible. Examples of this were people being asked about what drinks they wanted to have and when they wanted to be assisted to rest in their bedroom.
• When people lacked mental capacity the service manager had ensured that decisions were made in each person's best interests. This included consulting with relatives and healthcare professionals when a significant decision needed to be made about the care provided. An example of this was the service manager liaising with a person's relatives when it was necessary for bed rails to be fitted to reduce the risk of the person rolling onto the floor.
• Some people had made advanced decisions about the care they wanted to receive. Others had given their relatives the power to make decisions on their behalf when they were no longer able to do so for themselves. This included making important decisions about whether a person should be resuscitated. There were suitable records to describe these arrangements and care staff knew about the decisions that had been made.
• A relative said, "The staff always try to involve me in making decisions about my family member's care. They say that I know my family member best which is of course true. Now that my family member has dementia I'm looking out for them."
• The service manager had made the necessary applications to obtain authorisations when a person lacked

mental capacity and was being deprived of their liberty. There were arrangements to ensure that any conditions placed on authorisations were implemented. These measures helped to ensure that people only received care that respected their legal rights.

Enough improvement had been made and the registered persons were no longer in breach of regulation 11.

Staff support: induction, training, skills and experience
• New care staff had received introductory training before they provided people with care. The training was equivalent to the Care Certificate. This is a nationally recognised system to ensure that new care staff know how to care for people in the right way. New care staff had also completed a number of 'shadow shifts' to observe and learn from a more experienced colleague.
• Care staff had received refresher training to keep their knowledge and skills up to date. Each member of care staff had met regularly with a senior colleague to review their work and to plan for their professional development.
• Some care staff did not have all the knowledge and skills they needed to enable them to care for people in the right way. Some care staff were not confident they could identify all the warning signs when a person is at risk of becoming dehydrated. In addition, some care staff were not able to fully describe how to recognise when a person is developing a pressure ulcer and the action to take. These shortfalls increase the risk that care staff would not always quickly note when a person was becoming unwell so that appropriate assistance could be provided.
• We raised this with the service manager. They assured us that the skills and competencies of care staff would continue to be reviewed. This was so that shortfalls could be identified and training provided.

We recommend the registered persons consider current guidance on supporting people to drink enough and to keep their skin healthy and take action to update their practice accordingly.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The service manager and/or operations manager met each person before they moved into the service. This was to establish the care a person wished to receive. It also ensured the service had the necessary equipment and resources to safely meet their needs. The assessments considered if people needed to use special equipment such as fixed and mobile hoists and easy-access baths. In addition, the assessments identified when a person had a healthcare condition requiring the use of items such as special dressings.
• The assessment also established what provision needed to be made to respect people's protected characteristics under the Equality Act 2010. An example of this was respecting a person's cultural or ethnic heritage by enabling them to choose the gender of care staff who provided their close personal care.

Supporting people to eat and drink enough with choice in a balanced diet
• Kitchen staff prepared a range of meals that gave people the opportunity to have a balanced diet. People had been consulted about the meals they wanted to have. A person said, "The food here is pretty good. If there's nothing on the menu that you like the cook is quite happy to make you something else." A person with special communication need gave us a thumbs-up sign when we pointed towards the kitchen.
• In the dining rooms the tables had were laid with tablecloths and condiments. People could choose to dine in the privacy of their bedroom if they wished. Meals taken to people in their bedrooms were covered with plate guards to help keep the food clean and warm. Care staff had access to the kitchen at night and so could make people drinks and snacks.
• People's weights were being monitored so that significant changes were noted. Care staff had liaised with doctors and dietitians when they had concern that a person might not be eating enough. Some people who were at risk of losing weight were having their meals fortified with extra creamy dishes. There were 'rehydration stations' where people could choose from a selection of cold drinks.

