Eight Ash Court Limited

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Inspection report

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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
Eight Ash Court Limited is a residential care home set across two bungalows. It provides accommodation and personal care for up to 12 people, including those living with a physical disability, learning disability and/or autistic people. At the time of the inspection there were 12 people living at Eight Ash Court.

People's experience of using this service and what we found
Infection prevention and control (IPC) measures at the service were poor, and up-to-date government guidance on the management of COVID-19 was not being adhered to in practice. This placed people at risk of infections. Risks to people's safety were not assessed and mitigated effectively, and we identified shortfalls and gaps in medicine records. There were not sufficient numbers of competent staff deployed at all times to ensure the service was safe, particularly at night. Lessons had not been learned following recommendations made at the last inspection, or from the input of other professionals.

The service was not well-managed, and quality assurance, monitoring and oversight systems were either poor or not in place. We were concerned about indicators of a closed culture, including in relation to the reporting of safeguarding concerns. It was not demonstrated people had consistently good outcomes, or they were always consulted and engaged with to ensure person-centred care. Other professionals reported concerns the management team did not respond adequately or in a timely way.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe and well-led. The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• The model of care did not maximise people's choice, control and independence.
• People were not supported to participate in meaningful activities personalised to their interests.
• Staff lacked training in how to support autistic people and people with a learning disability. Despite this being identified at the previous inspection, improvements on providing staff training had not been made.

Right care:

• The care people received was not always person-centred and did not always promote people's dignity, privacy and human rights.
• Effective systems were not in place to identify, report and take effective action to safeguard people from abuse.
• People were not always supported in a clean and hygiene environment, which ensured their dignity.

Right culture:
• The service was not ensuring Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.
• There was a lack of leadership oversight and knowledge to support autistic people and people with learning disabilities to promote a positive culture.

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 25 October 2019).
At this inspection enough improvement had either not been made or sustained and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to safeguarding, risk management, staffing levels and infection control. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

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 to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the management of the service, staffing levels, identifying and

reporting safeguarding, infection control, and risk management at this inspection. The provider had also failed to notify the Commission of incidents as required by law, including abuse or allegations of abuse.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
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 six 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Eight Ash Court Limited

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
The 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
Eight Ash Court Limited 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.

There was a registered manager in post who was also a co-director of the company which owned the service. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Notice of inspection
This inspection was unannounced. The inspection activity started on 7 July 2021 when we visited the service and finished on 22 July 2021. We completed some of this inspection remotely to reduce the risk of COVID-19.

What we did before the inspection

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We reviewed information held about the service, including information provided by the local authority and other professionals. We used all of this information to plan our inspection.

During the inspection
We met seven people using the service. Where people were unable to express their views, we observed how staff interacted with them and monitored their welfare. We also spoke with the registered manager and six members of staff including the administrator, deputy manager, team leader and support workers. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and medication records. We looked at training records, two staff recruitment files, staff rosters, minutes of staff meetings and incident reports. A variety of records relating to the management of the service, including responses from the provider in relation to safeguarding concerns raised, medication audits, policies and procedures were reviewed. An Expert by Experience telephoned and spoke with six people's relatives or representatives to gain their views of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We raised concerns with other professionals including the local authority quality and safeguarding teams and the Clinical Commissioning Group (CCG).

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 this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

At our last inspection we recommended the registered manager used a reputable source to assist them in providing a more effective oversight in relation to infection control audit and risk assessments. This was to support them in identifying all potential infection control risks within a care home setting. In not acting on this had led to a deterioration into the cleanliness of the service.

