Hinckley Care Limited

The Ashton 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
The Ashton Care Home is a purpose built residential home providing personal and nursing care for up to 72 people. The service supports a range of needs including older and younger adults and people living with dementia across three separate floors. At the time of the inspection the service was supporting 51 people.

People's experience of using this service and what we found
There was unsafe assessment, monitoring and management of risk for people with support needs regarding behaviours that may challenge. Staff practice, and reporting systems to safeguard people from abuse, were not always effective to ensure people were safe from harm. Lessons were not always learnt, and actions not taken to investigate safety incidents and prevent them re-occurring. Staff did not always have the required competencies or knowledge to meet people's individual needs safely.

There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs and keep them safe.

Medicines were not always managed safely. People had not always received their medicines as intended when they needed them.

Service management and the provider's wider quality assurance and governance systems had not ensured actions were taken to address any issues and risks in a timely manner. People's care records were not always up to date or accurate.

The provider had failed to act upon known areas of concern, non-compliance and risk to improve the quality of care for people at The Ashton Care Home. This had exposed people to on-going poor care and risk of avoidable harm.

The provider had acted to manage infections during the Covid-19 pandemic. Additional infection prevention and control measures in line with Department of Health and Social care guidelines had been put in place to ensure people's safety. Staff wore personal preventative equipment (PPE) when supporting people. The provider had ensured there were adequate stocks and supplies of PPE available.

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 7 November 2020). The service has been rated inadequate for two consecutive inspections. At the last inspection we found multiple breaches of regulations. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We undertook this focused inspection in response to concerns we had received and to confirm the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulations 12, 13, 17, 18 in relation to: safe care and treatment, safeguarding people from abuse and improper treatment, good governance and staffing.

We have also identified a breach of Care Quality Commission (Registration) Regulations 2009 in relation to failing to notify CQC of incidents regarding abuse or allegations of abuse in relation to service users.

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 continue to monitor information we receive about the service until we return to visit. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains 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 act 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.

The Ashton 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 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.

Service and service type
The Ashton Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. There was an interim management team overseeing the service. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

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 focused our inspection planning on concerns we had received in relation to people's safety, in order to assess if the service was safe and well led.

During the inspection
We spoke with five people who used the service to gain their views. We also spoke with 13 members of staff including seven care staff, one nurse, two housekeepers and three senior managers within the interim management team. We carried out observations within communal areas to help us understand people's experience of care and support. We reviewed risk assessment and behaviour and incident forms for three people and food, fluid and re-positioning records for a further three people. We also reviewed staffing rotas, accident and incident reports and a range of records relating to the management of the service, including audits and checks.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed information around staffing, dependency levels and staff training in supporting behaviours that challenge. We also spoke with five relatives and one health and social care professional by telephone to gain their views about the care provided.

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 inadequate. At this inspection this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks relating to people's physical and non-physical behaviours that may challenge were not always assessed, monitored or managed safely. Several people could display behaviours causing emotional distress or physical harm to themselves, or other people and staff at the service.
- One person had been involved in several similar incidents where their behaviours had placed them at high risk of harm and caused actual harm to other people and staff. The person's care needs had not been effectively reviewed and staff did not know how to keep the person and others safe when this situation occurred again.
- A second person had been involved in several incidents where their behaviour had escalated resulted in high risk of harm to others. The person's care needs had not been reviewed to identify interventions that may reduce the person's distress.
- We observed two people becoming increasingly anxious and distressed during our inspection visit. There were limited interventions from staff to provide the reassurance and re-direction people needed and in some cases they were ignored by staff. On one occasion, the inspection team had to redirect a person away from another person's room to prevent a potential incident.
- There was not enough guidance or information available for staff about what people's behaviours may mean. People's care plans did not include robust or up to date interventions and strategies that staff could use to prevent or reduce people becoming distressed at an early stage. This increased the risk people might get hurt and continue to display unsafe behaviour to staff and people. There was a general acceptance from staff that physical and verbal aggression was to be tolerated.
- Staff were not always monitoring people's behaviours that may challenge when they happened. It could not be checked people were being supported safely. For example, two people required observations every 15 minutes. We saw two occasions when a person was left for 30 minutes without being checked. Staff consistently told us 15 minute recorded observations were not effective in monitoring behaviours as incidents frequently occurred between checks.
- Staff were supporting one person in an unsafe way by physically supporting them when they presented behaviours that may challenge during personal care. The potential risk of harm from this action had not been identified or monitored, to prevent the person being hurt or restricted unnecessarily.

