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

Summary of findings

Overall summary

We inspected Ashcroft Nursing Home (known as 'Ashcroft' to the people who live and work there) on 19 and 22 June 2017. Both days of the inspection were unannounced. This meant the home did not know we were coming.

Ashcroft is a care home registered to provide nursing and residential care for up to 40 people. It consists of one building with three floors accessed by two passenger lifts. The majority of rooms are single with ensuite facilities. There were 33 people living at the home at the time of this inspection.

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 is also located on the ground floor; this has an enclosed garden area with seating.

Ashcroft was last inspected in November 2015. At that time it was rated as Requires Improvement overall as it was deemed to be Requires Improvement in all five of the key questions of care: Safe, Effective, Caring, Responsive and Well-led. We asked the registered provider to send us an action plan to tell us how they were going to tackle breaches of regulation relating to consent, safeguarding people and good governance.

The home had a registered manager; at the time of this inspection she had been on a period of extended leave since December 2016 and was due back to work in October 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Not all risks to people had been assessed and managed. For example, people's care plans did not contain information on how to support them to bathe and shower safely.

Control measures identified as required to reduce risk posed by the building were not in place. Other checks on the building's utilities and equipment had been completed.

We identified concerns around the way medicines were administered, stored and recorded. Medicine stock levels reconciled with recorded amounts.

Feedback about staffing levels from people, their relatives and staff was mixed. We raised concerns about the dementia unit which was staffed by one senior care worker. Our observations showed people's needs were met but staff were busy.

People said they felt safe at Ashcroft. Staff could describe the forms of abuse and knew how to report concerns appropriately.

Records showed staff did not have access to regular supervision; records made of supervision sessions were not detailed. The same concerns were raised at the last inspection in November 2015.

The home was not compliant with the Mental Capacity Act 2005 as mental capacity assessments had not been made for some people known to have problems making decisions. This was a breach of regulation at the last inspection in November 2015.

People and relatives gave us positive feedback about the food and drinks served at Ashcroft. We observed the dining experience was pleasant and people were offered choices. One person's records contained contradictory information about their nutritional needs and their records did not evidence whether they received their prescribed supplements.

Most interactions between care staff and people were kind and caring, although we observed some which were disrespectful.

People were supported to maintain their independence and told us staff respected their privacy and dignity.

It was not possible to tell from people's records whether they had been involved in planning their own care. People had access to independent support with decision-making if they needed it.

The thank you cards we saw from relatives of people who had received end of life care at Ashcroft were highly complimentary. Care staff could describe the important aspects of good end of life care.

The quality of care plans was variable. Most were detailed and person-centred, although some we saw had not been updated when people's needs had changed or lacked the information staff would need to provide effective care. This was a concern at the last inspection in November 2015.

Most of the feedback from people about the activities offered at the home was positive. Throughout the inspection we observed people had opportunities to take part in activities. People and relatives told us visitors were welcome at any time.

None of the people or relatives we spoke with had made a complaint about the home since the last inspection, but all said they felt confident to complain if they needed to.

Concerns raised at the last inspection in November 2015 had not been resolved. Audits undertaken by staff at the home and by the registered provider had failed to identify issues with care plans and medicines management.

The provider's governance arrangements for the extended absence of the registered manager were not adequate. The deputy manager was not given protected time to manage the home because they were needed to cover nursing shifts.

Regular meetings were held at which people, their relatives and staff could feed back about the home.

We found breaches 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 not all been fully assessed and managed.

We raised concerns about the way medicines were managed and administered.

Feedback about staffing levels was mixed. We observed people's needs were met but staff were busy.

People felt safe at Ashcroft. Staff knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not compliant with the Mental Capacity Act 2005. This was a breach of regulation at the last inspection.

Care staff did not receive regular supervision. This was a concern at the last inspection. We also found gaps in training.

People liked the food and drinks served at Ashcroft. Some records relating to people's nutritional needs were not complete.

People said they had access to a range of healthcare professionals to help support their wider health needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Most interactions between care staff and people were respectful and supportive, but some were not.

Care workers supported people to retain their independence and most were mindful of people's privacy and dignity.

Records did not evidence how people had been involved in planning their own care. People had access to advocacy services

if they needed them.

Care staff could describe the important aspects of good end of life care. Feedback from relatives of people who had received end of life care at Ashcroft was positive.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Most care plans were detailed and person-centred, although some were not up to date. This was a concern at the last inspection.

Feedback about the activities on offer was mostly positive. We saw people taking part in different activities throughout the inspection.

None of the people or relatives we spoke with had made a complaint since the last inspection, but all said they would if they needed to.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to resolve concerns raised at the last inspection and we identified new breaches of regulation at this inspection.

Governance arrangements in place for the extended absence of the registered manager were not effective.

People, their relatives and staff were provided with opportunities to feed back about 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 19 and 22 June 2017. Both days were unannounced. The inspection team consisted of three adult social care inspectors on the first day of inspection, and two adult social care inspectors and one 'expert by experience' on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had been a user of healthcare services for many years and had supported adult social care inspectors on numerous other inspections.

Before the inspection, the provider completed a Provider Information Return (PIR). 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. We used this information to help plan the inspection.

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

During the inspection we spoke with seven people who used the service, six people's relatives, a visitor, four members of care staff (including one nurse), the deputy manager, the activities coordinator, and a cook. At the time of this inspection the registered manager was on a period of extended leave.

We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care 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 three people's care files in detail and selected care plans from seven other people's records. We also inspected three staff members' recruitment documents, staff supervision and training records, nine 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 we spoke with told us they felt safe at Ashcroft. One person told us, "Safe? Very much so", and a second person said, "Yes, I do feel safe here." Relatives also felt their family members who used the service were safe. One relative commented, "Absolutely", and a second said, "Much safer than at home."

As part of the inspection we checked records to see how risk to people had been managed. People's care files contained a range of risk assessments for aspects such as falls, skin integrity, nutrition and moving and handling. Risk control measures to reduce identified risks were described in people's accompanying care plans. During the inspection we observed care workers encouraging people to use sun screen before going to sit outside, as it was hot and sunny. Records also showed people who needed support to reposition in bed to prevent damage to their skin received the help they needed. This meant some risks to people were managed well.

However, we raised concerns where some risks to people had not been fully managed. For example, people's care files did not contain personal emergency evacuation plans (PEEPs). PEEPs contain the information emergency personnel would need in order to safely evacuate people. People's moving and handling care plans stated what equipment was needed to help them move, but did not contain detail about how this equipment should be used. There was no information in people's care plans about how staff could safely support them to bathe and shower. Two people whose care plans we sampled used air mattresses to reduce risk to their skin integrity. We found their care plans did not state the pressure setting for the mattress pump and staff we spoke with could not tell us what the settings should be. One person who was nursed in bed had experienced steady weight loss due to their declining health. They could not sit safely on the weighing scales or in a hoist with scales. Records showed other means of estimating the person's weight from body measurements had not been employed so healthcare professionals supporting the person had to estimate their weight-loss from how they looked and the fit of their clothing. This meant action to quantify and manage risk to people was not always taken.

We checked building, utilities and equipment records to see if regular monitoring was undertaken and looked at related risk assessments and emergency plans. Utilities and equipment had been monitored for safety, including call buzzers, water temperatures, fire extinguishers and moving and handling equipment. Risk assessments for the building and a fire risk assessment were supplied after the inspection by the provider. Our observations showed risk control measures identified by the provider as required for the stairs and a kettle in the dementia unit were not in place at the time of the inspection. For example, the building risk assessment stated stairgates were in use to reduce the risk posed by open staircases, whereas we saw none in the building. This meant risks to people presented by the building and facilities had not always been assessed and managed appropriately.

Concerns around risk assessment and management were a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as measures were not always taken to ensure people were safe from the risk of harm.

As a result of us raising concerns after the first day of our inspection the deputy manager put PEEPs in place for each person at the home by the second day of this inspection; these were discussed with people who had mental capacity and signed by them. The deputy manager also consulted the other nurses and reviewed the settings for all air mattresses. They told us people's care plans had been updated to include the type of air mattress they used and the correct setting. The monthly mattress audit was amended to include a check of the air mattress pump and pressure setting. We will check this at our next inspection.

We observed a medicines round and inspected records relating to the administration and management of medicines. The nurse administered medicines in a caring manner, speaking to each person politely and giving them time to ask any questions and take their medicines. However, during the round we saw the nurse took Paracetamol to a person for whom it was prescribed 'when required', in other words, when the person said they had pain. We asked the nurse how they knew the person had pain and they told us the person usually did in the morning, however, when the nurse asked the person if they had pain, they said they did not. This meant the person may have been given medicines they did not need.

During the medicines round we also observed the nurse went to administer medicines to a person on the far side of a large room, leaving the medicines trolley unattended with the keys in the door and one person's dosette box lying on top. We saw they had their back to the trolley. We also noted tubs of people's prescribed thickening agents were stored in the communal dining area on the first day of inspection. National guidance was produced following the death by asphyxiation of a person who accidentally ingested a drinks thickener, which states all thickening agents must be stored safely to reduce risk to people. This meant prescribed medicines were not always stored safely.

We noted the Medicines Administration Record (MAR) for the person with 'when required' Paracetamol showed they had received it between two and four times a day in the three weeks prior to the inspection. According to the registered provider's medicines policy, 'when required' medicines should have an accompanying care plan to guide staff on their administration, and contain person-centred details of the individual's signs and symptoms. There was no care plan for Paracetamol for this person. The time of administration, very important for medicines like Paracetamol, was also not routinely recorded. This meant it was not possible to tell if the required four hour time gap had elapsed between doses. Another person had also been receiving 'when required' pain relief for a week prior to the inspection. They did have a medicine care plan for their 'when required' medicine but the time of administration was also not routinely recorded. The registered provider's medicines policy also stated people requesting 'when required' medicines on a regular basis should be referred to their GP for a medicines review. Neither of these people had been referred to their GP for review until we raised concerns.

Another nurse took over the medicines round part-way through. We saw they took a medicine to a person which should be taken 30 minutes before food and on their way back asked care staff to take the person their breakfast. When we queried the required 30 minute delay, the nurse replied, "Oh yes, I should. Sorry", and then carried on with the medicine round without speaking to the care workers providing breakfast. This meant the person did not get their medicine as prescribed.