- The premises were not clean and hygienic. We identified numerous concerns, included a heavily stained shower curtain, a build-up of grime where the shower room floor was not sealed, ripped furniture, dusty radiators and food residue in microwaves. The registered manager told us there was no dedicated cleaning team, and no formal audits were completed on infection prevention and control (IPC).
- At our last inspection, a broken bath plug chain which had been replaced with string had become black and slimy. Staff had not identified the porous string created a potential breeding ground for bacteria. The provider took action at the time to replace this with a chain. However, during this inspection, string had again been used as a bath chain and for bathroom light pulls and was seen to be discoloured and soiled.
- Clinical waste was not disposed of safely. We observed one member of staff dispose of gloves used for personal care in the kitchen general waste bin where a meal was being prepared, and another put a used disposable apron in a laundry basket. A number of used gloves were found in a pot without a lid in the laundry room, which could contaminate clean washing.
- Personal protective equipment (PPE) was not being worn correctly in line with up-to-date government guidance, and we observed unsafe PPE practice throughout the inspection site visit. This included staff wearing fabric face masks, masks worn under a staff member's chin, and inappropriate use of gloves and aprons throughout communal areas which could pose a contamination risk. No effective measures or supervision was in place to support staff to improve.
- Whilst the provider told us COVID-19 testing was being undertaken on staff and people living at the service, this was not being managed safely or hygienically. We found 21 used Lateral Flow Device (LFD) COVID-19 test cartridges in a plastic bag pinned to the staff notice board, and another used test swab in amongst clean PPE that was being stored on the floor next to fresh food. We asked the registered manager to dispose of these items.
- Inspectors were not asked to have their temperatures checked, provide proof of a negative LFD test or screened for signs and symptoms of COVID-19 at the door, despite this previously being identified as a concern by other visiting professionals. Whilst adequate checks were not being completed, steps had been taken to create an outside visiting space for families. One person's relative told us, "They have built a gazebo for visiting safely."
- We were not assured the provider understood how to safely re-admit people to the service following a hospital stay, as the information provided by the registered manager was contrary to government guidance.

● Open buckets and washing bowls were used to transfer items contaminated with bodily fluids. This raised a potential risk of cross contamination and breathing in moisture droplets whilst transporting items to the laundry room waiting to be washed. The registered manager told us staff should be using specialist bags which reduce this risk. They were not observed to be in use during the inspection or mentioned in the infection control policy.

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

Assessing risk, safety monitoring and management

At our last inspection we recommended the registered manager uses information from a reputable source, to support them in consistently identifying and taking effective action to minimise potential risks. This had not been acted on, which had resulted in no effective improvements being made.

● It was not demonstrated that effective systems were in place to identify, monitor and mitigate risks to people's safety. As the care plan records we reviewed were contradictory, it was not clear the information held was accurate, had been reviewed and met people's current needs.
● One person had an 'as required' medication protocol for pain relief which stated, "When tearful and agitated staff need to check when period is due". A period tracker was in the person's care file, but had not been completed, which could place the person at risk of being in pain. The registered manager was not able to confirm whether the person had periods or not, and contradictory information was provided by another member of staff.
● We found one person's Personal Emergency Evacuation Plan (PEEP) incorrectly stated they had a greater level of mobility than was the case, as this document had not been updated in line with their changing needs. This placed them at risk in an emergency evacuation situation.
● Fluid monitoring charts were not being consistently completed to ensure people received adequate hydration. One person had a partially completed record, with no entries for the previous two days. We raised this with the registered manager who could not provide an explanation for the missing entries.
● One person's relative told us they were concerned about inconsistent monitoring and documentation of their loved one's seizures, and told us, "They are not being recorded".
● The service was in the process of transitioning to a new electronic care planning system. The registered manager acknowledged that one person's paper care plan records were out of date but told us a new electronic one had been created. However, as not all staff could not access this system and had not been trained on how to use it, the information was not accessible.

Using medicines safely
● Medicines were not stored safely and securely. We found keys to medicine safes, including for controlled drugs, hanging up in an office with the door unlocked and open.
● Medicine Administration Records (MARs) were not always completed in line with best practice guidance. For example, we found one MAR had been signed to confirm the person had received their medicine, but then a code to state the person was in hospital had subsequently been written over the signature and the amount of medicine remaining in stock changed back by one.
● Another person did not appear to have received the correct dose of medicine as prescribed, as only one tablet had been given instead of two. No refusal or reason for this had been recorded on their MAR and this discrepancy had not been identified by oversight systems in place.
● During stock checks, we found one person's emergency epilepsy medicine in the bungalow they did not live in. We raised this with the registered manager who told us they were checking the medicine. We asked them to return it so it would be immediately accessible if urgently needed and staff knew where it was.

