Healthcare Homes (LSC) Limited

Ashley Gardens Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ashley Gardens Care Centre is a residential nursing home providing personal and nursing care and treatment of disease, disorder or injury to up to 89 people. The service provides support to older and younger adults with dementia needs and nursing needs. At the time of our inspection there were 76 people using the service.

Ashley Gardens Care Centre is a purpose-built care home, with accommodation across three separate floors Each floor has separate adapted facilities, such as dining room, kitchen area and lounge. People had their own bedrooms and toilets.

People's experience of using this service and what we found
Risks to people had not been fully mitigated since our previous inspection. Some people with constipation or other health conditions such as diabetes did not always receive their assessed care.
We observed there were times when there was not enough staff, and people, staff and relatives confirmed this. Some people did not receive medicines when they should, meaning they were at risk of experienced discomfort or distress. Accidents and incidents were not always reported to managers which meant that lessons may not have been learned and shared, and improvements made.

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.

Quality audits had not always highlighted where improvements were needed in service delivery and some concerns had not been shared with managers. Some incidents of bruising to people had not been reviewed to ensure risks were mitigated.

Risks to people from falls and complex eating and drinking needs had been addressed by the provider and care plans were improved. A new management team had been driving improvements and a new manager had started and was in the process of registering with CQC.

People told us they liked their staff and we observed caring interactions. One person commented, "The staff are kind and caring; you can't fault anything to do with that."

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

Rating at last inspection and update:
The last rating for this service was Inadequate (published 14 October 2022) and there were 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 we found some improvements had been made and the provider

was no longer in breach of regulations relating to safeguarding. However, despite some improvements the provider was still in breach of regulations relating to safe care, good governance and staffing.

Why we inspected
The inspection was prompted in part due to concerns received about diabetes care and staffing. A decision was made for us to inspect and examine those risks.

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.

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

Enforcement and Recommendations
Following our last inspection we imposed conditions on the location meaning the provider must send reports of audits completed every month. The provider has been complying with this condition and updating CQC on the improvements they are making in the service.

We have identified continued breaches in relation to safe care, staffing and good governance.

Please see the action we have told the provider to take at the end of this report.

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

Special Measures
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Ashley Gardens Care Centre

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 team consisted on three inspectors on the first day and one inspector on the second day.

Service and service type
Ashley Gardens Care Centre 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. Ashley Gardens Care Centre 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. However, a new manager had started the day of our second site visit and will be registering with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the 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
During the inspection we spoke with three managers, five nurses, four care staff, the chef and domestic staff. We spoke with nine people, seven relatives, and professionals who visit the service. We reviewed seven people's care plans and risk assessments, and a range of documentation such as medicines records, audits, and recruitment files.

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 Inadequate. At this inspection the rating has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, using medicines safely, and learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people and learn lessons when things had gone wrong. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Despite some improvements not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Not all risks had been managed safely. Some people were living at Ashley Gardens Care Centre were prone to constipation. One person had been prescribed 'as required' PRN medicines for this condition. These were directed to be given after three days of not opening their bowels. However, the person went six days with no bowel movement and had not had their bowels effectively monitored or received any of their PRN medicines. This left the person at risk from associated health conditions and poor bowel health.
- Some people needed their fluid levels to be monitored and for staff to give more fluids when they had not drunk enough. One person had different levels recorded in care plans for their recommended daily amount of fluids but had not reached any of these levels in four days preceding our inspection. This was at a time they were experiencing constipation, so would have needed extra fluids to be given to help this condition. Their dehydration risk assessment had also not been scored correctly. This left the person at risk from dehydration.
- One person with diabetes had not received safe care. They had had their blood sugar levels checked before and after lunch and this had shown a reduction in glucose levels. However, they did not have their bloods checked again for almost four hours and was found by a relative who described them a 'fitting' due to low blood sugars.
- We spoke with the relative who found the person and they told us that other family members had recently found the person having seizures caused by low blood sugars. The relative told us they were concerned the person was left in their room, with blood sugars that were falling. They said, "I would expect nurses to check bloods an hour after (the last check) at the latest; especially if (name) was left asleep." This left the person at risk of poor health from their diabetes.
- We raised this with the management team on the day of the inspection and were given assurances around diabetes management and monitoring.
- Some people were prescribed PRN medicines for conditions such as pain relief. However, we found some examples that did not follow best practice. For example, we could not see that PRN pain relief was being offered outside of standard medicines administration rounds. Additionally, one person with pain relief did not have pain charts, or evidence of monitoring for the effectiveness of pain relief.