We saw examples of MARs being signed to show a person had received their medicines when the nurse did not know if they had been taken yet. For example, during the medicines round the nurse took a person a pot of tablets and then left their room before the person had taken them. We also found a dietary supplement on the table in the lounge belonging to a person, which according to their MAR, they had already taken. Some MARs had been amended in a way which guided staff to administer them not as prescribed. For example, one person was prescribed a topical cream to be applied 'as needed to the affected area.' Their MAR had been highlighted for the morning medicines round and the topical MAR for the person's cream

read, 'apply to both legs daily.' Signatures showed the cream had been applied once daily, in the morning. Another person was prescribed a topical cream to be used 'as directed.' Their MAR had been highlighted for the morning and bedtime medicine rounds and their topical MAR showed it had been applied at these times. No reason for either change to the MAR by the GP was recorded, which meant someone other than a prescriber had changed medicine administration instructions.

We inspected the medicines storage room and checked to see whether medicine stock tallied with records. We sampled a number of medicines, including controlled drugs, and found accurate records were kept of the medicines in stock. An effective system was in place for the ordering, receiving and returning of medicines to pharmacy and the temperature of the medicines storage room and fridge were taken on a daily basis. However, most non-refrigerated medicines should be stored at or below 25°C; on the days of inspection we found the temperature of the medicines storage room had been 26°C or higher for over three weeks and effective action had not been taken to resolve the issue. This meant medicines were not always stored according to their manufacturers' instructions which may affect their efficacy.

Concerns around management and administration of medicines were a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection in November 2015 we identified a breach of the regulation relating to safeguarding people, as the registered manager had failed to notify the local authority and Care Quality Commission (CQC) about incidences of abuse or alleged abuse. At this inspection we checked records and found all concerns had been notified appropriately. Care workers we spoke with could describe the different forms of abuse people may be vulnerable to and said they would report any concerns to their manager. Senior staff could explain the process of reporting concerns to the local authority and CQC. All staff said they would whistleblow if they thought a colleague was abusing or endangering people at the home. This meant safeguarding procedures at the home had improved.

At the last inspection in November 2015 we noted the six-bedded dementia unit at the home only had one senior care worker allocated to provide people with support. On one occasion the care worker on duty was observed to leave the unit unattended. At this inspection we looked at staffing levels across the home and spoke with people, their relatives and staff.

Feedback from people about staffing was mixed. Comments included, "Yes, there are enough staff", "There could be a five to 10 minute wait, depends on what they're doing", "Lunch and weekends are not too bad, but there are not enough (staff)", "There are always enough (staff), nothing ever directly impacted me", "My worst wait was three quarters of an hour, but they did pop in and explain and made sure it wasn't an emergency", "Sometimes there are, sometimes not. They are stretched at night", and, "They are always complaining to me. They told me to tell you they are short-staffed."

Relatives told us they thought there were enough staff deployed to meet people's needs. One relative said, "There's enough for what [my relative] needs, on no occasions have [they] needed more", and a second told us, "You can see a member of staff all the time. I have never seen any impact of short staffing."

We looked at staffing rotas and the dependency tool used to calculate the number of staff required to meet people's needs. We also made observations of staffing levels throughout the inspection. Rotas showed most morning shifts were staffed by a nurse and five care workers, most afternoon/evenings by a nurse and four care workers, and most nights by a nurse and three care workers. One senior care worker was always allocated to the six-bedded dementia unit and we were told other care staff would come to support when it was required. The deputy manager showed us a new dependency tool they had used to review the staffing

levels; they had recently asked for the registered provider to increase staffing by one care worker each morning and afternoon/evening shift and the provider had agreed. However, the deputy manager told us there were not sufficient staff employed at the home to increase staffing levels at the time of inspection so more staff were in the process of being recruited.

Our observations in the main communal conservatory area of the home supported the feedback from people, in that people's needs were met but staff were seen to be busy. In the morning on the dementia unit we saw the care worker struggled to support people to get up and dressed, have their breakfast and take their medicines. When this worker was in a person's room providing support, the other five people were unattended. It also meant there was no support to ensure the care worker was not disturbed as they administered medicines, as is recommended in guidance from the National Institute of Clinical Excellence (NICE). A visiting healthcare professional we spoke with after the inspection told us, "That concerns me. If someone (staff) takes one person to the toilet there's nobody", then added, "I feel they need another member of staff on there, just for safety." We discussed our observations with the deputy manager. They agreed with our findings and told us an extra member of staff would be made available to support the senior care worker on the dementia unit at busy times once new staff had been recruited. We will check this at the next inspection.

We inspected three sets of records relating to the recruitment of staff to the home. All contained evidence the correct checks had been made to ensure the staff members were suitable to work with vulnerable people.

During the inspection we sampled records of accidents and incidents which had occurred at the home. Records showed appropriate action had been taken in response to accidents and incidents and measures put in place to reduce the risk of further incidents, if required.

