Regal Care Trading Ltd

Ashcroft Nursing Home

Inspection report

Fairview Close
Cliftonville
Margate
Kent
CT9 2QE

Tel: 01843296626

Date of inspection visit:
18 October 2022

Date of publication:
29 December 2022

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Ashcroft Nursing Home is a residential care home providing accommodation with personal and nursing care to up to 88 people. The service provides support to people with nursing needs, physical disabilities and people living with dementia. At the time of our inspection there were 48 people using the service. The accommodation is arranged across two floors with lift access. There is a third floor, currently out of use.

People's experience of using this service and what we found
Audits on the service had been completed but quality assurance processes were not robust enough to identify shortfalls and take appropriate action. People had been asked their opinions of the service, but their feedback had not always been acted on.

People and their relatives told us they felt safe living in Ashcroft Nursing Home. One person said, "I am safe here, all the people are friendly." Another person said, "I feel safe, permanent staff are good and make it safe, but there are a lot of agency." One relative said, "Yes, I believe [relative] is safe. The staff respond." Another relative said, "Oh yes, it's a very good home. I can't praise them enough. There's plenty of people to keep an eye on them."

Peoples' needs were assessed before they moved into the service to make sure their needs could be met. Potential risks to peoples' health and welfare had been assessed. There was guidance in place for staff to minimise the risks and keep people as safe as possible. Checks had been made on the environment including fire safety and electrical checks.

The service had been adapted to meet peoples' needs. There were signs around the service and pictures on communal areas to help people find their way around. The service had cleaning schedules in place. People and relatives said the home was kept clean. One relative said, "The room is very clean and I'm very impressed."

People received care from staff who knew them well and people and relatives used words to describe the staff, such as kind, caring, lovely, helpful and friendly. One relative said, "The staff are excellent, gentle, patient and go above and beyond. I see enough staff present. You see a change of faces with agency coming in."

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

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

Rating at last inspection

The last rating for this service was good (published 7 July 2021).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels, training and standards of care. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We found no evidence during this inspection that people were at risk of harm from these concerns. Please see the safe section of the full report. However, we found evidence the provider needs to make improvements. Please see the well led section of the full report.

The overall rating for the service has remained good based on the findings of this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 safe. Details are in our safe findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
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

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Ashcroft Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ashcroft Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we received about the service since the last inspection. This included details about incidents the provider must notify us about, such as serious injuries. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who lived in the service and nine relatives about their experience of the care provided. We observed multiple interactions between people and staff throughout the day. We spoke with nine members of staff including the registered manager, operations director, nurses, care workers and support staff. We reviewed a range of records including four peoples' care records and multiple medication records. We looked at four staff recruitment files. A variety of records relating to the management of the service were reviewed including policies, health and safety checks, meeting notes, training records and audits.

Good

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● Staff had a good understanding of safeguarding and knew how to report signs of abuse and to whom. Staff were confident that actions would be taken if they were to report something. Staff told us and records confirmed that safeguarding training was up to date.

● Staff had recorded and reported allegations of abuse to the appropriate authorities. Safeguarding records were completed and showed staff cooperated with investigations. The registered manager shared lessons learned at supervision sessions or staff meetings.

● People and their relatives told us they felt safe living in Ashcroft Nursing Home. One person said, "I feel safe. It's nice here, we get the things we want." Another person said, "I feel safe; there are lots of people around." A relative said, "[Relative] is definitely safe. They check them and ask how they are." Another relative told us their relative was, "Absolutely safe. They are checked regularly and moved to prevent skin damage."

Assessing risk, safety monitoring and management

● Assessments were undertaken before people moved into the service to ensure their needs could be met. Risk assessments were clear, comprehensive and up to date. They contained enough information for care staff to provide safe care and manage any risks, such as falls, or choking. The provider used recognised tools for assessing risks such as skin damage and nutrition.

● Where people required monitoring charts such as weight, fluids or repositioning, these were in place and had been completed correctly. Where people required pressure relieving mattresses, we saw these were set correctly and checked regularly. People received safe care and treatment by the permanent staff who knew them well.

● During meal service, each person had a 'tray card' which detailed peoples' food likes, dislikes, allergies and intolerances. Some people needed modified diets due to a risk of choking; the cards also contained these details. This minimised the risk of people being given the wrong consistency of food or food they may be allergic to.