● We found some concerns with the timings of medicine administration rounds which left the potential for risk. Some people were receiving their medicines after their lunch and this could be as late as 15:00. They were then receiving further medicines at around 17:00 and there was a risk there may not be sufficient time between the doses. We raised this with the management team and asked them to review this practice.
● When things went wrong or an incident occurred the provider did not always investigate it properly to learn lessons. We saw that one person had a bruise that was unexplained but there was no incident or accident report for this. We raised this with managers and found this was an oversight.
● The person who had experienced low blood sugar had been assisted by a nurse but had not had an incident report completed. This would have highlighted the issue to the management team so that action could be taken to reduce the risk of reoccurrence.

The provider had failed to assess, monitor and manage risks to service users' health and safety, provide safe care and treatment, manage medicines safely, or ensure lessons were learnt. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a continued breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The deployment of staff was still not managed safely. We observed that there were times when there were not enough staff to support people. Some people were re-positioned in bed to an upright position and left in an upright eating position for almost three hours, as there were not enough staff to support everyone during lunch time.
● Staffing levels in the mornings did not allow for people in lounges to be observed and supported. We observed at different times that people who were at risk of falls were in lounges without staff or a call bell trying to stand or walking with frames and struggling.
● One person had personal care with continence aids at 05.00 and then not again until midday for lunch and had been incontinent. Another person told us that they didn't call for staff to help them to the toilet during mealtimes as there weren't enough people to help. The same person also told us they waited a long time to use the toilet at night. The person said, "Three hours I was waiting, watching the clock."
● One staff member told us, "Staffing levels (are) low; no hospitality staff, so it's hard to manage snacks and lunch service. Most people in beds are fed, it takes time to support everyone and they don't finish lunch until two or two thirty." One relative who frequently visited the service told us, "I'm really, really, pleased with the staff they do a really good job. I don't think there is enough of them especially when it comes to mealtimes: there's not enough staff to monitor the dining area and support people to eat in bed. People are in a line waiting to be fed."
● The provider was using a dependency tool to determine how many staff were needed. However, this was not being updated so did not reflect every person's current need. Although the provider was allocating more staff than indicated on the dependency tool, the level indicated did not accurately reflect people's needs and people, staff and relatives told us there were times when there were not enough staff. This corroborated what we saw during the inspection.

The failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had been recruited safely to the service and there had been checks of people's identity and backgrounds, including references.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure people were safeguarded from abuse and improper treatment. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People were protected from abuse as staff and managers knew how to report any concerns and had done so openly. During our inspection we found possible safeguarding concerns with medicines and the provider had sent these to the local safeguarding adults team.
● Managers used an electronic system to record and track all safeguarding incidents. Managers had tracked when safeguarding alerts were made, that the correct people had been notified, and when they had been closed.
● Staff were able to speak about their role in safeguarding people from abuse, knew how to escalate concerns and were able to tell us how different people may present if they were victims of possible abuse. One staff spoke about a person and knew they may be nervous or 'jumpy' if they were unhappy about something. The staff said, "I report any issues or concerns: I report it, which is the protocol, to the nurse and senior."

● Since the last inspection there had been a large reduction in falls and falls management had significantly improved. The provider was using falls diaries, monitoring and auditing falls and referring people to falls clinics where needed.
● We found a significant improvement in the support people received with complex eating conditions and people were being supported in the correct position and with the correct consistency food to reduce the risk of choking or infection of the lungs. Choking risks had been assessed and staff knew how to safely support people with eating and drinking.
● The chef kept accurate records of people's eating and drinking needs and ensured food was prepared to the correct consistency. Risks to people from malnutrition were being monitored and people's weights were effectively audited. The chef was fortifying food for people at risk of being underweight and we saw people had gained weight where this had been identified as a risk.
● Fire safety risks had been reviewed and a risk assessment had been carried out and actions taken. People had emergency evacuation plans which staff knew how to enact plans to safely get people out of the building.
● People at risk from skin breakdown or pressure wounds were being supported to be repositioned. Where there was a risk to people's skin the provider ensured skin integrity checks happened, good hygiene was encouraged, and a Waterlow assessment was completed. A Waterlow assessment is a tool used to determine the level of risk of skin damage.
● We observed medicines rounds and saw that nurses administered medicines to people safely and that people's medicines were stored securely.

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. Any conditions related to DoLS authorisations were being met.
● People had MCA assessments for specific decisions and where they were found to lack capacity there had been a best interest meeting to decide the least restrictive measure to keep the person safe.
● We found one instance where there had not been an MCA assessment for a restriction but the provider addressed this on the day of our site visit and ensured that the correct process was followed to meet the requirements of the MCA.