We found systems were either not in place or robust enough to demonstrate safety was effectively managed, including for infection prevention and control and the safe management of medicines. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we recommended, to help embed safeguarding into practice, staff training should also include discussions about the provider's whistleblowing policy, scenarios to practice and staff's accountability in reporting any concerns at the time. This had not been acted on, which had resulted in no effective improvements being made.

● Whilst some relatives did not have concerns about the safety and quality of care, there were concerns about how some people's anxieties and needs impacted on others living in the service. The leadership had not fully recognised this in order to explore and seek external professional's advice on how they might reduce these occurrences and improve people's experiences
● Incidents were not being effectively recorded, acted on, or triaged to see if they met the criteria or threshold for reporting a safeguarding to the local authority and/or required reporting to the police. This meant there were missed opportunities to promptly reduce risks for the individual and potentially others at risk of harm. One person's relative told us there had been a reduction in support for their loved one which did not reflect their needs and, "When I asked the manager why he said they needed incident forms with triggers and outcomes." Care records and staff could not demonstrate how people's changing needs were being met in the interim when they sought help or other professional advice
● The lack of effective systems in this area was identified by the local authority safeguarding team, rather than the provider, during visits to the service following concerns.
● It was not demonstrated there was a healthy and proactive safeguarding culture embedded at the service. Staff had anonymously reported whistle-blowing concerns to the CQC, rather than feeling comfortable or able to inform the management team for referral to the local authority.

Safeguarding was not embedded in practice. Effective systems were not in place to identify, report and take effective action to safeguard people from the risk of abuse. 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.

Staffing and recruitment
● We were not assured that staff had the appropriate skills and competency to support people with behaviour linked to anxiety, distress or other factors.
● At the time of inspection, several people at Eight Ash Court were living with epilepsy. Despite this, 15 out of 28 staff members did not have up to date training in administering buccal medication, which is used to treat epileptic seizures in emergencies. There was not always a trained person available during the night shift. This placed people at risk of not receiving timely emergency treatment which could result in poor health outcomes.
● There was one member of staff assigned to work at each bungalow during the night. However, the staffing model did not consider the risks for occasions when two staff were needed, or arrangements for staff breaks to ensure people were safe. The registered manager told us they were recruiting additional night staff but there were no interim arrangements. The provider could not demonstrate how the numbers and deployment of staff were linked to the current assessed needs of people during the day and at night.
● We received mixed feedback about staffing levels and consistency. One person's relative told us, "[Staff]

do a fantastic job, just an issue with staffing levels." Another person's relative told us, "The care staff do change a lot, especially the men."

● Although people had been living at Eight Ash Court for several years, there was no tool in place to check staffing levels were still correct, despite people's changing needs. The opportunity to reflect on changes which could trigger formal reviews to assess whether people required more support had not been taken.

● There were no dedicated cleaning staff employed, and the provider had not considered the impact on this of staff having to complete cleaning duties as well as providing people with care and support. This meant cleaning standards were poor.

There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment checks were undertaken on staff, including references from previous employment and Disclosure and Barring Service (DBS) checks. However, interview questions and responses were not documented to show how staff had been assessed as suitable for the role.

Learning lessons when things go wrong

● The provider did not respond promptly and take effective action when concerns were raised by external professionals. This prevented any learning that could have been generated being shared with the wider staff team to support improvement.

● There had been an outbreak of COVID-19 at the service in one of the bungalows. Despite this, IPC measures, including the safe management of COVID-19, remained poor.

● Concerns raised at the previous CQC inspection of the service had continued, including use of string for bath chains and poor recording of incidents.

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 this key question has now 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

At our last inspection we made a recommendation the provider review how they use resources more effectively to support the leadership with keeping up to date with best practice. We further recommended they use this to address shortfalls identified during the inspection and to be a driver for continuously achieving good outcomes for people. At this inspection, insufficient action had been taken in line with our recommendation.