● Environmental risks were managed including fire safety, hot water, windows, electrics and maintenance of equipment. A maintenance folder at reception was checked daily so that faults could be rectified without delay. Staff had been trained in fire safety and knew how to move people safely in an emergency. Evacuation training had been completed and evaluated.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● The registered manager had made DoLS applications and had systems in place to track expiry dates and conditions.

Staffing and recruitment
● There were enough staff deployed to meet peoples' needs. The care management system had an in-built dependency tool, which helped the registered manager calculate the number of staff needed. Rotas showed planned shifts had been filled. People told us their call bells were usually answered quickly, depending how busy the staff were.
● Most staff told us they had enough time to carry out their role and spend quality time with people. One staff member said, "I could always do with more time, but I get what I need done and can still spend time with people for a chat." Another staff member said, "If there is a good team on, everything gets done and we don't seem to be too rushed."
● The service had staff vacancies. The registered manager had an ongoing recruitment campaign and at the time of our inspection two potential new care workers were awaiting outcomes from their pre-employment checks. Agency nurses and care workers were regularly booked to cover shortfalls in staffing levels.

Using medicines safely
● Medicines were managed safely in line with national guidance. Medicines were stored securely in clean, temperature-controlled conditions. People told us they got their medicines on time. One person told us, "The nurse gives me my medicine when I need it." A relative said, "There's no problem with medicines. The nurse gives them."
● Medicine administration records were completed accurately. Medicines were administered by nurses who had been trained and assessed as competent. Where people needed medicines through a skin patch the sites were rotated to prevent skin irritation. Where people had medicines 'as required' (PRN), for example for pain relief, protocols were in place and clear.
● Medicines were audited regularly. Medicines requiring additional control were recorded in line with legislation and were checked regularly by nurses.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was supporting people living at the service to minimise the spread of infection.
● We were assured the provider was admitting people safely to the service.
● We were partially assured the provider was using PPE effectively and safely. Not all staff wore their masks correctly over their mouth and nose. We discussed this with the registered manager; they were aware of this and were continuing to reinforce the requirements.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or

managed.
● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
The arrangements for visiting had not been updated in line with current guidance. Although visiting was not restricted people still had to make appointments to visit their relatives. We discussed this with the registered manager, and they will change this in accordance with guidance.

Learning lessons when things go wrong
● There was a system in place for recording accidents and incidents and staff knew what to do if someone had an accident. Records had been completed and were up to date. Professional advice was sought if necessary, for example, from the GP or emergency services.
● Accident and incidents were analysed to establish any trends or patterns, for example, time of day or day of week that the incident occurred. This enabled the registered manager to put measures in place to mitigate the risk. Lessons learned were shared through supervisions and staff meetings.

Good

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans were detailed and personalised and reflected peoples' preferences in all areas. There was information about peoples' likes and dislikes including their religious and cultural preferences. There was a life history for each person with information about people and events that were important to them. This helped staff get to know the person better and enabled them to provide person centred care.
- People were supported by staff who knew them well and understood their needs. Staff we spoke to, including agency staff, had good knowledge of the people they were supporting on the day of our inspection. Notes from a recent meeting with people stated, 'staff treated them well and their choices and preferences were respected'.
- Peoples' food preferences, likes and dislikes were documented, and most people told us they had a choice of meals. One person said, "There is normally two options," and confirmed they could ask for something different if they didn't like either. Relatives agreed choices were offered. One relative said, "They show [relative] pictures to help them pick their meal." The chef was knowledgeable about people and had a comprehensive list of peoples' dietary needs.
- The provider had a system in place for regularly reviewing the care plans and risk assessments and these were up to date. Any changes in a persons' needs or wishes were shared with staff during handover meetings.
- Peoples' choices about how they wanted to spend their time and who with was documented. People with mobility difficulties were supported to spend time with other people living in the service they had developed friendships with. They were supported to share interests such as having a beer together or watching a film or the football. During our inspection we saw a group of people sitting in the garden together enjoying a drink. One person living in the service oversaw planting flowers and vegetables.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Peoples' communication needs were assessed, and care plans documented people's preferred names, how they communicate and what assistance they needed from staff. For example, if people had hearing problems, staff were encouraged to face the person and speak slowly at their level and make sure the person had understood. Care plans also documented how staff could support people to stay in touch with

family and friends, such as ensuring the person's mobile phone was charged.
● Staff were observed communicating effectively with people. When people required spectacles or hearing aids, staff made sure they were working, and people used them properly to support better communication. If people needed pictures to help with communication, these were used. Documents were available in large print or other languages if these were required.
● Signage in the service was clear with pictures as well as words to aid understanding, for example, signs for the dining room, lounge and bathrooms.

