Four Seasons Health Care (England) Limited

Ashcroft Nursing Home - Chesterfield

Inspection report

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Date of inspection visit:
30 April 2019

Date of publication:
07 June 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 – Chesterfield is a residential care home that was providing nursing and personal care to older people and people living with dementia. They were registered to provide care for 42 people and there were 25 living at the home when we visited. The accommodation is across two floors with communal areas on each.

People's experience of using this service:
The service met the characteristics of requires improvement.

There were not always enough staff to meet people's needs promptly and safely. Infection control systems were not always embedded to protect people from harm. Some risks to people's wellbeing were not effectively managed to ensure they were safe and their dignity was met. Staff did not always have the time to spend with people to engage in activities or speak with them when they were distressed. Staff training was not always sufficient to ensure they had could support people effectively. The governance of the home was not effective in making the improvements required in a timely manner. People were not always supported to have maximum choice and control of their lives nor supported in the least restrictive way possible; the policies and systems in the service were not followed to review this practice. The environment required some maintenance and signage to ensure people's independence.

People's nutritional needs were met and there were good systems in place to monitor their weight and skin integrity. There were relationships in place with local healthcare providers to ensure people's health needs were met. Medicines were managed to reduce the risks associated with them and were administered as prescribed. Families felt well informed of people's wellbeing and welcomed to visit at any time.

When people required end of life care, there were measures in place to understand their wishes. People felt able to raise concerns about their care and be confident they would be dealt with promptly.

The registered manager was approachable and there were systems in place which encouraged people to give their feedback. Safe recruitment procedures were followed.

More information is in the full report.
Rating at last inspection: The service was last inspected on 6 February 2018 and was rated good.

Why we inspected: This inspection was brought forward due to concerns raised from reviews of the home completed by other professionals.

Enforcement: We found three breaches in regulatory standards and you can see what action we told the provider to take at back of full version of the report.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as

per our re-inspection programme. If any concerning information is received we may inspect sooner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe

Details are in our Safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Requires Improvement

Ashcroft Nursing Home - Chesterfield

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 checked 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 was prompted in part by information shared from the local authority about increased risk and an action plan which was put in place to improve the service. This inspection examined those risks.

Inspection team: The inspection was completed by two inspectors and a specialist adviser. The specialist adviser had expertise in nursing.

Service and service type: Ashcroft Nursing Home - Chesterfield is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and 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.

Notice of inspection: This inspection was carried out on 30 April 2019. It was unannounced.

What we did: We used information we held about the home which included notifications that they sent us to plan this inspection. We also received information from professionals involved with monitoring the home. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers 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. Therefore, we gave opportunities for them to update us throughout the inspection.

We used a range of different methods to help us understand people's experiences. We spoke with five people who lived at the home about the support they received. However, as a lot of people were living with dementia and found verbal communication more difficult, we also observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit. We also spoke with two people's relatives to gain their feedback on the quality of care received.

We spoke with the registered manager, the deputy manager, the regional manager, one nurse, one senior care staff, five care staff and two domestic staff. We reviewed care plans for seven people to check they were accurate and up to date. We also looked at medicines administration records and reviewed systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. These included accidents and incidents analysis, meetings minutes and quality audits.

Requires Improvement

Is the service safe?

Our findings

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

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. Regulations were not met.