• Support from speech and language therapists had been sought when people were at risk of choking. This had been done to establish if a person's food needed to be prepared in a particular way. Care staff were following the advice they had been given. This included some people having their food blended and drinks thickened so they were easier to swallow.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Care staff supported people to receive coordinated care when they used or moved between different services. This included care staff passing on important information when a person was admitted to hospital. It also included providing people with overnight bags to take with them to hospital. These bags contained a change of night clothes, toiletries and reading material such as magazines.
• Arrangements were promptly made for people to see their doctor if they became unwell. They had also ensured that people had consultations with other healthcare professionals including chiropodists, dentists and opticians.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that people were supported and treated with dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; Respecting and promoting people's privacy, dignity and independence
At the last inspection the registered persons had failed to consistently provide people with person-centred care that promoted their dignity. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements had been made to address the shortfalls identified at the last inspection in relation to regulation 9. Previously, care staff had not been provided with enough written guidance about how to support a person when shaving and how to reassure a person if they became distressed. Although both these matters had been put right, at this inspection there were additional shortfalls that meant the registered persons were still in breach of regulation 9.

• People were positive about the care they received. A person who had special communication needs smiled and waved to a nearby member of care staff when we used sign-assisted language to ask them about their care. Another person said, "I like the staff because they're fine with me." A relative said, "The staff really are kindness itself and I really can't find anything bad to say about them."
• However, we witnessed some occasions on which people were not fully supported to experience care that promoted their dignity. A person who was lying on their bed was unfortunately exposing some of their undergarments because the bedcovers had become dislodged. The door to the bedroom was open and a member of care staff took no action even though they went into the bedroom to check the person had a drink to hand. Eventually, we asked a member of care staff to assist the person to rearrange the blanket on their bed.
• Another person who liked to wear socks had not been assisted to put them on. As a result they were wearing lace-up shoes that rubbed against their skin. The person had special communication needs and when we asked them about their footwear they wrinkled up their nose to indicate disapproval. A third person who lived with dementia was left to eat their lunch without assistance even though care staff were present in the lounge. The person placed some of their pudding on their dinner plate where it became mixed up with the meat and vegetables. The person did not enjoy the rest of their meal because it was unpalatable and they ended up leaving most of it. A member of care staff removed the meal without asking the person if they wanted something else.
• We saw a person who had developed a runny nose. Although care staff were present none of them noticed that the person's nose was running. This was the case even though the person's blouse was wet and obviously stained. Two other people were seen more than two hours after lunch to have their shirts stained

with food. Although care staff were present they did not offer to assist the people to put on clean garments.
• We saw another person had placed a slipper in their pocket after which they walked in an awkward manner from one part of the lounge to another area. Care staff were present but they did not offer to help the person place the slipper on their foot until we brought the situation to their attention.
• These shortfalls had occurred because the service did not have robust systems and processes to monitor, assess and revise the assistance people received so it was consistently caring and person-centred.
• On the first day of the inspection there were a large number of records relating to people no longer living in the service had not been stored securely. The documents contained information such as the care provided and other material such as relatives' contact details. The documents were stored in boxes in a courtyard. As such they could be accessed by anyone in the area including relatives and trades people. In addition, they were exposed to the weather and in windy conditions may have been carried out into the nearby public street. This arrangement increased the risk that confidential private information would not be kept secure. We raised our concerns about this matter with the service manager who by the second day of our inspection visit had moved the documents to a locked room within the service.

Failure to provide person-centred care that promoted people's dignity was a continuing breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Please note at the last inspection the original breach of this regulation was included in our key question, 'responsive'.)

• There was a calm and relaxed atmosphere in the service. Staff had prepared a colourful seasonal display in the foyer of summertime scenes and activities. Care staff recognised the importance of not intruding into people's private space. People could use their bedroom in private whenever they wished. A person said "My bedroom door is always open, but the staff still knock before coming in." Communal bathrooms and toilets had working locks on the doors.
• Care staff wore 'free hug badges' that invited people to affectionately embrace them if they wished to.
• Care staff only discussed people's individual care needs in a discreet way that was unlikely to be overheard by anyone else. A relative said, "I've noticed that the staff are very tactful and they've never discussed anything with me that isn't about my family member."
• Computer records were password protected so that they could only be accessed by authorised members of staff. Care staff knew about the importance of not using public social media platforms when speaking about their work.
• Care staff recognised the importance of providing care in ways that promoted equality and diversity. They had received training and guidance in respecting the choices people made about their identities and lifestyles. This included people who had been supported to meet their spiritual needs by attending religious ceremonies held in the service. It also included people being offered the opportunity to raise funds for a national charity of their choice.

