Isys Care Limited

Ashdale Care Home

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
Ashdale Care Home is a residential care home providing the regulated activities of personal and nursing care to up to 22 people. The service provides support to people aged 65 and over and adults with physical disabilities. At the time of our inspection there were 16 people using the service. Accommodation is provided over 2 floors. A communal lounge with a dining room is based on the ground floor.

People's experience of using this service and what we found

Records relating to people's care did not always contain information and guidance to enable staff to provide the safe care and support people required. Risk management was not in place for some people who were at a high risk of choking, falls and needed to use bedrails to keep them safe.

People were not supported by staff who had been appropriately trained and assessed as being competent to deliver safe care and treatment to people. People were left at risk of being supported by staff without the skills and knowledge to support their identified needs. People had not received their medicines in a safe way and as prescribed by their GP.

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 or in their best interests; the policies and systems in the service did not support this practice.

The service was not well-led. There was no effective governance system in place to monitor the quality of the service provided to people. The provider continued to fail to recognise risks and concerns in relation to risk management, safeguarding, and medicine management. Lessons were not being learnt or action taken by the provider when additional support was provided to them by the local authority in-between inspection visits.

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 4 November 2022). The service is now rated inadequate. This service has been rated requires improvement for the last 2 consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and further risk was found.

Why we inspected
The inspection was prompted by information shared by stakeholders. We received concerns in relation to the management of medicines, people's nursing care needs, staffing, poor care planning and risk assessing. As a result, we undertook a focused inspection to review the key questions of safe 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 have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection
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 Ashdale Care Home on our website at www.cqc.org.uk.

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.

Enforcement
We have identified breaches in relation to safe care, consent to care and governance at this inspection.

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
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.

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 safe findings below.

Ashdale Care 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 2 inspectors and a specialist nurse advisor.

Service and service type
Ashdale Care 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. Ashdale 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
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. 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 observed people and their interactions with staff and each other throughout the inspection. We spoke with 5 people, 4 relatives/representatives and 1 health and social care professional to gain their views. We also spoke with 9 members of staff including the nominated individual, independent consultant, manager, 2 nurses and 5 care staff. 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 9 care plans and all medicine records. We reviewed a range of records relating to the management and oversight of the service, staffing, risk assessments and health and safety records. After the inspection we continued to receive and review health and safety records, information relating to training and a range of policies and procedures.

Inadequate

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 requires improvements. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were at risk of repeated incidents because lessons were not learnt when things went wrong. Two people had fallen and sustained serious injuries. There was no investigation of the accidents and staff had not been provided with clear guidance to prevent similar falls occurring again. This left people at high risk of repeated incidents and injury occurring.
- People were at risk of injury from unsafe moving and handling techniques. One person's care plan stated they needed equipment to transfer in and out of a chair. We observed Staff transferred the person 3 times using an unsafe technique and without the required equipment. The inspector explained their safety concerns to staff, but the person was then moved a fourth time in the same unsafe way. This meant improvements had not been made to safe moving and handling when concerns were raised.
- On the first inspection day, we raised moving and handling concerns to the management team and action was taken to train staff on safe moving and handling techniques. However, over the 3 inspection site visits we found staff had not received clear written guidance on how and what equipment people needed to mobilise them safely. This lack of guidance could impact staff's ability to apply their training to meet people's needs.
- People were at risk of choking. On the first day of inspection, staff had conflicting guidance on what texture food a person needed to safely swallow their food. The person's lunch time meal was prepared to an unsafe texture. We observed the person to struggle to eat their food and staff did not intervene. This put them at high risk of choking. These choking risks were raised to the management team. When we returned on the second and third inspection visit, we found limited action had been taken to improve choking risks at the service. This meant people at the service remained at high risk of choking on an inappropriate texture diet.
- People were at risk of injury when in bed. Risk assessments identified certain people were at risk of being confused and climbing over bed rails, this would put them at serious risk of injury. Despite this identified risk, bed rails were still provided, and other options had not been considered. We raised this concern to the management team on the first day of the inspection, they advised they would take action. When we returned, we found action had not been taken and people remained at risk of injury.
- Fire risks were not safely managed. We found a warning light showing on the fire alarm panel which suggested a fault. Staff told us the warning light had been showing for 3 months. The management team could not explain why action had not been taken. The provider had a fire risk assessment with 12 identified actions, but no action had been taken. These failings left people at high risk of harm in the event of a fire.