Staffing and recruitment
• There were not always sufficient numbers of suitably skilled staff deployed to meet people's needs safely.
• One relative we spoke with said, "Staffing levels could be better and some days are stretched; especially at weekends."
• We saw there were occasions when the staffing levels impacted on how safe people were. Some people were living with dementia and on occasion interacted with each other in a way which could cause harm, without staff being able to intervene. For example, one person pushed another person across a communal room in a chair which had wheels on it. One member of staff was supporting another person who was distressed and did not observe this. A relative who saw this told us, "This is the sort of thing that happens when the staff are not looking."
• On another occasion one person was agitated and shouting; they left the communal room but the staff member in the room was unable to follow them as they told us they needed to maintain a staff presence there at all times.
• The staffing levels also affected how promptly people received the care they required. For example, at times there was only one member of staff available in communal areas. When one person asked to go to the toilet they were told they would have to wait until a second member of staff was available and we saw this took over ten minutes.
• At other times the member of staff available to support people in the communal areas was not a member of the care staff but in one room an administrator and in a second domestic staff. For example, a buzzer for staff attention had been going for five minutes. The member of care staff in the communal area asked a domestic member of staff to watch the people in the communal area. The care staff was gone for seven minutes. The domestic and administration staff did not have the training to support people safely; for example, they had not received training in recognising safeguarding concerns or moving people safely.
• People did not always receive their medicines in a timely way. The medicines administration was prolonged until late morning on one of the floors. When we spoke with one member of staff they explained this was because they were the designated member of staff in the morning to ensure there was a staff presence in the communal area. They said this meant they were unable to leave the room to take people their medicines in their bedrooms.
• When we spoke with staff they told us that staffing levels could cause difficulties, particularly if staff were off sick at short notice. For example, they explained care could be delayed for people and it was difficult to meet people's needs.
• We reviewed staff rotas and found there were variable staffing levels across the last month. On seven days there were less staff available to support people than on the inspection visit and on one weekend there were two less staff. We checked the staffing levels against the tool the provider used to plan safe staffing levels

and found that on these occasions there were insufficient staff to keep people safe. There were also three nights in the past month when there were unsafe members of staff to meet people's needs.
This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• Risks to people's wellbeing were not always assessed, monitored or managed sufficiently to protect them from harm.
• Some people had plans in place to guide staff in supporting them to manage their behaviour. These were not always followed to reduce the risk of behaviours which could cause harm to people. For example, for some people the guidance was to engage people in activities and staff were not always available to do this when people needed it. Another person needed to be prompted to use the toilet if they were restless and we saw staff did not do this when required.
• One person's plan advised time in their room away from others if they were anxious or distressed. We spoke with the member of staff supporting the person who told us they often spent time with the person in their room. When we reviewed their records, there was no description of any agitated behaviour in line with their care plan to show why this was needed.
• Other people had plans to ensure they were safe when walking independently and this detailed they should wear shoes or non- slip socks. However, we saw these were not always followed and some people only wore socks which put them at increased risk of falls.

• Other risks to people's health and wellbeing were assessed and the plans put in place were followed. People were moved safely using equipment, there were systems in place to ensure their skin didn't become sore from increased pressure and their weight was regularly monitored.

Preventing and controlling infection
• Since November 2018, the home had been under review by a specialist infection control team. This included three visits and setting an action plan. The latest review was four days prior to our inspection visit. Although improvements were recognised there were still areas which required attention and the home did not meet the required standard. This included an unclean mattress and worn pillows as well as areas of the home which needed to be fixed and maintained. This meant the systems in place to keep the home hygienic and manage infections were still not effective.

Learning lessons when things go wrong
• Systems had been reviewed and altered to ensure learning when things went wrong took place. For example, a system for reviewing people's challenging behaviour was implemented and we saw when changes were identified these were recorded in people's care plans. However, we also found that other behaviours were not always recorded and this meant some other changes had not been identified; for example, when there was an increase in one person's self-neglect.
• Other changes had been made in response to things going wrong and internal investigations into the cause. The care provision was now across two floors to avoid people travelling in lifts several times a day. Relatives we spoke with said this change also improved the atmosphere of the home and it was calmer with less incidents of people becoming vocal and distressed. However, we also found that staffing levels were not always adequate to cover two floors rather than one communal area. Therefore, although learning had taken place and action was taken it was not fully implemented to ensure there were safe staffing levels.

Systems and processes to safeguard people from the risk of abuse
• Staff were knowledgeable about safeguarding and could explain the processes to follow if they had concerns.

• Relatives we spoke with told us that they felt people were safe in the home. One relative said, "I feel relaxed knowing my relative is safe and well cared for here."
• When staff noticed unexplained marks or bruising on people they kept detailed records and reported to their line managers for review.
• When safeguarding concerns were raised and investigated, we saw that action was taken to protect people from further harm.

Using medicines safely
• Medicines systems were organised and people were receiving their medicines when they should. The provider was following safe protocols for the receipt, storage, administration and disposal of medicines.
• One relative we spoke with told us how their relative's medicines were kept under regular review; for example, when one medicine was considered to be causing drowsiness staff requested a review with the health professional and the prescription was altered.
• Some people were prescribed medicines to take 'as required'. Staff asked some people if these were required; for example, for pain management. There was guidance in place to support staff to know when this was needed.