Supporting people to express their views and be involved in making decisions about their care
• People had been supported to express their views and be actively involved in making decisions about their support as far as possible. An example of this was a member of care staff showing a person two different items of jewellery they often liked to wear. This was so the person could decide which piece they wanted to put on. We heard another member of care staff asking a person when they wanted to be assisted to go to the bathroom to wash. They also asked the person if they wanted to have a bath or a shower.
• All the people had family, friends, solicitors or care managers (social workers) who could support them to express their preferences. In addition, the service manager had developed links with local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to weigh up information, make decisions and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question remains as Requires Improvement. This meant people's needs were not always met.

End of life care and support
At the last inspection suitable provision had not been made to establish how people wanted to be supported at the end of their lives to have a dignified death. At this inspection a number of improvements had been made to strengthen the end of life care and support provided in the service.
• There were suitable arrangements to care for people at the end of their life to have a comfortable, dignified and pain-free death. In consultation with relatives and healthcare professionals people nearing the end of their life had been asked how they wished to be supported. The service manager was aware of the need to carefully approach this subject so that a person was not unnecessarily upset.
• There were arrangements for the service to hold 'anticipatory medicines'. This is so that medicines are available for carers to quickly dispense in line with a doctor's instructions if a person needs pain relief.
• The service manager had developed close working relationships with a local hospice whose staff regularly called to the service. The hospice was supporting the service to develop its of end of life care so that it could be accredited as meeting a nationally recognised standard.

Improving care quality in response to complaints or concerns; Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with adaptive needs and in some circumstances to their carers.
• People and their relatives had been given a copy of the service's complaints procedure. The procedure presented information in an accessible way for example by using large print and photographs to explain how complaints could be made. People who live with dementia or who have sensory adaptive needs often find it helpful to have information presented to them in this way. This oversight increased the risk that people living in the service would be unsure about how to make a complaint and about what action to take if a concern was not dealt with to their satisfaction.
• We spoke with all the people who used the lounge accessed by the broken stair-lift that we have mentioned earlier in our inspection report. Two people told us they wanted to make a complaint about the stair-lift not being quickly repaired. The same people also said they wanted to complain about their meals sometimes being too cool by the time care staff had delivered them to the lounge. They told us they were not satisfied with these parts of the service they received. They were not sure how to get things sorted out. They could not recall having seen a copy of the complaints procedure and said no one had explained to them how they could get things put right.
• After the inspection visit, the registered manager told us people were also given accessible information about the complaints' procedure in a more general guide about the service. They also assured us a probe was used to ensure that hot food was served at the correct temperature.