Preventing and controlling infection
● 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 promoting safety through the layout and hygiene practices of the premises.
● 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.

People were able to receive visitors to their home. The provider was following the latest government guidance about safe visiting in care homes.

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 Inadequate. At this inspection the rating has changed to Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to ensure good governance. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Despite some improvement, not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- Following our last inspection, we imposed conditions on the registration of this location which compelled the provider to complete a monthly audit and report the findings to CQC on areas such as falls, diabetes, fire safety, hydration and skin integrity.
- During this inspection we found some concerns remained in areas around diabetes care, hydration, constipation, staffing levels, learning from accident and incidents, and as required medicines.
- We spoke to the managers about why these issues were not highlighted or put right by governance systems or audits. Managers reflected on the pace of change and how they had addressed care plans and staff culture but were reliant on staff reporting things correctly.
- Audits had not always been effective in identifying tings to be put right. For example, we found two people with bruising that were not included in a tracker. Some people had care plans that had identified a lack of bathing and this was not picked up in audits.
- There have been breaches of regulation 12 relating to safe care, regulation 17 relating to good governance, and regulation 18 relating to staffing. These breaches have been in place for three consecutive inspections. The breach for Regulation 13 relating to safeguarding people from abuse had been met at this inspection.
- There had been a high staff turnover, including in nursing and management positions. This meant that a high number of daytime nursing shifts were being worked by agency nurses. Managers accepted that this had at times led to information not being escalated or shared correctly.
- There was not a registered manager in day to day control of the service during our inspection. However, there was an experienced new manager who had just started employment and was in the process of applying to register with CQC.

The failure to ensure quality assurance and governance systems were effective and risks to people's safety were identified and managed safely is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The management team had been an active and visible presence in the service following our last inspection. There had been a change in management and the provider had ensured that senior managers were on site to oversee changes needed. Despite continued breaches of regulations, we did see improvements in relation to falls, complex eating needs, fire safety, skin care, care planning and risk assessments.

● People and their relatives told us that managers were available to speak with them. One relative said, "(Director) is lovely. (Area manager) is nice and I've seen him here at the weekends and has been here every day." A person told us, "They (managers) do come and say hello and ask how you are. (Name) comes along and asks how I am."

● Staff told us they felt supported by the management team. One staff told us, "(Managers) are trying their best to sort out staffing. (Director and area manager) and helpful and approachable."

There were suggestion boxes for staff to share improvement ideas with managers and staff told us they used these but also, they approached the management team and spoke with them about ideas. Suggestions made by staff, such as requesting specific health reviews for people, had been acted upon by the management team and had led to one person regaining mobility.

● The management team had shared risks with the staff team to change the culture in the service. One manager told us, "July, August September and October saw a shift in the right direction: serious incidents went down, constantly talking to staff doing daily walk around, monitoring of resident of the day, all these things helped and we need to sustain this level of input from management and support the staff to understand the risks."

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

● Where there had been incidents that were reported to the management team, these were shared openly with families where appropriate. Some incidents had not been reported to managers and this has been reported on in the Safe section of this report.

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

● People's relatives told us they were listened to by staff at the service. One had experienced an issue with their loved ones' room being unclean. They spoke to a nurse about this. The relative said, "(Names') clothes are washed and bedding changed and the room is never dirty now. They put a new carpet in for (name) when they had an accident, and there are fresh clothes every day."

● Staff were able to suggest new ways of working and had asked managers to purchase equipment for people, such as different slings to help people be moved. Some staff told us they felt they were being listened to by new managers. One staff said, "We support each other, they listen to our worries and concerns and we are cheerful for the residents."

● There were limited opportunities for people to access their local community and this was something the new management team were aware of and working towards.

Working in partnership with others

● The provider had worked closely with CQC following the last inspection and had accepted the need for change in the service. Following the imposition of conditions on the location the provider was sending audits and reports to CQC.

● The provider had been working with the local authority and a recent monitoring visit had taken place. One manager told us, "Recently the local authority came in and any actions are followed up and shared with

staff. Any action to follow from any healthcare professional is included in an action plan and followed up to completion." □

● The service had been facilitating visits from professionals such as tissue viability nurses, speech and language therapists amongst other healthcare professionals. Where information about people was being shared by the provider it was being done safely via encrypted messaging services.

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 failed to assess, monitor and manage risks to service users' health and safety, provide safe care and treatment, manage medicines safely, or ensure lessons were learnt.

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 ensure quality assurance and governance systems were effective and risks to people's safety were identified and managed safely.

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 deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff.