Care Quality Commission

Four Seasons Health Care (England) Limited

Ashcroft Nursing Home - Chesterfield

Inspection report

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Chesterfield
Derbyshire
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Ashcroft Nursing Home Chesterfield is a care home registered to provide personal and nursing care to up to 42 people. There were 32 people living there at the time of this inspection. The home is set over two floors, there are communal living and dining areas on each floor.

People's experience of using this service and what we found
The provider had failed to ensure government guidelines for working safely in care homes during the COVID-19 pandemic were implemented and adhered to. Staff were not always provided with clear guidance to support people who presented with behaviours that challenged. The governance systems used by the provider had not always identified areas requiring action or improvement. Relatives we spoke with told us they were confident their relation was supported by kind and caring staff.

The provider did not demonstrate there were always safe staffing levels, or that all staff had completed training before starting their role. Both of these issues were identified at the previous inspection we undertook last year, and the required improvements had not been made. We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed or that social distancing was promoted by the layout of the premises. The provider was not routinely monitoring people for the early signs of COVID-19.

At the last inspection a breach in regulations was identified in relation to the need for consent. This was addressed in the Effective domain of the last report. As this inspection is only reviewing the Safe and Well-led domains we were unable to review this breach.

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 Requires Improvement (published June 2019) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
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. We received concerns in relation to staffing. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led

sections of this report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashcroft Nursing Home Chesterfield on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to safety, staffing, safeguarding and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Care Quality Commission

Ashcroft Nursing Home - Chesterfield

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 Care Act 2014.

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
This inspection was carried out by two inspectors and an Expert 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 Chesterfield is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. 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 announced. We sent an email to the provider and registered manager to announce this inspection five minutes before we arrived.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and 14 relatives about their experience of the care provided. We spoke with 14 members of staff including the provider, registered manager, regional manager, nurses and care staff.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who have knowledge of the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection the rating has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were always safe staffing levels. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider is still in breach of this regulation.

● The provider was unable to provide evidence of there always being safe staffing levels. We identified two shifts in recent weeks where the rota did not show there were enough staff on duty as required by the provider's dependency tool. We asked the registered manager to provide evidence of how many staff were on duty on these dates and they were unable to do so.
● The provider's dependency tool recommended there be four staff on duty on night shifts. The provider was unable to explain how this was a safe staffing level given that there would only be two staff members on each floor and there were a number of people who required two staff to support them with personal care. This meant there would not be another staff member available to support people in communal rooms or respond to people in a timely manner.
● Staff told us there were not enough staff on night shifts. One staff member said, "There should be a staff member in the lounge at all times, but we can't do that because there's only four of us, staff are exhausted and many are leaving, we've requested more staff and it never happens."
● The provider was unable to demonstrate that all staff had completed training to carry out their role safely. The training matrix showed that nine staff had not started training the provider deemed to be essential, including safeguarding, fire safety and infection control. 11 staff were documented to have essential training that had expired. The records relating to staff competency assessments showed that five staff had not had their competencies assessed in any areas.

The provider had failed to ensure there were always enough suitably qualified, competent staff on duty. Staff had not always received appropriate support or training to carry out the duties they were employed to perform. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the provider contacted us to inform us they had increased staffing levels in the evenings from four staff to five.

● Safe recruitment practices were seen with staff having been interviewed and pre-employment checks such as references and criminal records checks were completed.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from abuse and improper treatment. For example, when reviewing people's daily notes, we found two documented occasions where people had been physically or verbally abused by another person. This had not been identified, investigated or referred to the local safeguarding authority and people's relatives had not been informed. This meant there had not been an opportunity for an independent investigation to ensure every precaution was taken and people were safe from avoidable harm.

● Staff told us they did not always feel confident to support people when they presented with behaviours that challenged, and had at times, reluctantly left people in uncomfortable or undignified positions.

Systems were not operated effectively to prevent abuse of service users. This was a breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the provider assured us these incidents would be followed up with communication with people's families and referrals to the local authority safeguarding team.

● There was a safeguarding policy in place and staff told us they would feel confident to raise concerns with the registered manager or with relevant professionals if they believed someone was at risk of abuse.

Preventing and controlling infection

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed or that social distancing was promoted by the layout of the premises. The provider had not ensured government guidelines for reducing the risk of COVID-19 in care homes were fully adhered to.

● The provider was not routinely monitoring people for the early signs of COVID-19. People and staff still sat close to each other in communal areas and staff did not always support people to remain socially distant where possible. Staff did not always take their breaks alone or socially distanced from people.

● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. PPE was provided for staff, but there was no designated area for staff to put on and remove PPE and no pedal bins for them to dispose of this safely. Pedal bins were put in place before the end of the inspection.

● Not all staff wore PPE appropriately. Some staff had face masks that were ill fitted and therefore did not offer the required level of protection.

● Staff training records did not demonstrate that staff had completed training to care for people during the COVID-19 pandemic.

● Although the home was visibly clean, there were areas in the home where infection risks had not been reduced, such as dried flower displays and areas where there would be lots of staff (such as the entrance hall as staff were leaving and arriving at the same time) where no action had been taken to promote social distancing or increase the frequency of cleaning of high touch areas.

Using medicines safely

● The provider did not always follow nationally recognised guidelines for medicine administration in care homes. Where people were prescribed medicines for as and when required (PRN) there was not always guidance for staff about how and when this medicine should be taken. Some Medicine Administration

Records (MAR) were hand-written, guidance states this should only happen for emergency prescriptions such as anti-biotics. This meant there was a risk of staff not recognising when people required their medicines and of there being errors in recording on MAR charts.