• In addition, the registered manager said each person would be consulted to find out if they had any complaints that needed to be addressed. We heard them discussing with a team leader the arrangements necessary for this to be done.
• There was a procedure for the service manager and operations manager to follow when managing complaints. This required the service manager to clarify what had gone wrong and what the complainant wanted to be done about it. It also required the operations manager to monitor and agree all actions taken to resolve a complaint. The operations manager told us that no complaint would be considered as closed until the complainant was satisfied with the conclusions reached and solutions offered.
• Records showed that the registered persons had received two complaints in the 12 months preceding our inspection visit. We noted that suitable steps had been taken to resolve each of them. These included examining relevant records and documents and speaking with care staff to establish what had gone wrong. They also included informing the complainants of the improvements that had been made as a result of their concerns.
• Some parts of people's care plans were written in a user-friendly way using an easy-read style with pictures and graphics. When necessary care staff quietly repeated explanations they had given to a person about their care. If it appeared a person had not understood what had been said we saw care staff using other means to engage a person's interests. An example of this was a member of care staff who thought that a person who lived with dementia might appreciate being assisted to go to the toilet. The member of care staff discreetly pointed in the direction of a nearby toilet and asked the person if they wanted to 'have a break' before taking lunch. The person was pleased to be assisted to leave the lounge to use the toilet.
• Menus were written in larger print and there were pictorial signs on communal bathroom and toilet doors. In addition, people had been supported to personalise the outside of their bedroom door so it was easier to identify which bedroom they occupied.
• Important documents presented information in an accessible way. An example of this was a leaflet that explained the role of the local safeguarding of adults authority and which gave the authority's contact details. Another example was a leaflet that explained people's rights to have their liberty protected under the Mental Health Act 2005.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Care staff had consulted with each person, their relatives and healthcare professionals about the care to be provided and had recorded the results in an individual care plan. The care plans were being regularly reviewed by care staff so they accurately reflected people's changing needs and wishes.
• People told us that care staff provided them with all the assistance they needed as described in their care plan. A person said, "The staff always seem to be on hand and they're always willing to help." Another person said, "The staff help me but they don't take over and leave me to get on with what I can do for myself."
• There were a number of examples of people receiving personalised care that was responsive to their needs. This included people being supported to move about their home and being assisted to use the bathroom when they wished. Call bells were placed next to people so they were easy to use. Care staff responded quickly when people used their call bell to request assistance.
• People had been consulted about when and how they wanted their bedroom to be cleaned. Care staff regularly called on people who were resting in their bedroom. They did this to make sure they were comfortable and had everything they needed. A person who preferred to spend most of their time in their bedroom said, "The staff come and check on me and make sure I'm comfortable."

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 spent their day as they wished and they were free to relax in their bedroom whenever they wanted.

A person said, "I do what I want, when I get up and go to bed is up to me. Things are relaxed here."
• People were also supported to pursue their hobbies and interests. There were three activities coordinators who invited people to participate in a number of small group activities. These included gentle exercises, crafts and gardening. The activities coordinators also provided people with individual support to enjoy activities such as reading the newspaper, puzzles and nail care. There were entertainers who called to the service to play music and to support people to enjoy singing. A person said, "There's something going on pretty much every day and you can choose to join in or just watch."
• People were supported to keep in touch with their families. With each person's agreement the service manager and team leaders contacted family members to let them know about any important developments in the care being provided. In addition, the service had an internet connection and so people could use emails and other media platforms to keep in touch with their families. A relative said, "I like the staff keeping in touch with me and I like how they're very welcoming whenever I call to the home."

Requires Improvement

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question remains as Requires Improvement. This meant the service management and leadership was inconsistent . Leaders and the culture they created did not always support the delivery of high quality, person-centred care.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At the last inspection the registered persons had failed to establish robust systems and processes to operate, monitor and evaluate the running of the service so that people consistently received safe care and treatment. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements had been made to address each of the shortfalls we identified at the last inspection in relation to regulation 17. Previously, audits had not been effective in ensuring hot water taps were temperature-controlled to a safe level, care staff were given enough written guidance about how to safely assist people and a new item of fire safety equipment had been installed. Although new quality checks had ensured that these matters had been put right, at this inspection there were additional shortfalls that meant the registered persons were still in breach of regulation 17.

• The registered persons had not established all the systems and processes that were necessary to operate, monitor and evaluate the operation of the service. Although quality checks had been completed of key aspects of the service they had failed to identify and quickly resolve the new shortfalls we have already listed in our inspection report. These shortfalls included reducing avoidable risks to people's health and safety, the management of medicines, preventing and controlling infection and ensuring the competency of care staff. Also included were the maintenance of the accommodation, the provision of person-centred care and the provision of accessible information.

Failure to have robust systems and processes to operate, monitor and evaluate the running of the service was a continuing breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People and their relatives considered the service to be well run. A person said, "It is quite sorted really as the staff are here, the meals arrive and things tick along." A healthcare professional said, "The new manager has made a noticeable difference to standards of care, staff morale, and support for families. I have always found care to be very good."
• Care staff had been provided with policies and procedures that were designed to help them to consistently provide people with the right assistance. This included updated information from the Department of Health

about the correct use of use of equipment, medical devices and medicines.
• There was a senior member of staff on call during out of office hours to give advice and assistance to support staff.
• Care staff had been invited to attend regular staff meetings to develop their ability to work together as a team. Records showed that at recent meetings they had discussed important subjects such as each person's changing needs for care.
• Care staff said there was an explicit 'no tolerance approach' to any member of staff who did not treat people in the right way. Care staff were confident they could speak to the service manager if they had any concerns about people not receiving safe care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and their relatives had been offered the opportunity to comment on their experience of using the service. There were regular residents' and relatives' meetings at which people had been invited to suggest improvements to the service.
• People and their relatives had also been invited to complete questionnaires to give feedback about the service. There was a 'bright ideas' book where people and their relatives could make suggestions about the development of the service. In addition, we saw two of the activities coordinators chatting with people on a one to one basis to receive feedback about their experience of living in Ashcroft Nursing Home.
• Records of the residents' and relatives' meetings and analysis of the questionnaires showed that people had been generally positive in their assessment of the service. There were examples of suggested improvements being implemented such as changes being made to the menu so that it better reflected people's changing preferences.
• The service subscribed to a social media platform that can be used by anyone to submit anonymous feedback of their experience of using the service. We examined the posts on the website made during 2019. All the contributions were positive about the care and facilities provided in the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 service manager had worked in the service since February 2018 and had taken over from the former registered manager in July 2018. In that time the service manager had developed a vision for the service. As a result they had made a number of positive changes. An example of this was the creation of a 'relatives' room' that was a private space in which visitors could meet with people living in the service. Another example was the emphasis placed upon receiving and acting upon feedback. During the inspection visit the service manager took notes and used these to respond to our concerns.
• The service manager had established a positive culture in the service in which care staff considered themselves to be valued employees. All the care staff appreciated the way the service manager took a personal interest in their well-being. A relative said, "This isn't a miserable place at all. The staff obviously get on together and the manager isn't stuck in their office. They're always out and about and easy to talk to. The manager's got a lovely manner."
• The service manager and operations manager understood the duty of candour requirement. This requires them to be honest with people and their representatives when things have not gone well. They had consulted guidance published by the Care Quality Commission and there was a system to identify incidents to which the duty of candour applied. This helped to ensure that people with an interest in the service and outside bodies could reliably be given the information they needed.
• It is a legal requirement that a service's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The registered persons had

conspicuously displayed their rating both in the service and on their website.
• Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. This is so that we can check that appropriate action has been taken. The service manager had submitted notifications to Care Quality Commission in line with our guidance.

Working in partnership with others
• The service worked in partnership with other agencies to enable people to receive 'joined-up' support. The service manager and operations manager subscribed to a number of professional publications relating to best practice initiatives in providing care for people who live with dementia.
• This had supported the service to run special training both for its own care staff and for care staff based in other services. The training involved using tools to help care staff better appreciate how people living with dementia often manage with reduced physical senses and comprehension. Also, relatives were offered the opportunity to learn more about dementia. This helped them to better understand how people living with dementia can be supported to experience their lives in a positive way.
• Another example was the service manager and operations manager knowing about important changes being made to the strengthen the provision made to ensure people only receive support that is lawful and the least restrictive possible. This had enabled the service to anticipate the changes and ensure that the service was ready to implement them.

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 9 HSCA RA Regulations 2014 Person-centred care The registered persons had failed to provide person-centred care that consistently promoted people's dignity and respected their right to privacy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to provide safe care and treatment to reduce risks to people's health and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered persons had failed to provide premises and equipment that was designed, adapted and decorated to meet people's needs and expectations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to put in place robust systems and processes to operate, monitor and evaluate the running of the service.