Cedars Care Group Limited

Ashcroft House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 19 October 2016 and was unannounced.

Ashcroft House Nursing Home provides accommodation and nursing care for up to 31 older people. There are gardens to the front and the rear of the premises. A large car park area is located at the front. The service is located close to the centre of Formby and near to Formby train station

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe at the home. Each care file included a dependency tool to calculate the level of need for each individual. This was used to inform staffing levels to ensure there were sufficient staff on each shift. There were enough staff on the day of the inspection.

The recruitment process was robust to help ensure suitable staff were employed at the service. Appropriate policies were in place with regard to safeguarding and whistle blowing. Staff had received training in safeguarding and those we spoke with were aware of the issues and confident of the reporting procedure.

Medication systems were robust and medicines were managed safely at the service. Individual and general risk assessments were in place. Equipment was fit for purpose and was regularly serviced and maintained to ensure it was in good working order.

The induction programme helped ensure new employees were equipped with the skills, knowledge and competence to work at the home. Training was on-going and mandatory training was refreshed regularly.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA). Deprivation of Liberty Safeguards (DoLS) authorisations were in place where required and staff were aware of the implications of these.

People's nutritional and hydration needs were assessed and recorded appropriately. Special diets were adhered to by the chef and people were given choice with regard to meals.

People we spoke with felt the care was good and staff were kind and caring. We observed good interactions between staff and people who used the service throughout the day. People who used the service and their families were involved in discussions about the delivery of their care. Staff respected people's dignity and privacy.

People who were nearing the end of their lives were cared for, as far as possible, in accordance with their wishes. Staff had undertaken appropriate training in end of life care and people's end of life care plans were thorough and comprehensive.

Care files we looked at evidenced that care was delivered in a person centred way, taking into account people's preferences, likes and dislikes. People we spoke with said staff responded quickly to call alarms. There was a programme of activities at the home and people were encouraged to participate if they were able to. Some one to one interaction was undertaken with people who were unable to participate in group activities.

There was an appropriate complaints policy and this was displayed throughout the home. Concerns were responded to in a timely and appropriate manner and the service had received a number of compliments and thank you cards.

People told us the staff and management were approachable. Staff felt the manager was supportive towards them. Regular team meetings were held, and staff were given supervisions on a regular basis. Residents' and relatives' meetings were also held.

We saw evidence of regular checks and audits that took place at the service to help ensure continual improvement with regard to care delivery.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe at the home. A dependency tool was used to calculate the level of need for each individual and help ensure sufficient staff were on duty.

The recruitment process was robust and appropriate policies were in place with regard to safeguarding and whistle blowing.

Medication systems were robust and medicines were managed safely at the service. Individual and general risk assessments were in place.

Is the service effective?

Good

The service was effective.

The induction programme helped ensure new employees had the right skills and knowledge to work at the home. Training was on-going and mandatory training was refreshed regularly.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional and hydration needs were assessed special diets were adhered to.

Is the service caring?

Good

The service was caring.

People we spoke with felt the care was good and staff were kind and caring. We observed good interactions between staff and people who used the service throughout the day.

People who used the service and their families were involved in discussions about the delivery of their care. Staff respected people's dignity and privacy.

Staff had undertaken appropriate training in end of life care and

people's end of life care plans were thorough and comprehensive.

Is the service responsive?

Good

The service was responsive.

Care files evidenced that care was delivered in a person centred way and people we spoke with said staff responded quickly to call alarms.

There was a programme of activities at the home one to one interaction was undertaken with people who were unable to participate in group activities.

There was an appropriate complaints policy and concerns were responded to in a timely and appropriate manner.

Is the service well-led?

Good

The service was well-led.

People told us the staff and management were approachable and staff felt the manager was supportive towards them.

Regular team meetings staff were given supervisions were held and there were residents' and relatives' meetings.

We saw evidence of regular checks and audits that took place to help ensure continual improvement with regard to care delivery.

Ashcroft House Nursing Home

Detailed findings

Background to this 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 was planned to check whether the provider is 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.

The inspection took place on 19 October 2016 and was unannounced. The inspection was undertaken by two adult social care inspectors from the Care Quality Commission (CQC).

Before this inspection we reviewed the previous inspection report and notifications that we had received from the service. Prior to our inspection we were provided with a provider information return (PIR); this is a document that asked the provider to give us key information about the service, what the service does well and what they improvements they are planning to make.
We reviewed all of this information to help us make a judgement about this service.

During our inspection we looked around the building. We spoke with the registered manager, the nurse on duty, three care staff and the cook. We spoke with three people living at the home and with two relatives.

We looked at records at the service, including four people's care records and records relating to the management of the service including policies and procedures, maintenance, quality assurance documentation, staff training, supervision and appraisal records and the complaints file.