The provider had not done all that was reasonably practicable to mitigate all risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have signposted the provider to resources to develop their approach.

● The provider had introduced measures to prevent visitors from catching and spreading infections. The home was closed to visitors at the time of the inspection. When professional visitors needed to come in they had their temperatures taken and were provided with PPE to wear.
● We were assured that the provider was admitting people safely to the service. People were only admitted to the service after a negative COVID-19 test and there were plans in place to ensure people who moved in could shield in their bedrooms. We were assured that the provider's infection prevention and control policy was up to date. We were assured that the provider was accessing testing for people using the service and staff.
● At the last inspection we found that where people took their medicines covertly (without their consent, e.g. crushed in their food) the provider had not ensured the relevant guidance for staff and legally required documentation was in place. At this inspection we found improvements were in place, there was clear guidance for staff and all documentation had been signed by relevant professionals.
● Staff responsible for administering medicines were knowledgeable about people's care and we saw they took the time to be kind, calm and caring whilst supporting people to take their medicines.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● At the last inspection we found the provider had not assessed or mitigated risks to people's safety effectively. At this inspection we found some areas where risks continued to not be assessed effectively; however, we found improvements had been made in other areas, for example in the assessment and review of falls.
● When people had had a fall or an accident, there was a review and measures were in place to reduce further risk. People's weights, food and fluid intake and skin integrity were monitored to ensure signs of deterioration could be monitored and responded to early.

Inadequate

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 the last inspection this key question was rated as Requires Improvement. At this inspection the rating has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to implement systems and processes to ensure good governance. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider is still in breach of this regulation.

● The provider had failed to ensure government guidelines for working safely in care homes during the COVID-19 pandemic were implemented and adhered to. We sign posted the registered manager to guidance for identifying early signs of COVID-19 during the inspection visit, four days later these measures had not yet been implemented because the provider told us they could not locate the guidance. This meant people continued to be at risk because the provider had not kept informed of government guidelines during the COVID-19 pandemic.
● Staff were not always provided with clear guidance to support people with behaviours that challenged, this was also identified at the last inspection. For example, one person was known to become distressed and lash out when supported with personal care. The guidance in their care plan guided staff to give this person space and not invade their privacy. It was not clear how staff could support them with personal care and also give them space. Some staff told us they did not feel confident to support this person and some staff had been injured whilst supporting this person.
● The provider had not always identified times when staff had noted in people's daily logs that they had displayed behaviours that challenged, this included being violent to people and staff and the times when staff had been injured. The appropriate Antecedent, Behaviour, Consequence (ABC) charts had not always been completed. When they had been completed, the registered manager did not always review these or people's daily logs. This meant there had been times when there were missed opportunities for de-briefs for staff or independent investigations to mitigate future risk.
● The provider had not always ensured staff were supported to complete training to carry out their role. The provider's policy for 'Essential Training' noted it was the responsibility of the registered manager to monitor staff training and ensure this was completed. The registered manager was not aware of the gaps in staff training recorded on the training matrix and competency assessment record and had therefore not taken

steps to address this.
● The registered manager had not kept clear records of staff who had worked at the home. When asked to confirm when agency staff had worked at the home the registered manager did not have this information, including the staff members full name. The registered manager told us they would need to contact the agency to confirm people's names and when they had worked at the home. This meant the provider could not be assured that agency staff had completed training or that there had always the right number of staff on duty.
● There were some missing entries for full days from people's daily log records. This was in relation to a person who received one to one support. This meant the provider was not able to evidence this person had received their one to one support on those days.
● The registered manager undertook audits of infection control and medicine records. However, they had failed to identify the issues we identified with the lack of COVID-19 precautions, missing PRN guidance and hand-written MAR charts.
● The provider's website and statement of purpose contained some misleading information. They both noted that the home had been awarded a, 'quality banding Premium' by the local authority. The 'Premium' banding is an outdated term that is in relation to finance payment options and is not a reflection or judgement on the quality of the care provided.

The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of a regulated activity. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Working in partnership with others
● The provider had not always adhered to the duty of candour. They had not always identified when incidents of behaviours that challenged had occurred and had therefore failed to inform people's families or the relevant professionals.
● We reviewed notifications the provider is legally required to submit to us and found these were submitted to us.
● The local authority and clinical commissioning group informed us they received regular communication from the registered manager.
● The provider is legally required to display their CQC rating on their website, we saw this had been done.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
● Staff did not feel listened to, valued or supported. Some staff expressed they did not always feel their safety was considered. One staff member said, "There is a blame culture, we get shouted at for any little thing, the manager really isn't listening to staff." A different staff member said, "I have raised concerns, I was listened to, but I'm still worried the home can't cope with some of the people who live there."
● Due to COVID-19 restrictions relatives had not been able to visit so we phoned and asked about the communication they received from the home. Relatives told us they were confident their relation was supported by kind and caring staff and they had received clear and regular communication since the home had to close to visitors this year. One relative said, "I can relax knowing [Name] is safe." Another relative said, "They [staff] are really good, I have nothing but praise for them, they really listen to the residents and know them."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not operated effectively to prevent abuse of service users.

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 The provider had failed to ensure there were always enough suitably qualified, competent staff on duty. Staff had not always received appropriate support or training to carry out the duties they were employed to perform.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of a regulated activity.

The enforcement action we took:

Notice of Decision to impose conditions on registration.