People and relatives told us they thought Ashcroft was clean and tidy. Comments included, "They clean every morning", "Yes, it's clean", and, "It's always clean and since they changed the flooring it's never smelled." During the inspection we looked in people's rooms (with their permission), in communal areas and shared bathrooms and toilets; we found the home to be clean and odour-free.

Requires Improvement

Is the service effective?

Our findings

People told us they thought staff at the home were well trained. One person said, "They are well trained. They are very good with the equipment." Relatives also thought care staff had the skills they needed to support people. Comments included, "Trained enough as far as looking after [my relative], [they] are looked after well", and, "They deal well with people. They are trained enough for [my relative]."

At the last inspection in November 2015 we found staff had not received supervision on a regular basis and records of supervision were brief. At this inspection we checked to see if this had improved. The registered provider's supervision policy stated employees were to receive a minimum of six supervision sessions per year. There was no supervision matrix which listed all staff members so we checked the files of 11 members of staff to see how many supervision sessions they had received in the year prior to the date of inspection. We found one staff member had received four supervision sessions, four had received three supervision sessions and the remaining seven had received two or less. Records of supervision we saw were still brief; they did not include details about staff training needs or development requirements. Supervision is an important means of evaluating staff performance, identifying personal and professional development needs, and motivating staff. This meant staff were still not receiving well documented supervision on a regular basis.

The home's training matrix showed most staff were up to date with the training courses they needed, although the matrix had some gaps and not all staff were included on it. We noted moving and handling training for nine of the care staff had expired in 2017 and refresher training had not been booked at the time of this inspection. Fire training for 12 staff had either expired or was not recorded, although staff we spoke with could describe what action to take in the event of an emergency. The deputy manager told us the registered manager, who had been on extended leave since December 2016, usually coordinated training at the home and so it had been overlooked in her absence. The deputy manager told us they would review and update the training matrix and book any training that was required.

Concerns around staff training and supervision demonstrated a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The deputy manager told us the home did not employ care staff who had not worked in health and social care previously, as they preferred those with experience. This meant no staff were required to undertake the Care Certificate (or equivalent). The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. We noted the provider's training policy had not been updated to include the Care Certificate, which was launched in April 2015.

At the last inspection in November 2015 we identified a breach of the regulation relating to consent, as people who had decisions made for them in their best interests had not been assessed for their mental capacity first, as is required by regulation. At this inspection we checked to see if improvements had been made.

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 authorisation 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.

At the time of this inspection nine people had a DoLS authorisation in place and applications for 12 other people had been made. Two people's DoLS we sampled contained conditions relating to activities; their care records showed staff were abiding by the conditions.

Care files of three people we sampled who lived with dementia lacked decision-specific MCA assessments and best interest decisions. Their mental capacity care plans made generalised statements, for example, two people's care plans stated, 'due to short term memory loss [name] is unable to retain information, therefore lacks capacity to make life changing decisions such as property and financial matters.' One person had an MCA assessment in their file related to their capacity to make 'informed decisions and choices about their care'; it did not specify what these decisions or choices were. We saw no best interest decisions had been recorded in any of the three files. Two people's files we saw stated their relatives had Lasting Power of Attorney (LPA) to make decisions on their behalf and they had signed some documentation. There was no evidence to show the relatives had been granted LPA to act on behalf of their family members, so we could not determine whether they had the correct legal authority to do this.

During the inspection the deputy manager showed us updated template care documentation which included a statement at the bottom of each care plan detailing the correct process for obtaining a person's consent, and whether or not a person's representative signing the care plan had LPA or had been involved in best interest decision-making. The deputy manager said work was underway to revise and update all people's care plans and to ensure the correct MCA assessments and best interest documentation was in place. The deputy manager also supplied five mental capacity assessments which had been completed for two other people at the home. One of these related to a person's capacity to 'make informed choices and decisions' and was therefore not decision-specific as required by the regulations. Others were decision-specific, but none of the five evidenced how the person had been involved in the process. This meant the assessment process had not followed that laid down by the Mental Capacity Act Code of Practice or the provider's own policy.

People known to lack capacity to provide consent to their care and treatment still lacked the required MCA assessments and best interest decision-making documentation. This was a continuous breach of Regulation 11 (1) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People gave us positive feedback about the food and drinks served at Ashcroft. Comments included, "Good choice, good food", "The meals are superb, well cooked and varied", "There are snacks and drinks during the day. They would make coffee if I wanted", and, "It's well cooked. There is enough to eat." Relatives agreed. One told us, "[My relative] is very happy with the meals", and a second commented, "You see hot drinks and fresh fruit being given out."

We spoke with the chef who told us there were two choices of lunch every week day and one choice at weekends. They told us there were always plenty of fresh fruit and vegetables. In the kitchen area we saw a list of people who required a soft or pureed diet and records of people's meal choices for that day. The chef told us people's dietary needs were recorded in their care plans.

We observed two mealtimes during the inspection and one of our inspection team shared a meal with people. People were offered choices of food and drinks by staff and tables were set nicely with condiments available. Vegetables were served on the table in dishes so people could help themselves to more if they wished. People who needed support to eat and drink or cut their food were offered and provided with assistance respectfully by staff, and staff offered people aprons to protect their clothing if they wished. The member of our team who shared the lunch meal reported the food was hot and plentiful and the dining experience was pleasant.

