Continuum Healthcare Limited

Ashcroft 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

We inspected Ashcroft Nursing Home (known to people using the service, their relatives and staff as Ashcroft) on 15 and 17 January 2018. The first day of inspection was unannounced. This meant the home did not know we were coming.

Ashcroft is registered to provide nursing and residential care for up to 40 people. When we inspected, 34 people were using the service. It consists of one building with three floors accessed by two passenger lifts. The majority of rooms are single with ensuite facilities. In one part of the ground floor there is a communal lounge and dining area within a large conservatory which has access to an outdoor paved seating area. A separate unit for up to six people living with dementia called Terrace Way is also located on the ground floor; this has an enclosed garden area with seating.

Ashcroft is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

At the last inspection we rated the home as 'Requires Improvement' in four of the five key questions and overall, and as 'Inadequate' in the key question of well-led. We identified breaches of the regulations relating dignity and respect, staffing, consent, safe care and treatment, and good governance. As a result, we served the registered provider with three warning notices and two requirement notices.

Following the last inspection, we met with the provider to discuss the improvements required at Ashcroft. They provided an action plan to show what they would do and by when to improve all the key questions to at least good.

Ashcroft had a registered manager. At the time of the last inspection in June 2017 she was on extended leave; at this inspection the registered manager was back in post. 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.'

Risks to people were assessed and managed. Hoists were serviced but not subject to 'thorough examination' as required by Lifting Operations and Lifting Equipment Regulations 1998. Action to minimise Legionella risk was lacking.

Most feedback from people, their relatives and staff about staffing levels at Ashcroft was positive. Some concerns were raised about the staffing of Terrace Way; we fed these back to the registered manager and she immediately implemented a solution.

Medicines were managed and administered safely. This was an improvement from the last inspection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Records showed staff access to training and supervision had improved since the last inspection. Staff we spoke with told us they felt supported.

Feedback about food and drinks at Ashcroft was positive. People were given choices at each meal and the cook knew the specific dietary needs of individuals.

A system of communication was in place at the home to facilitate team-working. People were supported to meet their wider health needs. Care and treatment provided was based upon established evidence-based good practice.

People told us staff were caring and respected their privacy and dignity. All interactions we observed during this inspection were polite and supportive. This was an improvement from the last inspection.

People and their relatives were involved in planning and reviewing the care and treatment people received. The service supported people to meet their diverse needs.

Care plans at Ashcroft had been improved. We saw they contained person-centred detail and had been reviewed and updated regularly. People had care plans containing information about their communication needs in line with the Accessible Information Standard.

Care workers were now responsible for providing activities at the home. We saw a range of activities were ongoing during the inspection and feedback from people and staff was positive.

No complaints had been made since the last inspection. People and their relatives told us they felt able to complain if they wanted to.

People had end of life care plans in place. Staff were knowledgeable about end of life care and feedback we saw from relatives of people supported at the end of their lives was positive.

A system of checks and audits was in place to monitor safety and quality at the home. This had led to improvements, although failed to identify gaps in safety checks.

Feedback about the registered manager, nominated individual for the registered provider and other senior staff at the home from people, their relatives and other staff was positive.

People and staff were asked for feedback and ideas on how to improve the service.

The service learned lessons went things went wrong, and sought to improve using good practice and by partnership working.

We found one breach of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

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.

Risks to people had been assessed and managed. Action to minimise some risks posed by the building and equipment had not been taken.

Improvements had been made to the administration and management of medicines since the last inspection. Systems were now safe.

Sufficient staff were deployed to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff were supported with training and supervision to provide effective care and treatment.

The service was compliant with the Mental Capacity Act 2005.

People were supported to maintain and promote their wider health needs and access a range of healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

People and their relatives described staff as kind and caring. We observed only positive interactions during this inspection.

People told us staff respected their privacy. Staff supported people to retain their dignity and independence.

The service promoted an open culture whereby people's equality and diversity was respected.

Is the service responsive?

Good

The service was responsive.

People's care plans contained person-centred detail. We saw they had been reviewed and updated regularly.

Staff supported people to engage in a range of activities.

No formal complaints had been made since the last inspection. People and their relatives said they knew how to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A system of audit was in place at the home, however, it had failed to identify and address risks posed by the building and equipment used.