Care and treatment was not being provided in a safe way to people. The provider failed to ensure they were doing all that was reasonably practicable to mitigate risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 not always working within the principles of the MCA.
● Mental capacity assessments had not been completed for all decisions where people's capacity was in doubt. For example, no MCA's had been completed for medicines, personal care, and use of equipment where people's capacity to consent was in doubt.
● Mental capacity assessments and best interest decisions were not always in place for people who had restrictions. We identified 12 people had bed rails and bumpers to prevent them falling out of bed. Some of these people experienced confusion and records showed they could not understand the risks of bed rails. However, no documentation had been completed to assess if these rails would be suitable and in their best interest.
● Best interests decisions had not always been carried out to demonstrate decisions had been made in people's best interests. For example, the provider had asked relatives to sign consent forms for the use of bed rails. Best interests is a statutory principle set out in the MCA.

The provider failed to ensure consent to care, and treatment was in line with the law and guidance. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

●There were not enough staff to meet people's care needs.
● The provider was using high level of agency staff to cover shifts. Agency staff had not been provided with clear information and guidance on people's health care needs. For example, an agency staff member who had been there for a week could not explain if a person's wound had healed. The care plan had not been updated to guide the agency staff member on the history of the wound. This meant people were at risk of developing new wounds in the same area and staff not recognising these.
●We received mixed views on staffing levels. People, staff, and relatives did not always feel there was enough staff to meet people's individual needs. One person told us, "I want to be looked after more. I don't feel like they are looking after me enough, especially with my sore [wound management]." Staff told us, "I think they [staffing levels] have gone down but they are using a lot more agency than ever. That's because people are leaving, I do think the staffing is at safe levels." A relative told us, "The staff is hit and miss. I would say yes (There are enough staff) but a lot of it is agency staff."
●Staff were not always sufficiently trained to meet people's needs. For example, staff had not received training to support people with swallowing difficulties. Kitchen staff could not explain how to prepare meals of different modified textures to meet people's assessed needs to ensure they did not choke. Twice staff had served the wrong texture diet to a person during our inspections. On the second day staff had asked the inspectors if the second meal was the right level as they were unsure how to prepare it. This lack of knowledge and training placed people at an increased risk of choking.
● Staff had not received regular supervisions and competency assessments to ensure they were competent to carry out their role. This placed people at risk of not receiving safe care and support.

The provider had failed to ensure people received safe care by deploying enough trained staff to meet their needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

Systems and processes to safeguard people from the risk of abuse

● Safeguarding training was overdue for all staff. The provider was aware but did not take action to ensure staff were suitably trained to recognise and respond to potential signs of abuse.

● People were not always safeguarded from the risk of abuse. The provider had not investigated incidents to ensure abuse was identified or investigated appropriately. Action had not been taken to reduce the risk of abuse occurring.

● Analysis of incidents to identify themes and trends in relation to falls, medicine management and choking did not take place. This meant people were exposed to the risk of avoidable harm.

● Staff did not always speak to people respectfully. For example, during lunch time we saw a person did not want to eat their meal. The staff member argued with the person and told them that they had ordered the meal and would need to wait for an alternative. The conversation and tone used by the staff member was unkind and lacked any compassion.

Using medicines safely

● People were not administered their medicines as prescribed. For example, people who needed to have medicine at a specified time before food intake, had not been given their medicine on time Staff in charge of medicines told us, they give people all the medicines at the same time and were not sure when people had food before or after the administration. Not giving time-specific medicine at the right time, could potentially impact the effectiveness and cause a deterioration in their health.

● Some people had swallowing difficulties and were prescribed a thickening agent to add to their drinks. Thickening agents ensure people's drinks are made to a certain consistency to help the person swallow safely. We found drinks thickener had been left in a communal area and could be accessed by anyone which meant people were at risk of choking if accidentally ingested.

●Health professionals had visited the service in August 2023 and had identified poor medicine managements. The provider failed to take action from their feedback, and we found medicine Incidents had recurred because action had not been taken to prevent them. For example, missed medicine doses because they had ran out of stock. This meant people were at risk of avoidable harm and not receiving their medicines as prescribed by the GP.