Good

Is the service safe?

Our findings

People told us they felt safe at the home. One person said, "I do feel safe and well looked after. All the staff are very kind and caring. I have no worries or concerns". Another told us, "The girls [staff] are marvellous. They do everything they can to make sure I have everything I need. I know I am safe living here". One relative told us, "My [relative] is well looked after. I have peace of mind knowing that [relative] is safe; there are some not very nice people out there and I worried about [relative] living alone. I have no worries or concerns about the care [relative] receives". Another relative said, "Safety is important. [Relative] is safe", and a third told us, "[Person] is safe and secure at the home".

We looked around the home including bedrooms, communal areas, bathrooms and toilets. We found the premises to be clean and fresh and there were no unpleasant odours. One person told us, "I have nice room with all my own belongings, I like to spend most of my time in my room".

Each individual care file included a dependency tool. This was a tool used to calculate the level of dependency of the person to be used to inform staffing levels. We saw that staffing levels were sufficient to meet the needs of the people who currently used the service, including the registered manager, a nurse, five carers, the activity coordinator and the cook. The registered manager told us they brought in extra staff if the needs of a person who used the service deteriorated and they required more assistance. We spoke with the nurse and three care staff and none of them felt more staff were required. People who used the service also felt staffing levels were sufficient to meet people's needs.

We looked at three staff personnel files and saw a safe system of recruiting was in place. The recruitment procedures were robust to help protect people who used the service from being cared for by unsuitable people. The staff files contained proof of identity, an application form that documented a full employment history, a medical questionnaire, job description and two written references. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with vulnerable adults and informs the provider of any criminal convictions against the applicant.

The service had appropriate safeguarding and whistle blowing policies. Staff we spoke with had undertaken training and were aware of the procedures and were confident to use them if a concern came to light. We looked at the way the service dealt with safeguarding concerns. There had been one recent concern, which was regarding a medication error. We saw that there had been a thorough investigation and the service had followed up with actions, including extra staff training and a staff meeting to discuss the concern.

Care files included appropriate individual risk assessments relating to areas such as nutrition, falls and moving and handling. Falls, accidents or incidents were monitored to look for patterns or trends which could be addressed by the management. Call alarm use had been assessed and contingency plans were in place for those who were unable to use an alarm, such as checking on them regularly and anticipating their requirements.

We saw records and risk assessments were in place for all areas of the general environment and policies

were in place for ensuring compliance with health and safety regulations. We saw that equipment had been serviced in line with the manufactures' instructions. We saw systems were in place in the event of an emergency for example utility failures and other emergencies.

There were personal emergency evacuation plans (PEEPS) in place, so that people's individual needs in an emergency would be known. There was a central PEEPS file near the entrance to the home for easy access. Audits were undertaken around cleaning and maintenance and any issues identified were followed up appropriately. This was confirmed by the documentation we looked at.

Infection control policies and procedures were in place and regular infection control audits were undertaken and infection control training was included in the staff training programme. We saw staff wore protective aprons and disposable gloves for different tasks including when carrying out personal care. Liquid soap and paper towels were in communal bathrooms and toilets. This helped prevent the spread of infection. There was a first aid box located in the activities room. We saw records of regular checks of the contents, which were complete and up to date.

We looked to see how the medicines were managed. The service used the Biodose system. This is where medication is stored in a pod. Each pod contained either tablets or liquid. There was photographic identification on the front of each person's tray, this helped minimise medication mistakes. We saw medication was checked before being offered to people and then recorded on the individual's medication administration record sheet (MARs). We saw that medicines including controlled drugs were securely stored. Controlled drugs were recorded in the controlled drugs register and these had been signed and countersigned when administered. The home had a clinical lead nurse who was responsible for the ordering and disposal of medication.

There was a guide to the different consistencies used with thickening agents to help ensure staff were aware of how to make up thickened drinks. Allergies were clearly recorded in people's care records.

Good

Is the service effective?

Our findings

People spoken with told us the staff had the right skills and experience to meet their needs. One person told us, "I am really well cared for; the girls help me with all my personal care, they are great".

The registered manager told us that prior to people moving into the home they completed a comprehensive assessment to ensure staff could meet the individual needs of people and that all the necessary equipment required was in place.

We saw that on commencing work at the home all newly employed staff completed an induction programme. It contained information to help staff understand what was expected of them and their roles and responsibilities. We also that a training matrix was in place to ensure that staff received the essential training to equip them to safely care and support people who use the service. Staff members we spoke with told us training was on-going and mandatory training was regularly refreshed.

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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that capacity was assessed for each decision required and appropriate documentation was kept in the care files. DoLS applications had been made appropriately and documentation was in place. Staff we spoke with had undertaken training in MCA and DoLS and they demonstrated an understanding of the principles and application of MCA and DoLS.

We saw, within the care files we looked at, that consent or agreement documents had been signed, where possible, by the person who used the service. These related to the use of bedrails, photographs and agreement to the care and treatment provided. If the documents had been signed by someone else there was an explanation of why this was, for example, if the relative had Lasting Power of Attorney (LPA) and therefore had the authority to sign on an individual's behalf. Appropriate paperwork relating to LPAs was kept in the files.

We asked staff how they gained consent for care interventions from people who used the service. They told us they always asked, if the person had capacity. If not, they would use non-verbal communication, such as body language and facial expression to ascertain whether people were accepting or not. They explained how they gave simple choices to people who lacked capacity, so that they still had some control over their

lives.

Do not attempt cardiopulmonary resuscitation (DNAR) forms were in people's care files and included clear documentation about whether the individual had been involved in discussions about this. If they had not been included, the reasons for this were documented and decisions had been made in consultation with the appropriate people to help ensure the decision was in the person's best interests. There were discreet markings on people's doors to alert staff to whether or not they had a DNAR in place, a red dot for an agreed DNAR and green dot if the person required resuscitation.

People's nutritional and hydration requirements had been recorded within their care files and their risk of malnutrition or dehydration assessed. Appropriate referrals to other agencies, such as dieticians, had been made in a timely manner if required.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We spoke with the chef, who had a good understanding of people's likes and dislikes. The chef was aware of any special diets required for example pureed or soft diets. The chef told us they were updated daily by staff on any changes to people health and wellbeing and if they required any changes to their diet. The chef was able to tell us how they fortified food for people who needed a high calorie diet. We saw there were sufficient supplies of fresh and dried food in the kitchen.

We saw each person had a jug of water in their room and refreshments could be made at any time of the day in the activity room. We looked at the menus and saw that choices were available at each meal. Alternatives were also available. The chef spoke with each person and asked what they would like to eat. One person requested pasta which was not on the menu that day. We observed the chef speaking to this person asking what sauce they would like on their pasta. This was to be served with garlic bread and a glass of wine as was this person's request. People who used the service told us the food was "excellent" and there was plenty of it.

The kitchen was clean and well organised. The chef had audits of fridge temperatures and cleaning schedules. The home had a 5 Star rating from the food standards agency which is the highest attainable rating.

Records were completed after meals to monitor food and fluid intake. All people living at the home had a food and fluid assessment by the Speech and Language Therapy (SALT) team in relation to the risk of inadequate nutrition and hydration. These were in place as the home was caring for very frail and poorly people and monitoring was an essential part of their daily care.

Good

Is the service caring?

Our findings

We spoke with three people who used the service and two relatives. One person who used the service said, "It is very nice. The carers are all very good". A relative told us, "[Relative] has settled well and gets good care. I ask my relative when I take [them] out if [they] are happy and the answer is yes. There is also a good call bell response". Another visitor commented, "I have heard staff being really nice when they didn't know I was there. The girls [staff] are very approachable. If I ask anything it is dealt with straight away." A third visitor said, "Generally speaking the care is excellent. All staff are fantastic, nothing is too much trouble". Other comments included; "All the staff are lovely, they work so hard", and, "I couldn't ask for better care".

We saw people looked well groomed, well cared for and wore clean and appropriate clothing. Ladies had their hair done and gentlemen were clean shaven. We noticed that attention had been given to nail care.

Discussions with staff showed they had a good understanding of the needs of the people they were caring for. Staff told us they helped and supported people to maintain their independence. We found the atmosphere within the home was friendly and relaxed. There was a respectful rapport with staff and people who used the service and conversations were friendly and warm and staff provided care with kindness and compassion.

We saw that the staff respected and attended to people's needs discreetly, ensuring dignity and privacy was respected. Staff knocked on people's doors and waited to be invited in. Doors were closed when personal care was being given and staff members explained what they were doing. Staff we spoke with understood the need for dignity and privacy and were able to explain how this was respected.

We saw records within the care files of discussions held with families, helping ensure people close to the person at the home were kept fully involved and informed with regard to the individual's care. The files included family insight documents and evidence of lots of family involvement.

We asked the registered manager to tell us how staff cared for people who were well ill and at the end of their lives. They told us that staff had undertaken the Six Steps end of life training. This is the North West End of Life Programme for Care Homes. This means that for people who are nearing the end of their life can remain at the home to be cared for in familiar surroundings by people they know and could trust. The staff were still accredited with this but were now working towards the Gold Standards Framework (GSF) which is also an accredited national training programme for end of life care. All individuals at the home had a GSF coding within their care files. This coding indicated how close to the end of life the person was to help ensure that staff were aware of each individual's status. The coding was reviewed on a monthly basis as people's status could change.

We saw that there was information included in the care files about people's preferences when they were nearing the end of their lives, if they had wished to include this. We saw for one individual who was nearing the end of their life, the individual plan of care. This was thorough and included family information, assessments and plans relating to pain, interventions, psychological needs, spiritual and cultural needs,

food and drink, comfort and dignity and elimination.

We observed that some people were very poorly and were cared for in bed. We saw these people were warm and comfortable and appropriate beds and mattresses were in place. We observed that throughout the day staff checked on these individuals regularly to ensure their comfort. We were told that the home had an end of life champion who shared their knowledge with other staff.

Good

Is the service responsive?

Our findings

People spoken with told us that staff responded well to their needs. One person told us, "If I press the buzzer for assistance, they [staff] come as quickly as possible; I never have to wait long". Another relative spoken with said, "If my [relative] is not feeling well the girls [staff] would contact my doctor and arrange a visit, they're good like that. They keep us informed at all times, communication is good".

The care files we looked at included a range of health and personal information and were person centred. There was a document included entitled, "All about me" which included personal preferences, social history, family background and a range of other individual information. This helped staff understand the person they were caring for better. People's preferences for times of rising and retiring were clearly recorded and people told us they were given the choice of when to get up and go to bed. They also said they were offered drinks throughout the day and could choose what meals they wanted. We saw people make those choices at lunchtime. Care plans were reviewed on a monthly basis and updated as required. The ones we looked at were complete and up to date.

We asked about a transfer document, sometimes known as a hospital passport, which goes with people if they are admitted to hospital from the home. This document includes a range of health and personal information to help ensure the right care is administered. The registered manager told us that work was underway to include a hospital passport in each file, but these had not yet been completed.

We looked to see what activities were provided for people. The activity programme was displayed. Activities included outings, for a few people at once, to the local pub for lunch, entertainers, nail care, gentle exercises, arts and crafts and baking. For some people who may not be able to partake in activities one to one chats and were invaluable.

Staff told us they had enough equipment to meet people's needs. This included wheelchairs, walking aids and hoists. Suitable adaptations were in place such as grab rails and assisted bathing facilities to help promote people's safety, comfort and independence.

There was an appropriate complaints policy in place and this was displayed prominently around the premises. A relative told us that they had raised a minor concern and that an apology had been given and the concern had been dealt with immediately. Another visitor told us, "Concerns are dealt with by the registered manager".

We saw that the service had received a number of compliment cards from relatives thanking the registered manager and staff for their kind, compassionate care and support provided to their relatives during their stay at Ashcroft House.

Good

Is the service well-led?

Our findings

The home had a registered manager who had been in post for several years. The registered manager confirmed that they were supported by the provider who was in regular contacted with the service.

We asked people who used the service whether the staff and management were approachable. All said they were. One relative told us, "Everyone is helpful, the registered manager is great. [Registered manager] runs a tight ship. She makes it look easy but keeps a tight rein on things". Another said, "[Registered manager] could be approached if need be".

Staff spoken with spoke positively about working at the home and that they were supported by the management team. One member of staff told us the staff turnover was low with some staff having worked at the home for a number of years. This helped to provide continuity of care for people living at the home.

We were told that formal team meetings and residents meetings were held. Minutes of the meetings were available. The registered manager operated an 'open door' policy at the home so that people could approach them at any time.

One staff member we spoke with said, "Regular supervisions are helpful. Concerns can be aired. We have staff meetings and these also support us". Another staff member said, "We are supported well, there are lots of people to go to". A third staff member commented, "The manager is supportive in our jobs and the team are also very supportive to each other".

We asked the registered manager to tell us how they monitored and reviewed the quality of the service to ensure that people received safe and effective care. We were told that regular checks were undertaken on all aspects of the running of the home. We were provided with evidence of some of the checks that had been undertaken, for example medication records, care plans, infection control and environmental checks. We saw that where improvements were needed, action was identified and timescales for completion recorded. All audits we looked at were complete and up to date.

We saw maintenance checks for the service including fire equipment, gas and electrical, lift and hosts and small portable appliances had been undertaken and certificates were valid and in date.

We checked our records before the inspection and saw that accidents and incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by the management to ensure people were kept safe.

Handover meetings were undertaken at the start of each shift to help ensure that staff coming on duty were fully updated on any changes in a person's condition and subsequent alterations to their care plan was properly communicated and understood.

We saw the results of quarterly customer satisfaction surveys, completed by people's relatives. These

indicated a high level of satisfaction with the staff, communication, cleanliness, activities and service provided. We saw that 80% of the relatives were satisfied and 20% impartial. Comments included; 'Would be good to get regular updates, perhaps quarterly or every six months'; 'My [relative] spent two weeks in Ashcroft House before passing away. The staff could not have been more sensitive or caring'; 'Quite satisfied with the services provided'.