● Awareness and understanding of safeguarding processes was not demonstrated at management level. The registered manager had not notified the CQC of events that had occurred, including safeguarding allegations. Notifications are required by law to ensure the CQC can monitor the service and ensure people are receiving safe care.

The provider had not submitted statutory notifications of abuse or allegations of abuse as required to the CQC without delay. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● The service was not well-managed, with inconsistencies and shortfalls in oversight and identification of concerns and risks. There was no robust system in place providing assurance the quality and safety of care and support was being monitored and sustained. People did not have consistently good outcomes as a result.
● Auditing was either poor or not in place in key areas of the service such as medicines management and infection prevention and control (IPC). Concerns found during our inspection site visit had not been independently identified by the provider's own quality assurance processes. Where the provider was aware of concerns, for example following the input of external professionals, no robust action had been taken.
● At our last inspection we found the doorbell to one bungalow was high pitched and shrill. This was not in keeping with a homely, domestic environment, and one person's relative told us the noise "frightened" or startled them. Although the registered manager told us action would be taken to reduce the volume of the doorbell, at this inspection the doorbell remained extremely loud and intrusive.
● The management structure at the service was unclear, and we were provided contradictory information on whether a deputy manager was or was not in post. This did not demonstrate staff responsibilities and

accountabilities were set out in a straightforward way, so they could be understood and acted upon by staff.

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

● There was a lack of provider oversight, training and knowledge to support autistic people and people with learning disabilities, an indicator of a closed culture. Training records showed staff had not all been provided with this additional training on how to meet people's needs.

● It was not demonstrated people's care and support needs had been robustly assessed within the context of a shared living space, including any potential impact on other people. This showed a lack of compliance with the Right care, right support, right culture guidance.

● Everyone living at Eight Ash Court regularly attended a day centre, despite a staff member stating to the inspector some people, "Don't get much out of it". This activity had not been considered for people on an individual basis to ensure it was meaningful and engaging.

● We received mixed feedback from people's relatives about the quality of the service and whether the care and support was person-centred. Some people were happy with the service, whilst others expressed concerns. One person told us, "The manager is nice, but it is run as a business."

● The registered manager told us an anonymous staff survey was being planned to seek staff views on the service and management approach, including any suggested improvements.

● The provider has a set of policies and procedures in place for the running of the service. There is also a Statement of Purpose which sets out the ethos and purpose of the home. However, these do not reflect the experience of people using the service. There is a lack of understanding about current best practice. This includes being unable to demonstrate care is person-centred and that there are clear lines of accountability and responsibility alongside robust risk management.

● The provider is failing to ensure the service is being run to enable a focus for people with complex and changing needs. It also is failing to show how it promotes the principles of Right support, right care and right culture principles.

Continuous learning and improving care; Working in partnership with others; 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 provider had not acted on the recommendations made at our last inspection in a number of areas. This was a missed opportunity to learn and develop the service.

● It was not demonstrated the provider worked effectively with partner agencies to drive improvements and meet people's needs, missing deadlines or not returning required information in a timely manner. This led to delays including supporting people with a clean and hygienic environment, reporting safeguarding incidents and triggering people's reviews when their needs had changed.

● The impact of this poor or delayed response on people living at the service was not acknowledged by the provider, which did not reflect an open and transparent approach when things go wrong. One person's relative told us, "Communication with the manager is diabolical."

● As a result of this inspection we had to seek urgent assurances from the provider about staffing levels, as well as referring further concerns to other professionals such as the local authority and Clinical Commissioning Group (CCG).

Systems were either not in place or not robust enough to evidence effective oversight of the service and the fulfilment of regulatory requirements, placing people at the risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted statutory notifications of abuse or allegations of abuse as required to the CQC without delay.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding was not embedded in practice. Effective systems were not in place to identify, report and take effective to safeguard people from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or not robust enough to evidence effective oversight of the service and the fulfilment of regulatory requirements, placing people at the risk of harm.

The enforcement action we took:

Warning notice