Requires Improvement

Is the service effective?

Our findings

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

The effectiveness of people's care, treatment and support was inconsistent. Regulations may or may not have been met.

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

• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

• We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• One person was not supported in the least restrictive way possible to keep them safe. They were supported in their room with one member of staff and we found the bedroom door was locked. Some furnishings had been removed from the room and the member of staff said this was because the person would remove them otherwise. There was no record to evidence that this restrictive practice was required in the person's best interest to keep them safe on that day.

• Another person received their medicines covertly; this means they were not aware they were receiving them but it had been decided that it is important for the person to have the medicines to manage a health condition. This decision had been made in agreement with a healthcare professional. However, a DoLS application detailing this restriction had not been made.

• Staff were not always able to tell us which people had an approved DoLS in place. We found one person had conditions on their DoLS which some staff were unaware of. Records to demonstrate these conditions had been met to ensure the DoLS was legally met were not all clear.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff skills, knowledge and experience

• Staff did not always have sufficient training to ensure they delivered effective care to people. Some of the courses were under review by the provider to ensure that staff were skilled to keep people safe.

• Additional training had been organised for staff to understand how to support people when their behaviour was challenging. Staff we spoke with told us they felt this had increased their understanding. One member of staff told us it increased their understanding of why people behaved in certain ways and what this might mean for them.

• When we spoke with the regional manager about this training and their plans to ensure all staff completed it, they told us they were reviewing whether it was the right one to support people living with dementia and planned to consider other courses. However, this meant that some staff would continue to not complete

training in supporting people to manage behaviours and we found this was an area for improvement as reported in the safe domain of this report.
• We also found that staff without sufficient training were at times the only one in a communal area ensuring people were safe.
• We reviewed records and found some staff had not completed their induction training within the required timeframe. The registered manager told us about support that was now in place to ensure this training could be achieved.

Adapting service, design, decoration to meet people's needs
• Some of the environment required maintenance and improvement. The regional manager told us about a refurbishment programme which was in progress. For example, bathrooms had recently been upgraded and further improvements were planned.
• There was not sufficient signage throughout the home to assist people who were living with dementia to orientate. For example, some people did not have names or pictures on their bedrooms so they would know it was theirs.

Supporting people to eat and drink enough with choice in a balanced diet
• People were supported to have balanced diets and made choices about the kind of food they enjoyed.
• One relative told us, "The food is good and [Name] would say if they weren't happy with it."
• There was a choice of meals on offer. Some people needed to have a specialist diet and staff were knowledgeable about this.
• People who were at risk of losing weight were monitored. One relative we spoke with told us their family member had previously lost a significant amount of weight but that it had stabilised since moving into the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs and choices were met in line with national guidance and best practice.
• People's protected characteristics were considered so that people were protected from discrimination. People's needs had been assessed to ensure that staff could provide the appropriate care in line with current best practice guidelines and legislation. Where people had health conditions that had been referred to in their initial assessment this was then reflected in more detailed care plans.
• Some standardised, objective risk assessment tools were used to assess risks to people's health and safety; such as skin integrity and nutrition. When they were in place they assisted staff to provide people with care in line with current best practice guidelines.

Supporting people to live healthier lives, access healthcare services and support and providing consistent care across organisations.
• Nurses had responsibility for assessing and monitoring people's health. They ensured that care plans were kept up to date and made referrals to other professionals when required; for example, speech and language therapists.
• Relatives told us people had regular visits from their doctor when required and they were confident that any concerns would be actioned promptly. We saw evidence of this in their care records.

Requires Improvement

Is the service caring?

Our findings

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

People were not always treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

• People did not always have their privacy and dignity upheld and they were not always well supported.
• Staff we spoke with told us they did not always have the time to give people enough attention. One person remained in a state of undress throughout the inspection visit in communal areas. Although this was a recognised choice which was recorded in their care plan, we saw that staff did not prompt the person regularly to dress as described in their plan. This impacted on their dignity and on the other people in the communal room.
• When other people were anxious or distressed, staff were not always available to offer them comfort or spend time with them.
• People were not always offered choices about their care. When one member of staff asked what someone wanted to eat a second member of staff answered, calling across the room, "Give them a small meal as they won't eat it."
• Some staff we spoke with told us they felt the staffing levels impacted on their ability to offer individualised support. One member of staff said, "I think we are too task focussed."
• At other times during our inspection visit we did see kind and caring interaction between staff and people they were supporting. Relatives spoke about staff in warm terms. One relative told us, "The staff are very friendly and approachable." Another relative said, "The staff are kind and my relative's care is good."
• Relatives told us they were welcomed at any time and included in special events. One relative said, "On [Name]'s birthday the staff decorated a small room and made us afternoon tea. They all sang happy birthday with a cake. It was lovely and a special memory."

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People did not always have the opportunity to pursue interests and engage in activities.
• There was no longer a dedicated member of staff to organise activities and staff told us this was part of their responsibility. One member of staff told us, "All staff are encouraged to stop providing care at 2pm to participate in some activities even if it is just for 15 minutes." This demonstrated to us there was not a responsive approach to engaging with people when they wanted to.
• One relative told us, "There is very little going on for people other than the television and music sometimes."
People sat for prolonged time in chairs in communal areas. There was little interaction with staff and we saw no activities provided.
• People had care plans which were personalised, detailed and regularly updated. There were daily handover meetings to ensure that staff were aware of people's changing needs. However, these only took place twice a day and some staff came into work during the day. One member of staff told us, "We don't get a handover now, it is up to us to ask the nurse and other staff what has happened." This meant that changes to people's wellbeing may not be communicated in a structured way.
• There was limited information in different formats in the home to ensure people could understand; for example, using photos and pictures. We spoke with the regional manager who told us that some people living with dementia removed notices from the walls when they were put up. They told us they recognised their responsibilities under the Accessible Information Standard. This was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand.

Improving care quality in response to complaints or concerns
• Relatives we spoke with knew how to make complaints and were confident that they would be listened to.
• When complaints were received they had been recorded and reviewed in line with the provider's procedure.

End of life care and support
• People had plans in place for the end of their life, including choosing when they would want to be resuscitated.
• We spoke with the regional manager about their plans to improve the advance planning they completed with people to capture their wishes more fully.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

Continuous learning and improving care; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others

• In October 2018, the service was reviewed by the local authority and health authority and were asked to improve in a number of areas to ensure people received safe care and treatment. These included in skin care, medicines management, supporting people to manage behaviours and infection control. The provider agreed to suspend taking new people to live at the home while improvements were made. The registered manager told us they had weekly reviews against their action plan with the provider and had received ongoing support. The partner agencies also provided ongoing support and regular checks of progress.

• Although we found improvements had been made in some areas including medicines management and care plans, we also found areas that still required attention. The service had still not reached an acceptable level to meet infection control standards after three audits. Some of the systems implemented to support staff to help people to manage behaviours which could be challenging were not fully effective. This was impacted in part by the staffing levels in the home.

• Some of the improvements had been slow to be achieved; for example, it was noted in October 2018 there were no workable baths for people. This was only being addressed when we inspected in April 2019. This had a significant impact on people's choice and dignity over a prolonged period.

• Some of the provider's policies required review and although this was highlighted at previous audits it had still not been actioned. For example, there was no policy provided at the infection control audits around waste management. The infection control policy had limited information about managing infection outbreaks and this had not been reviewed.

• This demonstrated to us that although improvement had been made, the governance of the home was not sufficient to ensure managers had the information required to meet national standards. Improvements were not fully embedded to ensure people received safe and effective care.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had displayed their previous inspection rating in line with our requirements.

• People and relatives knew who the registered manager and provider were and felt they were approachable. One relative said, "The registered manager is really good and often approaches us to update us on our relative's wellbeing."

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

• There were regular meetings with people who lived at the home and their relatives. One relative told us, "The meetings are not well attended but the registered manager always attends and talks to us about improvements in the home. I suggested more music in the communal areas and that does happen sometimes now."
• Staff felt supported through regular supervisions and appraisals. Team meetings were regular and staff felt confident their views and opinions mattered and were listened to.

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 11 HSCA RA Regulations 2014 Need for consent People were not always supported in the least restrictive manner and legal safgeguards were not always met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place did not always ensure good governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff deployed to ensure people's needs were met promptly and safely.