Preventing and controlling infection

●We found the sluice rooms were soiled and there were wooden components. The wooden components would make it difficult to clean in line with good practice guidance. Other than the sluice room, the home was suitably clean.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Where medicines were prepared, administrated and disposed of was visibly dirty. For example, the medicine storage trolley and fridge had dried liquid stains and the sink within the medicines room was visibly unclean and dirty.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The visitor arrangements at the service were in line with current government guidance. Visitors were in the home throughout the inspection

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 our last inspection we rated this key question requires improvements. At this inspection the rating has changed 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

- People received a service that was not well-led. There was no registered manager in post at the time of our inspection. The nominated individual who also was the provider was managing the service. We had raised concerns, and we were informed that more management support would be available at the service. We found this increased management support did not occur in a timely way. When we returned 4 weeks later to the service, there was no management at the service, staff reported a lack of management support and we saw the same risks remained at the service.
- The Nursing team were not always aware of their role and responsibilities at the service. There was a lack of oversight of the clinical care due to no clinical lead and all the nurses on duty were agency nurses. Nurses were not supported to understand their roles and responsibilities in this area. This led to people being at risk of harm due to being exposed to ongoing unsafe care practices. For example, we found a person who required diabetic support did not always receive their support as required. A relative also raised concerns of poor diabetes management, which resulted in a person being hospitalised.
- We found the provider did not have a robust system for ordering medicines. We found 2 people had run out of medicines during our inspection. A staff member told us they were not aware of the process to order medicines and would tell the manager. We also found a control drug had been ordered when a person had passed away and was missing. This incident had not been reported to the police or the Commission. Staff could not explain what had happened. This meant there was poor oversight with medicine management.
- The provider had failed to ensure robust governance processes were in place to monitor the safety and quality of people's care. An audit process had been implemented; however, it was ineffective because the audits had not identified concerns and all audits completed showed the service was safe. The failure to have effective oversight in place restricted the ability to identify risks to people and address concerns.
- The provider failed to take adequate action to mitigate risks to people. We asked for reassurances on what action the provider had taken to mitigate the risks we identified and feedback after the inspections. The provider shared 3 action plans. However, over the inspection site visits day 2 and 3 we found these action plans had not been followed and risks to people had not been mitigated.
- The provider had not ensured they checked staff competencies to ensure they could safely carry out their role in line with their training and good practice. For example, staff were observed to use unsafe moving and handling techniques. Before the inspection staff had not received training or competency assessments to ensure they had suitable skills to care for people safely.

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, Working in partnership with others

● People were not always supported in an empowering way to enable them to have choice and be supported in a dignified way.

● The provider failed to ensure there was a system or process for people, staff, relatives and visitors to be involved in developing the service. The provider made no engagement with people to obtain their feedback to improve and develop the service. The last recorded staff meeting was over a year ago.

● The provider had failed to have system and process for staff to feedback to management. Staff did not have supervisions and staff team meetings were not held. Supervisions and staff meetings provide staff members with an opportunity to reflect and learn from their practice, check competence, identify training needs and discuss concerns. Staff told us, 'Not had a supervision or appraisals we used to have them every 6 weeks, but it has not happened.'

● The provider failed to have effective processes and systems to communicate with staff to ensure they were provided with information and guidance. Staff told us, "Since all our nurses have left, I don't feel supported, the agency nurses are so busy. There is no communication and when your off, you don't come back and have a handover."

● The provider had been working with the local authority. The local authority had completed visits to support the service to make improvements. However, the provider failed to implement the support, recommendations, or take appropriate action to improve the service.

●The provider had not made timely referrals or worked closely with other professionals to achieve the best outcomes for people. We found people had not been promptly referred when a change in their health or social care needs had been identified. This meant people were at increased risk of not receiving the appropriate health care support to keep them well.

Continuous learning and improving care

● The provider failed to have effective systems and processes for continuous learning and improving care.

● Concerns, risks, poor practice had been shared with the provider by the local authority and we found the same risks remained due to the lack of action taken by the provider to improve the quality of care.

● Lessons were not being learnt due to the lack of oversight by the provider or their management team. This left people in receipt of poor care and treatment.

● The provider failed to ensure staff were provided with the information and guidance to ensure they could do their role safely. Staff told us, "We do not get to know what we need to know about the residents and changes if we aren't on shift. It's not like what it used to be. A lot of the time the office door is shut."

●The provider had failed to demonstrate all staff had Disclosure and Barring Checks completed. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

The provider failed to ensure good governance systems were in place to assess, monitor and mitigate the risks to people or maintain securely accurate or up-to-date records of people's care. This was a continued breach of Regulation 17 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,

● The provider told us they understood their duty of candour. They told us they had made contact with people and relatives when things had gone wrong.

● Incident and accident records did not always show the duty of candour had always been followed when

things went wrong.

● We could not be assured the provider had notified the Commission of notifiable incidents because of the poor record keeping of incidents. Local authority had raised high risks concerns relating to medicines and health care not being providing as assessed that would be a notifiable to the Commission and these had not been reported.

● Relatives told us the provider communicates with them when things went wrong. "[person] had a couple of falls and they were dealt very well by the home, wasn't on the floor for a long time."