During the days of inspection we observed a tea trolley making regular rounds, and people were asked if they wanted drinks or snacks between meals. The first day of inspection was very hot; that afternoon care workers offered people ice lollies to help them cool down.

The list in the kitchen showed one person who needed their food consistency modified to make swallowing safer was on a 'soft' diet. When we looked at their care file, their diet was recorded as a 'soft' diet in one area and 'pureed' diet in another. In the eating and drinking section of the care assessment dated 09 February 2015 it stated, '[name] has a soft diet and has thickened fluids.' The nutrition section of the care assessment stated, 'soft diet, thickened fluids and supplement pudding.' The nutrition care plan dated 28 January 2017 stated, '[name] has a pureed diet, thickened fluids and supplements.' One staff member told us the person's diet was more 'soft' than 'pureed.' This meant there was confusion over the correct food consistency the person needed to swallow safely, which may place them at risk of choking.

The person's nutrition care plan dated 28 January 2017 also stated, '[name] has supplement puddings prescribed for them three times a day after their pureed meal and dessert. Maxijul two tablespoons to be added to all food and drink.' A second nutrition care plan dated 03 November 2016 stated, '[name] has been prescribed food supplements by the dietician and staff to ensure they have this as prescribed.' The care plan evaluation dated 26 May 2017 stated, 'continues on Forticreme dessert three times per day and Maxijul powder in all food.' One staff member told us both supplements were on the persons medicine chart recorded as 'M' which meant 'make available to staff.' However, when we looked at the person's diet chart it was not always recorded when both these prescribed items had been administered. A staff member told us other than monitoring stock levels they could not evidence when either supplement had been given. This meant it could not be established whether the person was receiving their dietary supplements as prescribed.

A second person who was previously on a soft diet and thickened fluids was discharged from hospital in August 2016 with a request to refer them for a liquids swallowing review. The hospital had found the person could manage normal foods safely and may potentially manage normal liquids safely too. We found the referral had not been made and the person was still having thickened fluids 10 months later, which meant they may be receiving modified fluids they did not need.

People and their relatives told us appointments with healthcare professionals were arranged when they were needed. Comments included, "The home arranges them all for me", "There is good access to all the services", and, "They got [my relative's] hearing aid and glasses sorted out." People's care records evidenced they had seen a range of healthcare professionals, including GPs, social workers, dieticians, and speech and language therapists. One healthcare professional who visited the home told us, "I think they do everything I

recommend", then added, "If there's any problems at all they usually contact us between visits. They're good like that." A second healthcare professional said, "They follow advice we give them." This meant the home supported people to maintain their wider health and made appropriate referrals most of the time.

Ashcroft's dementia unit had been adapted to help meet the needs of people living with dementia. People's doors had been painted different colours and picture signage was available to help direct people to communal areas, the bathroom and toilet. Pictures adorned the walls to help promote a homely feel and the corridor to the enclosed garden area was designed like a street. This meant good practice in dementia care had been used in the design of the unit.

Requires Improvement

Is the service caring?

Our findings

People told us the staff at Ashcroft were kind and caring, and their relatives agreed. Comments included, "Kind, considerate and friendly", "Superb attitude, 100%", and, "I can't think of them being anything else." Relatives agreed. One told us, "They do a good job, Kind, compassionate and patient. Hats off to them." A healthcare professional who visited the home told us, "The staff are lovely", and a second said, "Patients always look well cared for", then added, "I can only give good feedback about Ashcroft."

At the last inspection in November 2015 we observed some interactions between care staff and people were not respectful. At this inspection the majority of interactions we observed were supportive and caring. We saw care workers offering support to people, we heard laughter and banter, and there was a friendly atmosphere at the home. However, some interactions we saw were disrespectful. For example, as a care worker was passing a person, the person said, "I'm dead." The care worker responded, "It won't be long, love", and laughed to themselves. Whilst supporting a person nursed in bed who could not communicate verbally a care worker leaned over and said in their ear, "Thank you for that, even though you didn't know I was really here." We also saw a member of staff approach a person who was asleep slumped to one side in their wheelchair; they picked up a pillow and pushed the person upright to place the pillow without waking the person first so they awoke suddenly with surprise. This meant not all care workers treated people with respect.

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We observed staff supported people to retain their independence. Care workers encouraged people to mobilise safely with encouragement and prompting. We saw people were supported to eat their meals independently by use of aids such as plate guards and modified cutlery. Plate guards help to stop food sliding off the plate and onto the table. Care workers encouraged people to manage their meals themselves prior to offering assistance. This meant care workers promoted people's independence.

Throughout the inspection we noted people were supported to maintain their dignity. People appeared well cared for and they wore clothing that was clean and well-fitting. People told us care workers also respected their privacy. One person said, "They always knock and close the curtains and doors if they have to", and a second commented, "They respect my privacy and dignity, closing doors and things." Relatives also thought staff were respectful; one told us, "They respect [my relative's] privacy and dignity. They knock on the door."

People and relatives gave us positive feedback about the atmosphere at the home. One person said, "It's very happy and friendly", and a second told us, "Very nice. Nice staff – everybody is pleasant." Relatives comments included, "It has a nice atmosphere", "Friendly and comfortable", and, "Relaxed, friendly, calm and welcoming."

People had access to advocates if they needed them. The deputy manager could explain the process for referring people to advocacy services and gave appropriate examples of when they would consider a referral

would be required. Records showed a person at the home had been referred to advocacy services when they needed help to make a decision. This meant people received independent support with decision-making when they needed it.

Feedback from people about their involvement in planning their care was mixed. One person said, "I am involved in my care plan", a second person told us, "I can't remember seeing one (a care plan)", and a third said, "I am involved in my own care plan. My [relatives] get involved as well." Comments from relatives included, "I have seen the care plan but not really discussed it", "I am not involved in [my relative's] care plan reviews", "I have seen it (relative's care file)", and, "Yes, in setting it (the care required) up and in the reviews."

The care files we reviewed did not clearly evidence how people had been involved in making decisions around their care and treatment. The care plans of the three people we reviewed in detail had not been signed by them, although some documents had been signed by their relatives. As mental capacity assessments were lacking, it was not possible to tell the extent people would be able to be involved in their care planning and records did not describe what attempts, if any, had been made to discuss people's care with them. The deputy manager told us people with capacity signed their care plans, and staff talked to people about their care preferences, however this was not evident in the care plans we sampled. This meant not all people were routinely involved in planning their care.

We asked the deputy manager how they helped to promote an open and inclusive culture at the home. The deputy manager told us equality and diversity training was mandatory for all staff and the home's pre-admission procedures asked people if they had any cultural needs or beliefs. We also noted the home's welcome pack, which everyone had a copy of in their rooms, included information on how the home might meet people's religious and spiritual needs. The deputy manager also commented on the diversity of the staff, stating, "We have a diverse staff base and we try to accommodate them too. We have people fasting at the moment." None of the people at the home had any dietary needs related to their culture or religious beliefs, but the deputy manager gave examples of how the chef had cooked foods for individuals with these needs in the past. We noted the activities planner included a church service once a month at the home, which meant people had the option of seeking spiritual support if they needed it. This meant the home promoted the equality and diversity of the people who lived there.

We noted people's DNACPR forms, if they had them, were located at the front of their care files. The DNACPR or 'do not attempt cardiopulmonary resuscitation' decisions had people's correct name and address details on.

Ashcroft provided end of life care to people if it was their preferred place of death and their needs could be met. The deputy manager told us nurses at the home had received, or were about to receive, additional clinical training for use of syringe drivers, and most care staff had received training in end of life care. Syringe drivers can be used to provide medicines, such as pain relief, to people at the end of life who cannot take medicines orally.

As there was no one at the home receiving end of life care at the time of this inspection, we asked care staff what they thought was important in terms of care and support for people near the end of their lives. Replies included, "The wishes of the resident are important. They need TLC (tender loving care) and may need a syringe driver", and, "It's about recognising the signs that they are end of life. Dignity, privacy, pain relief, comfort and providing emotional support." This meant staff could demonstrate an awareness of the important aspects of good end of life care.

Feedback from relatives of people who had been supported at the end of their lives at Ashcroft was also complimentary. A sample of thank you cards we saw contained the following comments: 'We the family appreciated the helpful kindness and patience with which [our relative] was treated at Ashcroft', 'I can't thank you enough for the care and compassion you showed to my father' and, 'Thank you for all your love, patience and laughter! Thank you for helping [name] to keep [their] dignity.'

Requires Improvement

Is the service responsive?

Our findings

People and relatives we spoke with told us care staff provided support when people needed it. One person said, "The staff know me, how I am feeling, just from my face", and a relative commented, "They know [my relative] and us very well."

At the last inspection in November 2015 we found some care plans lacked the information staff needed to provide people with person-centred care. At this inspection we sampled care plans to see if improvements had been made.

People's care files contained various assessments and care plans for aspects such as eating and drinking, mobility, continence, personal hygiene and medical history, and were evaluated monthly. Most care plans we saw provided the detail staff needed, for example, the assistance people required to eat, wash and dress, to mobilise, and to communicate. Daily records evidenced care workers provided people with the support they required. For example, one person's eating and drinking stated a person needed full assistance to eat and described how they behaved when they had eaten enough. We saw this behaviour was described in the person's daily records to evidence the person had declined to finish meals. The person's care records also said they liked classical music; when we visited the person in their room we noted the radio was playing classical music. Other records showed people were supported to reposition in bed regularly to help reduce their risk of pressure damage to their skin, and had access to baths and showers.

People's care plans also contained person-centred details which care workers could describe to us. For example, one person's care records stated where they liked to keep their spectacles, their bathing preferences and what aspects of their personal care they could manage themselves. Care workers we spoke with could demonstrate knowledge of these preferences.

One issue we came across in some handwritten records was poor handwriting, such that we could not read entries made. We fed this back to the deputy manager who said they would speak with staff and make checks on documentation going forward to ensure improvements were made.

However, some care records we saw lacked detail or were not in place. For example, one person who experienced behaviours that may challenge others had no care plan for their behaviours. Staff had been completing 'ABC' charts for the person. ABC charts document the antecedent, behaviour and consequence of a behaviour, and can help staff understand the triggers to a person's behaviour so measures can be put in place to reduce their distress. The ABC charts we saw for this person had gaps and the lack of behaviours care plan showed the information from ABC charts completed had not been analysed to better understand and minimise the person's behaviours. A care worker told us the person did not like noise or being supported with personal care, and we saw staff supported the person to a quiet area when they became upset, which meant staff were aware of triggers for the person's behaviours.

A second person's care plan had not been updated following a fall nearly two weeks prior to this inspection which had changed the way they mobilised. We saw risk assessments had been updated and care staff

could explain to us how the person's mobility had changed and what support they needed, however, their care plan had yet to be changed. As at the last inspection in November 2015, some care plans lacked detail and we found they were not always up to date.

This was a breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as an accurate and contemporaneous record was not kept for all people.

Most people gave us positive feedback about the activities on offer at Ashcroft and told us their relatives could visit whenever they liked. One person said, "I do join in the activities in the conservatory", a second person told us, "Yes, I like them (the activities). I enjoy them and join in", and a third person commented, "Some are a bit simple, some are very good. I join in as much as I can." Other people told us they went out of the home with care workers. One person told us there were not enough activities and they preferred to stay in their room, stating the activities coordinator did not visit them there. Another described the activities as, "Very poor, not much change, monotonous."

The home had an activities coordinator and during the inspection we observed people engaged in a variety of activities. These included cake making and decorating, card games, singing, sitting outside in the sun, and watching TV. People were also offered newspapers and magazines to read. One relative told us staff at the home had arranged for a person to receive a newspaper from the area where they had previously lived. The large communal area contained different seating areas, so people could choose to sit near the TV or in a quieter area away from it. People from the dementia unit were also supported to join in activities in the conservatory area. We saw interactions between people which showed they had made friendships, and one person was visited by a friend who had themselves lived at Ashcroft previously.

An activities planner was displayed on the wall in the communal lounge area. Activities for the week we inspected included pet therapy, a music quiz, memory games, bingo, hand massages and afternoon tea. We saw activities were organised for every day of the week, including weekends. The home also produced a quarterly newsletter which included details of upcoming events, for example, trips on steam trains and canal boats, a summer fayre, and singers visiting the home. This meant people had opportunities to take part in meaningful activity, although they did not suit all those we spoke with.

We saw relatives coming and going throughout the inspection. There was friendly chatter between staff, people and relatives, and it was evident relatives were made to feel welcome at the home. People and their relatives told us they had not made any complaints about the home but would feel confident to if required. Comments included, "No, I haven't complained. There's nothing to complain about", "No (I haven't complained), but I know how", and, "I haven't made a complaint for over a year. Things were sorted out."

Records showed no complaints had been made since the last inspection. A complaints policy was in place and the welcome pack in each person's room gave instructions on how people could make a complaint if they needed to. A complaints and compliments file kept records of compliments received by the home, and we saw letters had been sent to relatives who had made donations to the home, thanking them for doing so. This meant the home recorded and responded to feedback it received.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us the home was well run. One person said, "It's run properly", and a relative told us, "It seems to be (well run)."

At the time of this inspection the registered manager had been on extended leave since December 2016 and was due back in October 2017. In her absence, the provider had agreed the deputy manager, who was also the lead nurse, would work Monday to Friday with only one of these days as a nurse. The other four days would be protected time to complete managerial tasks. However, the rota showed this was not happening. For example, in one 11 day period at the end of May 2017 the deputy manager had worked nine days, five of which were as a nurse. The week of this inspection the deputy manager had been rostered to work three days as a nurse. This meant on those days there was no acting manager at the home. A staff member told us other nurses were doing extra shifts to try and ease the deputy manager's workload. This meant the management arrangements put in place for the registered manager's absence were not being adhered to.

Feedback about the deputy manager from staff was positive. Comments included, "Staff work well and the (deputy) manager listens and is approachable", and, "I am happy, I feel supported and we work well as a team. The (deputy) manager is very approachable."

A range of audits was in place, most of which were completed on a monthly basis. At the last inspection in November 2015 we had found the audit filing system confusing, but at this inspection this had been resolved. We checked audits of medicines, mattresses, pressure ulcers, accidents and incidents, bedrails and care plans.

Some audits listed issues which had been identified, the actions taken to resolve them, and had been signed off as completed. Other audits had no action plans to show what action was to be taken, by whom, and by what date, even though issues had been identified. For example, on the medicines audit for May 2017 it had been noted the temperature of the clinic room had exceeded 25°C. The action recorded was to monitor the temperature and 'cool the room down on a hot day.' How this was to be done was not recorded and we found the clinic room was still over 25°C on our inspection nearly three weeks later. Another question on the medicines audit asked if all people's topical creams had been signed for; the auditor had added, 'To check TMAR (records of topical medicines) sheets', but whether this was done was not recorded.

At this inspection we found issues with medicines management. For example, not all 'when required' medicines had care plans, not all topical creams had body maps and charts to guide staff and record their application, and some medicines had prescription labels without appropriate instructions. None of these aspects was included on the medicines audit. The medicines audit also did not include a check of the fridge temperature, the management of homely remedies, or any checks on controlled drugs. The care plan audit used was a tick list of the expected care file content with an action plan of any issues identified. Actions we saw centred around missing care plans and whether people or their relatives had signed them; there was no question on the audit as to whether the content of care plans was up to date or person-centred, both of which were concerns we identified at this inspection. This meant audits in place at Ashcroft had failed to

identify and resolve the concerns we found at this inspection.

Audits for accidents and incidents identified whether appropriate action had been taken and/or measures to minimise future occurrences put in place for each individual incident. However, there was no overall trend analysis involving the location of accidents and incidents or the time of day they occurred, in order to identify any common themes. This meant information was not being audited to full effect.

Records supplied after the inspection showed the provider visited monthly to undertake a range of checks and audits, including aspects such as care plans, medicines, maintenance at the home, and the audits completed by the home's staff. Various actions had been identified by the provider as required, however, who was tasked with the action, when it was to be completed by, and whether the action had been completed, was not recorded. For example, the April 2017 audit found some staff required moving and handling training. There was a date of 17 May 2017 on the action plan and it was signed and marked 'completed.' At this inspection in June 2017 we found moving and handling training for nine care staff had expired. An action on the provider audit for May 2017 audit was, 'continue with regular supervision.' At both this inspection and the last inspection in November 2015 staff were not receiving regular supervision according to the provider's policy. This meant the provider's quality audits were not always effective means of driving improvement at Ashcroft.

At various points throughout this inspection we found the area where people's care records were stored in unlocked filing cabinets was unattended. This was both in the reception area and in the dining room of the dementia unit. This meant people, their relatives or visitors could access people's confidential information because it was not kept securely, as is required by regulation. Just as we were leaving on the final day of inspection the deputy manager located the filing cabinet key and said it would be used to secure people's information going forward.

At this inspection we identified a continuous breach of the regulation relating to consent. At the last inspection in November 2015 we raised concerns around staff access to regular supervision, incidences where staff were not respectful towards people, and the quality of people's care plans. These issues were found again at this inspection and comprised new breaches of the regulations relating to staffing, people's dignity, and good governance. We also identified a new breach of the regulation relating to safe care and treatment due to concerns with the management of medicines and risks to people. The lack of action taken to resolve concerns raised at the last inspection, and the identification of new breaches of regulation at this inspection, demonstrated a lack of governance and oversight by the registered provider.

Concerns around the lack of improvement and poor governance at Ashcroft were a breach of Regulation 17 (1) and (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection in November 2015 we identified a breach of the regulation relating to good governance as the registered manager had not notified the Care Quality Commission (CQC) about safeguarding incidents at the home, as is required by regulation. At this inspection we found all safeguarding incidents had been reported appropriately, so that specific regulatory breach was resolved.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to display the ratings of CQC inspections prominently on their websites and in their care homes. At this inspection we saw the ratings from the last inspection were displayed in the home; the provider does not have a website. This meant the provider complied with the regulations. Registered providers are also required to report other incidents to CQC in addition to safeguarding concerns, for example police call-outs and serious injuries. Records showed all notifications had been made as required.

Meetings for people and their relatives were held twice a year at the home. Minutes showed topics such as activities, entertainment and outings were discussed. An open forum was also held where people and relatives could ask questions or make suggestions. People, relatives and visiting healthcare professionals were asked to complete questionnaires about the home on an annual basis and a suggestion box was prominently displayed in the reception area. This meant people, their relatives and others had opportunities to feedback about the service.

Staff meetings were also held regularly at the home. Minutes showed various aspects, such as staffing levels, documentation, training, and the arrangements for the registered manager's period of extended leave had been discussed. The meetings had also been used as opportunities to praise staff for their efforts at the home. One care workers told us, "We talk about how to improve the home and the philosophy of the home. It's to give the residents the best." Other staff told us they could share their thoughts and opinions about the home at these meetings. This meant staff were provided with opportunities to feedback about how the home was run.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care staff did not always treat people with dignity and respect. This was also noted at the last inspection. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing We found gaps in staff training. Staff did not have access to regular supervision. This was a concern raised at the last inspection. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The home was not compliant with the Mental Capacity Act 2005. This was a breach of regulation at the last inspection. Regulation 11 (1) and (3)

The enforcement action we took:

We served a warning notice on the Registered Provider. They were told they must become compliant with the Regulation by 19 September 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks to people had been fully assessed and managed. Regulation 12 (1) and (2) (a) (b) Medicines were not always stored, administered or recorded safely. Regulation 12 (1) and (2) (g)

The enforcement action we took:

We served a warning notice on the Registered Provider. They were told they must become compliant with the Regulation by 19 September 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The home did not keep an accurate and contemporaneous record of the care and support people needed and received. Regulation 17 (1) and (2) (c)

Concerns raised at the last inspection had not been resolved. Governance arrangements put in place for the absence of the registered manager were not adequate. Records were not always kept securely.

Regulation 17 (1) and (2) (a) (b) (c) (f)

The enforcement action we took:

We served a warning notice on the Registered Provider. They were told they must become compliant with the Regulation by 19 September 2017.