Much improvement had been made since the last inspection. Ideas were sought from people and staff about how to make the service better.

The registered manager was keen to learn from mistakes and use good practice to make improvements to the service.

Ashcroft 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.

This inspection took place on 15 and 17 January 2018. The first day was unannounced. The inspection team consisted of two adult social care inspectors on the first day of inspection, and one adult social care inspector on the second day.

We did not ask the provider to complete a Provider Information Return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included the local authority safeguarding team, the local authority infection prevention and control team, Healthwatch Kirklees and the Clinical Commissioning Group. They did not share any information of concern. During the inspection we spoke with two healthcare professionals who visited the home regularly and spoke with one other by telephone after the inspection.

During the inspection we spoke with seven people who used the service, six people's relatives, five members of care staff, the registered manager, the lead nurse, and a cook. After the inspection we spoke with a director for the registered provider.

We spent time observing care in the communal lounges and dining rooms to help us understand the experience of people using the service who could not express their views to us.

As part of the inspection we looked at four people's care files in detail and selected care plans from two other people's care files. We also inspected three staff members' recruitment documents, staff supervision and training records, four people's medicines administration records, accident and incident records, and various policies and procedures related to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Ashcroft. One person said, "I was falling a lot before I came here but I've not fallen at all since I've been here." People's relatives told us they thought their family members were safe. Comments included, "Oh yes, I know [my relative's] safe. I know all the staff", and, "I think [my relative's] safe, yes." A third relative described how the home had placed a sensor mat as a safety precaution in their relative's bedroom after they had experienced a fall.

Care staff we spoke with could describe the different forms of abuse people at Ashcroft might be vulnerable to. All said they would report any concerns appropriately and whistle-blow if they needed to. Records showed any incidents of abuse between people using the service had been recorded, managed and reported correctly. This meant measures were in place to ensure people were safeguarded from abuse.

At the last inspection in June 2017 we identified a breach of the regulation relating to safe care and treatment as risks to people had not always been assessed and minimised. At this inspection sufficient improvement had been made to resolve the breach in regulation.

People had personal emergency evacuation plans in place; these were held in a central location which was easily accessible. People's care files contained assessments for their risk of falls and malnutrition, and to their skin integrity. Those using air mattresses to reduce their risk of pressure ulcers had the correct settings identified on the mattress pumps and in their care plans; records showed these were checked regularly. People's care plans also described the equipment and support they needed to move and mobilise safely.

During the inspection we observed care staff supporting people to reduce risk. For example, we saw one person with swallowing problems received modified food and fluids to reduce their choking risk, and people who needed pressure cushions to reduce their pressure ulcer risk had them placed in their wheelchairs or on chairs throughout the day. This meant improvement had been made to risk assessment and management relating to people's care and treatment.

Records showed most checks to ensure the safety of the building's facilities, utilities and equipment were made as required. This included the gas and electrical supply. Fire safety procedures were also in place and staff we spoke with could describe what action they would take if the fire alarm sounded. However, we did identify gaps in safety checks and actions to reduce Legionella risk at the home. In addition, checks made on lifting equipment were not in accordance with Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), in that hoists had been serviced on a six-monthly basis but not subject to 'thorough examination' as is required.

This was a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the registered manager told us Legionella checks in accordance with Health and Safety Executive Legionella guidance would be implemented immediately. We will check at the next

inspection. After the inspection we received confirmation hoist thorough examinations had been completed for all relevant equipment.

People and their relatives told us the home was clean. One person said, "It's very clean everywhere", and a relative commented, "It's really clean. There's never any smells." We found the home to be clean and odour-free throughout this inspection and observed domestic staff cleaning on both days.

Most feedback about staffing levels at the home was positive. Three people and four relatives told us there were enough staff deployed; one person said, "I don't have to wait", and a relative commented, "When [my relative] presses the buzzer staff come in a few minutes." A second relative replied, "There do seem to be plenty (of staff)." Two people felt there were not enough staff, however, they told us that despite staff being busy they responded quickly when each person asked for support and only occasionally asked them to wait. All staff we spoke with told us they thought sufficient staff were deployed to meet people's needs, although a healthcare professional who supported people using the service said they sometimes struggled to find a staff member to speak with about people's needs when they visited at mealtimes.

One relative said of Terrace Way, the six-bedded unit for people living with dementia, "I don't think one staff is enough sometimes", and a second relative said, "There's usually only one (care worker) in there. It can sometimes be a bit busy. They can ring for more (care staff) if they need to. I don't have concerns."

At the last inspection we raised concerns that the single care worker deployed on Terrace Way struggled to meet people's needs on their own at busy times. We saw at other times people's needs were met. Since then, care workers had been issued with a walkie-talkie and advised to call for support if they needed it. During this inspection we observed three people were unsupported for 20 minutes when a care worker was helping a person to get up, although a member of domestic staff was around. The registered manager advised us the care worker should have requested support in this instance. She also said she would change staffing arrangements on Terrace Way in response to our feedback such that a member of domestic staff who was also a trained care worker, would clean in communal areas during busy times on the unit. This would ensure care staff could be alerted if people needed support when the care worker allocated to the unit was with another person. On the second day of this inspection we observed this arrangement was in place; the care worker and domestic worker on duty told us they felt it was a good solution.

We checked staffing rotas and the home's dependency tool for calculating staffing levels, and made observations in communal areas as part of this inspection. We concluded sufficient care staff were deployed to meet people's needs.

Records showed a system of checks was in place for prospective new employees to the service. This included sourcing references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions. We did note employees' application forms and CVs did not always detail the months they were employed in other roles, but included years only. We fed this back to the registered manager who said she would amend the home's record of interview form to ensure this information was obtained in future, if required. We will check at the next inspection.

At the last inspection in June 2017 we identified a breach of the regulation relating to safe care and treatment due to concerns about the way medicines were administered, stored and recorded. At this inspection sufficient improvement had been made to resolve the breach in regulation.

People told us they received their medicines when they needed them. Medicines were now stored in people's rooms in locked cabinets, except for those controlled by misuse of drugs legislation. The registered

manager told us this meant people could be supported to take their medicines in private in a more person-centred way. We observed a medicines round and checked medicines management records. We found a safe system was now in place for the ordering, administration and return of people's medicines. Temperature checks were made to ensure medicines were stored correctly. People's medicines administration charts evidenced they received their medicines as prescribed; this included those to be taken at a set time before food.

At the last inspection we raised concerns about records relating to the application of people's topical creams. At this inspection we noted gaps in some people's medicine administration records (MARs) for their topical creams. When we checked people's rooms we found part-used creams and people we spoke with told us staff helped them apply their topical creams. The registered manager showed us daily care records which evidenced care staff applied people's creams; she said care workers had signed these records but had not always signed people's MARs for their creams as well. To remedy this, the registered manager changed the system such that both records were kept together, thereby prompting care workers to sign both. This meant medicines management and administration at Ashcroft was now safe.

The service learned lessons and had made improvements after things had gone wrong. Records showed changes had been made to security arrangements after a person went outside via a fire door in the night and an alarm did not sound. Fire door alarms were now checked daily by night staff when they came on duty. One person had developed a wound which staff had been unaware of, as the person managed their own personal care. Records showed changes had been made to raise staff awareness and minimise this type of concern happening again. The registered manager told us, "I felt we needed to learn from it and change our practice."

Good

Is the service effective?

Our findings

People and their relatives told us staff had the skills and training they needed to provide effective care. One person said, "Oh they (staff) are definitely well trained", and a second told us, "All know what they are doing." Comments from relatives included, "The nurses know what they're doing. They're (people) well monitored", and, "I've no concerns about that (the level of staff training)."

At the last inspection in June 2017 we identified a breach of the regulation relating to staffing as staff did not always receive adequate support in terms of training and supervision. This was due to the registered manager's period of extended leave. At this inspection we found sufficient improvement had been made to resolve the breach in regulation.

The home's training matrix showed staff were now up to date with courses deemed mandatory by the registered provider. These included fire safety, medicines administration, infection control, moving and handling, food hygiene, and safeguarding. Staff told us they attended training and could request further training if they needed it.

Care staff reported increased access to supervision with a manager since the last inspection and told us they felt supported in their roles. Records showed all staff had received at least two supervision sessions since the last inspection. One care worker said the registered manager had told them they were doing well, they told us, "Makes me feel I'm doing a good job." At the time of this inspection staff had been sent self-assessment documentation in preparation for planned appraisals. This meant staff were supported to provide effective care.

At the last inspection in June 2017 we identified a continuous breach of the regulation relating to consent as people thought to lack mental capacity to make decisions had not been assessed in accordance with the Mental Capacity Act 2005 (MCA). At this inspection sufficient improvement had been made to resolve the breach in regulation.

The 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards or 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.

At this inspection we found people thought to lack capacity to make all their decisions had been assessed for their capacity, and any decisions made on their behalf in their best interests were fully documented.

Records showed which people's relatives or friends had been granted lasting power of attorney (LPA) and their role in deciding people's care and treatment. This meant the service was now compliant with the MCA and we saw people were supported in the least restrictive way.

Feedback about food and drinks served at the home was positive. One person said, "I love the food – we have fish and chips on Friday", and a second person told us, "The food is excellent." Relatives also said the food was good at the home. Comments included, "I think the food's quite good. It's varied. [My relative] gets a full (cooked) breakfast every day", "It (the food) looks and smells nice", and, "[My relative] always compliments the food."

During the inspection we observed three mealtimes. We saw people were served food from dishes on the dining tables or could help themselves to more if they wished to. People were provided with choices at each meal. The cook told us people asked for preferences in advance had often changed their minds, so they ensured people could see the options and choose when the food was served. Between meals people were asked if they would like drinks and snacks on a regular basis. We saw one person asking for a second cooked breakfast. When staff brought it for them the person commented to us, "It looks nice doesn't it?"

Records showed people who needed support to eat or food and fluids modified to make them safer to swallow received the right support. Checks were also made in the kitchen to ensure food was stored and served at safe temperatures. A four-weekly menu was in place with two options for each meal, although we saw people who liked neither option were served an alternative of their choice. The cook was knowledgeable about people's dietary requirements, including those who required a diabetic diet or foods that were fortified to promote weight-gain. This meant the service supported people to meet their nutritional needs.

People and their relatives told us people were supported to access a range of healthcare professionals in order to maintain their holistic health. One person said, "The staff go with you if you need to see the dentist or go to the hospital", and a relative commented, "They (staff) make all [my relative's] appointment for [them]." People's records evidenced they had accessed GPs, district nurses, dieticians, speech and language therapists and dentists. People's relatives told us they were always informed by staff if their family member had an appointment or if their health needs had changed. One relative said, "They notify us when [my relative] needs the optician or dentist", and a second told us, "They (staff) always comment if there's an issue and keep me informed." Feedback we received from healthcare professionals about Ashcroft was positive in terms of the relevance of the referrals made and their confidence that staff followed advice they provided. This meant people were supported to meet their wider health needs and the service communicated well with their relatives.

Various methods were employed at the service to enable and promote good communication and team-working within the staff team at Ashcroft. Handover meetings were held at the beginning of each shift between staff coming on and the nurse just finishing. We attended a handover provided by an agency night nurse who had never previously been to the home; we were impressed by the level of detail they handed over and their awareness of people's needs. We saw their handover sheet of people's details had been amended by the head of care to highlight people's specific needs, for example, which people needed medicines a set time before their breakfast. During handover we saw care staff made notes of any changes in people's needs or requirements for that day. A communication book was used to share other information about people or the service, in addition to a diary of people's healthcare appointments. This meant systems were in place to ensure staff worked well together to provide effective care.

Risk assessment tools such as those for malnutrition and pressure ulcers were in line with current best

practice guidelines. Where these showed risk, care plans were in place to minimise risk. For example, a person had a high score on a skin integrity risk assessment, indicating a high risk of pressure ulcers. The person's care plan included use of an electric profiling bed, a slide sheet and a sling for bathing. We saw these were in place and care staff we spoke with knew the care required for the person to prevent pressure ulcers. A high malnutrition universal screening tool (MUST) assessment had led to one person's referral to a dietician; we saw a plan was in place for the person to be weighed weekly and to receive a high calorie diet with prescribed nutritional supplements. Records evidenced all these measures were in place and the person's weight had increased in the months prior to this inspection. This showed people's care and treatment was delivered in line with evidence-based practice.

Ashcroft had been adapted to better meet the needs of people living there. The Terrace Way unit for people living with dementia had been designed and decorated according to good practice in dementia care. People's doors were different colours, flooring was neutral and picture signage was in place.

In the other part of the home a programme of redecoration and upgrading had been implemented since the last inspection in June 2017. The dining room now had a café look and a portable juice bar had been installed so people and relatives could help themselves to drinks. One relative said, "They've decorated and done certain things. It is improving", and a second said, "I think it looks better." Minutes of the residents' forum showed changes at the home had been discussed with people and they had been asked for ideas. People had asked for better lighting in the main conservatory area and more seating in the dining area. Both these requests had been actioned. The registered provider's next project was to upgrade the outside patio area to encourage people to spend more time outdoors.

Good

Is the service caring?

Our findings

People and their relatives described staff at Ashcroft as kind and caring. Comments from people included, "They are all kind, I have a joke with them", "They are great, all kind to me", "We always have a laugh", "Nothing is too much trouble", and, "They all seem very nice." One relative said of the staff, "They always seem pleasant and have time for [my relative]", and a second relative commented, "I must admit the staff are lovely. [My relative] seems very happy with the staff." A third relative said, "They're really compassionate and patient." One healthcare professional said of the staff, "There's a nice level of care and consideration. Staff have a nice way about them", and a second told us, "They seem very caring."

At the last inspection in June 2017 we identified a breach of the regulation relating to dignity and respect as we observed some interactions between staff and people which were disrespectful. At this inspection sufficient improvement had been made to resolve the breach in regulation.

The nominated individual for the registered provider told us he and the registered manager had worked hard with staff to change practice so that people were treated with dignity and respect. The nominated individual said he wanted staff to think of people as customers, rather than residents, so they would strive to provide people with the care they deserved. He said this meant, "Doing things on their (people's) behalf, rather than to them." People, their relatives and staff told us the nominated individual had been much more visible at the home since the last inspection and regularly took part in activities with people. The nominated individual told us they were a role model for staff, and said, "I'm really passionate about care and I want staff to see that."

During the inspection we observed many caring and supportive interactions between staff and people. We saw a care worker passing by a person entering a toilet ask politely, "Can you manage?" to which the person said they could but would call if they needed help. Another member of staff noticed a person seemed distracted and asked if they were OK. The person said they had misplaced a piece of correspondence and was worried it was important. We saw the care worker and the registered manager both took time to reassure the person and help them find the letter, which involved supporting the person to their room to look. The registered manager said to the person, "I don't want you to be worried about it for the rest of the day. I could see you were worried." A third person became confused and upset about the whereabouts of their mother. We saw a care worker sat down with the person and provided reassurance and distraction until they seemed happier and more settled. This meant staff anticipated people's needs and knew them well as individuals.

Staff at the home could describe people's likes, dislikes, preferences and personal histories. One relative said of the staff, "They know [my relative's] little idiosyncrasies and have built a rapport with [them]." We saw people's rooms were personalised according to their tastes. People and their relatives told us staff respected people's wishes. One person said they refused some care and although staff tried to persuade them, "They won't make me (do something they did not want to do)." A relative said of their family member's lifestyle choices, "[Their] decision is [their] decision and they (staff) respect that." We also noted staff gave people choices in order to promote their independence, such as where to sit, what to eat and

what activities to take part in. One person told us, "You can do what you like, within reason." Other people's care records showed where people had refused care and staff had respected their wishes. This meant people were in control of their lives at Ashcroft.

People and their relatives told us staff respected their privacy and promoted their dignity. One person said they could lock their bedroom door and staff always knocked and called their name before entering. Two people who preferred to spend time in their bedrooms said they chose not to lock the door but staff always knocked before entering. Relatives said their family members' were supported with personal care according to their preferences in order to maintain their dignity. One relative said, "[My relative] always looks tidy", and a second relative told us, "They do [my relative's] hair very week." A third relative described how staff understood and respected their family member's preferences for clothing and the support they liked with their facial hair. Throughout the inspection we saw people were offered aprons at mealtimes to protect their clothing if they wished. This meant staff helped people maintain their dignity and respected people's privacy.

People's care files evidenced their involvement in planning and reviewing their care. Records showed people's relatives had also been involved with people's permission or when people lacked capacity. We saw people had signed their care plans and during the inspection we observed a care worker sitting with a person and discussing their care needs with them. One person told us, "I can't remember seeing a care plan but they always do what I ask them to", and a second person said they had seen their care plan and had, "Probably signed it." Relatives we spoke with were satisfied with their involvement in their family members' care plans. Comments included, "I'm happy we've both (relative and person) been involved", "I've seen the folder and signed things", and, "I was involved with the care plans." This meant people and their relatives had been consulted about the care and treatment people received.

People had access to advocates if they needed support to make decisions. The registered manager could describe the referral process and gave an example of a person without family support who she had requested an advocate for. She told us, "[They've] got someone to speak on [their] behalf."

The registered manager and registered provider promoted an open and inclusive culture at Ashcroft. The home's service user guide included a commitment to respect people's equality and diversity needs and to support people to meet them. We noted interviews for prospective staff included a question on equal opportunities and what this meant to the interviewee. A care worker told us one person attended church regularly. We saw a person with English as a second language enjoying food from their country of origin in accordance with their preferences. Care staff told us they tried to stimulate people with English as a second language by asking the people to teach them words and reminisce about their personal history. People who had expressed needs relating to their sexuality had received support and advice in order to maximise their choices and independence. Records showed staff had taken a sensitive approach and sought to enable people to meet their own holistic needs. The home's newsletter for October to December 2017 stated the next edition would contain information about supporting lesbian, gay, bisexual and transgender people living with dementia. This showed the service supported and promoted the diverse needs of people using the service.

Good

Is the service responsive?

Our findings

People and their relatives told us staff were responsive to people's needs. One relative said, "They're quick to respond. They do react if [my relative] needs something", a second relative said of the staff, "They meet [my relative's] needs." A third relative commented, "I think the staff respond to [my relative] and take care of [them]", and a fourth said, "They make sure [my relative] gets the right hygiene attention here."

At the last inspection in June 2017 we identified a breach of regulation relating to good governance as people's care plans were not an accurate and contemporaneous record of their care and support needs. At this inspection sufficient improvement had been made to resolve the breach in regulation.

People had person-centred care plans which reflected their needs; these included mobility, nutrition and cognition. Care plans for washing, dressing and continence recorded what people could do for themselves to maintain their independence and what carers needed to do to support the person. People's preferences with regards to clothes, toiletries, their hair, oral hygiene and preferred gender of staff to provide personal care had also been recorded. Records showed care plans had been reviewed and updated on a regular basis.

People's care plans included short and long term goals. For example, a person who lacked capacity to make some decisions and had a care plan for cognition. The short term goal was to, 'Maximise [name's] ability to do things for themselves', and their long term goal was, 'To maintain [name's] dignity and self-esteem.' This meant care planning for people had involved setting agreed goals for helping them meet their care and support needs.

The service used advice from healthcare professionals to inform people's care plans. For example, a person had been referred to and assessed by a speech and language therapist (SALT) when staff suspected they had swallowing difficulties. We saw their care plan included guidance given by the SALT and described altered food textures and thickened fluids. We observed staff supported the person to eat and drink in accordance with the care plan. This meant people's care plans had been improved and contained person-centred detail which was regularly reviewed.

The registered manager had not heard of the Accessible Information Standard. The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand, plus any communication support they need when receiving healthcare services. However, we saw care plans were in place for people who had difficulty communicating due to a sensory impairment or who had problems with verbal communication. These showed staff how to improve communication with the person. For example, a care plan for a person who could not communicate verbally described how they used facial gestures and made verbal sounds if they were uncomfortable or in pain. In addition, information about people's spectacles (if they used them) was available in people's rooms to remind staff to prompt people to wear them. The registered manager told us they would download the Accessible Information Standard, review the guidance and ensure any additional measures were put in place. We will check this at the next inspection.

We spoke with people about the activities on offer at Ashcroft. Two people chose to stay in their bedrooms most of the time and only occasionally joined in activities such as coffee mornings or entertainment. One said they preferred to watch television in their bedroom and that a member of staff came and gave them a manicure from time to time. A third person said they enjoyed playing dominoes and watching films in the communal lounge, and a fourth said, "I like the television and the radio." Relatives said of activities at the home, "All the times I'm here there's always something happening", and, "You regularly see them (people) sat round tables drawing and playing dominos."

Since the last inspection in June 2017 the activities coordinator had left their role and responsibility for activities had transferred to the care staff. The registered manager told us this had been a big success as staff were happier and feedback from people had been positive. One care worker said, "Staff are more involved in activities. We can have quality time with them (people)." Residents' forum meeting minutes supported this. Throughout the inspection we observed people and staff enjoying time spent in social interaction and activities.

During the inspection in the main conservatory area we observed staff engaging seven people in playing skittles. Others were encouraged to sit at tables to play dominoes and two people had manicures. A volunteer supported people to look at magazines in the morning. In the afternoons we observed music was played and people were asked if they wanted to participate by playing instruments or dancing. A care worker told us people often preferred quieter activities in the mornings and something more lively in the afternoons. The registered manager said people who wished to watch TV during the day would be supported to their rooms; "We move the TV (large TV in the conservatory) round in the evening. They (people) do like their soaps."

We observed activities in Terrace Way were more relaxed and involved conversation in the lounge area, music and TV. We saw people enjoying a musical, and one person was encouraged to help feed the pet budgie. People from Terrace Way were invited to join activities in the main conservatory area if they wished to. Staff said due to people's dementia diagnoses this had resulted in some people becoming confused and distressed and that most people therefore preferred to stay in familiar surroundings. This meant people had access to a range of activities at Ashcroft.

Two of the people and relatives we spoke with said they had raised a concern about the service in the past. Both told us they had spoken with a member of staff and it had been resolved to their satisfaction. All of the people and relatives told us they would speak to staff if they had a problem, most naming the registered manager as the person they would go to. We saw the registered provider's complaints policy was prominently displayed within the home and included in the service user guide. No formal complaints had been received by the home since the last inspection, although the registered manager could explain what action she would take if a complaint were made.

People's care files included care plans for their end of life care needs and preferences. Some of these lacked person-centred detail; the registered manager said these were a work in progress due to the reluctance of some people and relatives to talk about this aspect of care. Some relatives told us they had engaged when consulted about their family member's end of care wishes. One relative said, "We've had the end of life discussion", and a second told us, "We've got a 'do not resuscitate' plan." This meant the service had attempted to speak to people and their relatives about planning for the future.

One person was receiving end of life care at the time of this inspection. A plan had been discussed with relatives and anticipatory medicines had been prescribed and obtained. Staff told us about the Gold Standards Framework training they had previously used to support people at the end of their lives but said

they were about to receive training on a new method of planning care to ensure people had a pain free and dignified death. We saw thank you cards send by relatives of people who had been cared for at the end of their lives at Ashcroft. One said, "Thank you for all for the wonderful care you gave [my relative] in [their] final days." A second relative described the lead nurse who had cared for one of their family members at the end of their life as, 'A very kind and caring consummate professional.'

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us they thought Ashcroft was well managed and gave us positive feedback about the registered manager and nominated individual for the registered provider. Comments included, "As far as I'm aware they do everything well", "[The registered manager] seems efficient and is always very pleasant", "[The registered manager's] very, very good at her job. She's on top of everything and involved", "I have seen [the nominated individual] around a lot. I could talk to him", and, "I know [the nominated individual] really well and really like him."

Feedback from staff at the home about the management team was also positive. One care worker said of the registered manager, "She's very supportive; she's proactive", and of the nominated individual, "He's approachable", and, "He's just at the end of the phone." A second care worker said, "I like [the registered manager]. She's fair and to the point", and described the lead nurse as, "Approachable." A third staff member said of the registered manager, "It's nice because you have that boundary where she's your boss but you can go to her."

One healthcare professional we spoke with told us, "[The registered manager's] very approachable to discuss (staff) training needs", and a second said, "I found [the registered manager] accommodating and engaged with what I was saying."

At the last inspection in June 2017 we identified a breach of the regulation relating to good governance. This was due to a failure to take action to resolve concerns raised at the previous inspection and the lack of support provided to the acting home manager when the registered manager took extended leave. At this inspection we found sufficient improvement had been made to resolve the breach in regulation, however, some issues with oversight of the service's safety remained.

An improvement plan was implemented by the registered provider after the last inspection. The nominated individual told us this had focused on improving governance at the home and staff attitudes towards people. This had involved staff training and supervision and more frequent visits by the nominated individual to support the registered manager. The registered manager said the service had recently employed a head of care, whose role was to ensure people's care needs were planned for and met. They worked in a supernumerary capacity on one day a week, and alternate weekends, to support the registered manager and lead nurse in the running of the home.

A range of audits were in place to monitor the safety and quality of the service. Records for accidents and incidents showed each one had been followed up by the registered manager and analysed for trends. An audit of pressure ulcers included risk assessments for each person deemed to be at risk, to ensure all appropriate action had been taken. Medicines audits we saw contained action plans which evidenced issues that had been identified had been rectified. The responsibility for writing and reviewing people's care plans was allocated to specific care workers and a system was in place to ensure care workers did not audit the care plans they wrote. Health and safety audits were also in place; however, they had failed to identify the gaps in safety checks discussed earlier in this report.

The registered manager told us she made checks and observations around the service every day she was on duty, and spoke with people, their relatives and staff. She said of the new management team consisting of herself, the lead nurse and head of care, "I think the triangle works really well", as it meant when she could not be 'on the floor' the lead nurse or head of care were. The management team met every Monday to discuss the previous week and planned for the week ahead.

Records, feedback and our observations at this inspection showed there was an upward trajectory of improvement at the home since the last inspection, but there was more to be done. The nominated individual told us, "We've still got a lot to do but we're on the right track."

The registered manager and registered provider promoted an open and inclusive culture at Ashcroft and sought feedback and ideas from people, their relatives and staff. Minutes of residents' forum meetings showed people had been asked for their opinions on the redecoration programme, the food served at the home, and the activities on offer. The lead nurse described how feedback from people had been used to change the staff rota at the home. They said a lot of people liked to get up between seven and eight o'clock in the morning which was before the day staff came on shift. It was decided one or two day staff would start at seven o'clock in the morning to support night staff to help people who wanted to get up at this time to do so. This showed the home listened to people in order to improve the service provided.

Care staff said they felt staff meetings were useful. They told us they were asked for ideas about how to make the service better. One care worker said, "You can voice any concerns you may have."

The registered provider demonstrated transparency by sharing information about the findings of our last inspection in June 2017 with people and their relatives via the home's newsletter. A copy of the last inspection report with the service's ratings was prominently displayed in the home's reception area. Records showed inspection findings and areas for improvement had also been communicated to staff in supervision sessions and staff meetings. The registered manager told us she also promoted the vision and values of the service to staff in supervisions and at staff meetings to ensure all care and treatment was provided in line with them. One care worker told us the vision and values of the service were to provide good quality, responsive care that met each person's needs.

The registered manager told us she was keen to continuously learn and improve the service. Members of care staff had designated lead roles for dignity, infection control and palliative care. They attended meetings and good practice events and used their learning to make changes at the home. The registered manager attended good practice events for registered providers and the lead nurse was in the process of arranging training from a palliative care specialist on end of life care. In addition the registered manager arranged six-monthly audit visits by the pharmacy used by the home in order to compare their medicines practice against established good practice. This demonstrated efforts were made by the registered provider and registered manager to continuously develop and improve the service.

The service worked in partnership with other organisations, stakeholders and volunteers. The registered manager told us they fostered good working relationships with healthcare professionals such as GPs and district nurses who visited the home. Feedback from healthcare professionals we spoke with supported this. Ashcroft had a reciprocal arrangement with people living in nearby sheltered housing whereby joint coffee mornings were held either there or at the home. Volunteers were welcomed at the home, as were young people from the local high school who wanted to undertake work experience. This showed the service worked in partnership with local organisations and individuals.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk posed by some aspects of the building and equipment had not been properly assessed and managed. Regulation 12 (1) and (2) (a) (b)