Improving care quality in response to complaints or concerns
● The service had a complaints procedure. The registered manager investigated complaints received and outcomes were shared with complainants in accordance with the company's time scales.
● Most people and relatives we spoke to knew how to raise concerns and some had done so. One person told us they had raised a concern; the manager investigated and gave them the outcome and actions that they would take to minimise the risk of the same concern arising again. One relative said, "I raised a complaint and it all got sorted by the nurses." Most relatives told us they had no reason to complain.

End of life care and support
● The service was able to provide end of life care and support which enabled people to remain in the service if their needs increased and not have to move to a new service.
● Each person had an end of life care plan and peoples' wishes and preferences had been documented. Some were simple; saying their family knew their wishes and would make necessary arrangements. Others were very detailed and included music they wanted playing, what they wanted to wear, who they wanted informed and who they wanted with them. Religious and cultural preferences were also recorded.
● Staff worked with other health care professionals, such as specialist nurses, hospice teams and GPs to provide end of life care when required. Medicines were available to keep people as comfortable as possible.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was a management structure in place with a registered manager and two deputy managers. Nurses and care staff understood their responsibilities to meet regulatory requirements.
- The service did not have a clinical lead as part of the staff team; clinical oversight was provided by a manager who worked at another service locally. The registered manager told us they did clinical supervisions and had oversight of the clinical governance. However, we did not see any records of clinical supervisions or evidence to suggest this person met regularly with the nurses, including agency nurses, for the purpose of clinical oversight and governance. Some of these interactions were by telephone and since our inspection the registered manager has put measures in place to ensure these are accurately recorded.
- We were not assured the provider followed safe recruitment practices. Recruitment files had not been audited and were found to be incomplete. Gaps in employment histories had not been explored or documented and some records contained no evidence that an interview had taken place prior to appointment to assess the person's suitability for the role. The service used agency staff, but agency profiles held by the registered manager were out of date and incomplete. The registered manager could not be assured staff from the agency who were working in the service had the necessary skills and competence required for the role.
- The provider's senior managers visited the service regularly and undertook audits of the service. These audits had failed to identify some of the shortfalls found during this inspection, for example the sections on human resources and recruitment did not identify the issues with staff recruitment files nor the out of date agency staff profiles.
- We discussed these concerns with the registered manager and some immediate actions were taken to address them. However, these improvements had not been fully embedded into the service.

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

- Dignity meetings were held with residents every three months. Notes from these meetings did not detail how many residents attended, nor who, which made it difficult to assess if there was enough representation. There was no evidence that feedback had been acted on and there was no mechanism for obtaining views from people who were cared for in bed. Some people told us they had not been asked their views on the service. We discussed this with the registered manager who assured us actions would be taken to address this area for improvement.
- Staff told us, and documents confirmed they attended regular meetings. Handover meetings were held at the start and end of each shift so staff could be updated on any changes. Handover notes were recorded on

the care planning systems.
● The registered manager told us meetings with relatives had stopped because of the restrictions in place due to the COVID-19 pandemic. Although these restrictions had been lifted, meetings had not restarted. The registered manager told us they would be starting these again. There were no other mechanisms in place for liaising with relatives, for example, zoom calls or social media sites. Some relatives told us communication with the service could be better and many relatives would like the opportunity to have access to care records to give them a better understanding of their relative's care and support.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager told us they had an open-door policy and was always available for people and staff. Staff agreed; they told us they found the manager and deputy approachable and supportive. Staff said the teamwork was generally good and Ashcroft House was a good place to work.
● People and their relatives mainly spoke positively about the service. One relative said, "It's not bad, but not excellent, seven out of ten." Another relative said, "As I walk in, I sense a nice atmosphere going around. It's lovely and relaxed; nice and friendly. The staff work well together." A third relative said, "The atmosphere feels jolly and happy."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The Care Quality Commission (CQC) sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing support, truthful information and an apology when things go wrong. The provider understood their responsibilities.
● Relatives told us nurses contacted them if there were any changes in their relative's condition or if anything significant had changed, for example, a change in medicines.

Working in partnership with others
● The registered manager worked in partnership with local health and social care teams and had a good working relationship with safeguarding and commissioning teams. They played an active role in the local provider forum.
● Managers and nurses liaised regularly with other health professionals, such as dieticians, speech and language therapists, specialist nurses and hospice teams when required.