At our last inspection the provider had failed to ensure staff followed safe procedures to control the risk and spread of infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst improvements to infection prevention and control had been made and risks addressed, at this inspection we identified new concerns that the provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to people. In relation to incidents that affect the health safety and welfare of people, this is a

continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Due to our urgent concerns about the risk of harm relating to people whose physical and non-physical behaviours that may challenge, we asked the provider for immediate assurances about what they would do to make sure people were safe. The provider sent us an action plan telling us how they would address the issues quickly. We are continuing to monitor the progress of this plan.

Staffing
● There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.
● We reviewed the provider's dependency tool and staffing rotas for the dementia unit. The tool identified five members of staff were required to support people safely. We reviewed staffing rotas from October 2020 to the date of inspection and found there were frequent occasions when staffing fell to four members of staff, including during our inspection visit. Staff told us four members of staff was not sufficient to keep people safe or meet their needs. We observed people were left for long periods of time without any interaction or stimulation. People did not receive the supervision and support they needed to keep them and others safe, particularly as people moved around the unit. Staff were stressed and felt care was rushed as a result of insufficient staffing levels.
● People told us they had to wait for assistance at times when the service was 'short staffed'. We observed people who requested assistance, for example to return to their rooms, being told they would have to wait until staff were available to support. One person waited for over 30 minutes for a staff member to support them back to their room.
● Many people living in the nursing unit were in bed at the time of our inspection. It was not clear if this was a choice, a need or due to staff being engaged in other tasks, such as medicine administration.
● The provider's dependency tool did not reflect people's current needs, or identify individual factors that impacted on the level of staffing required to keep people safe.
●Staff had not received adequate training or support to be able to deliver safe or effective support for people with behaviour's that may challenge. This placed people and staff's safety and well-being at increased risk.
●Staff did not demonstrate they were skilled enough to meet people's behaviour that may challenge, or support people's needs safely or effectively.
●Staff had received behaviour support documentation training to help them complete behaviour monitoring forms. Despite this, staff were not competent and could not complete behaviour support documents to a good standard.

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

Systems and processes to safeguard people from the risk of abuse
● Systems in place for staff and management to report, review and investigate safety and safeguarding incidents were not always effective.
● The provider had not used incidents, particularly those involving behaviours that challenge, to identify potential abuse and had not taken preventative actions.
● The provider had not worked in partnership with other agencies, including people's relatives, to keep them informed of incidents and involve them in key decision making to keep people safe.
● The provider had failed to notify the Care Quality Commission of abuse or potential abuse in relation to service users.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure of the provider to notify the Care Quality Commission of events of occurrences within the service is a breach of Regulation 18: Notification of other incidents, Care Quality Commission (Registration) Regulations 2009.

Using medicines safely

●Medicines were not always managed safely.

●Senior care staff undertook audits and checks on medicines but these were often rushed and irregular due to lack of time.

●Audits and checks were not effective in identifying errors in administering medicines or supporting timely intervention to ensure people did not experience any adverse effects. For example, we found one person had only received one tablet when they should have received two tablets in line with their prescription. Staff had not identified this error for four days. No action had been taken to ensure the person had not suffered any adverse effects. There were no systems to report this error to managers.

● Some people required their medicines to be administered within a specific time frame, referred to as time critical medicines. Staff told us and medicine records showed people did not always receive their medicines at the correct time. There were occasions when time critical medicines were administered over 30 minutes late. Staff told us this was because they were so busy and they had to rely on their own reminders: the electronic medicine system did not alert them.

Learning lessons when things went wrong

●Systems in place for staff and management to report, review and investigate safety incidents, and act to prevent them re-occurring were not always effective. This increased the risk that incidents would not be investigated and acted on to prevent them from happening again.

●During this inspection we identified issues relating to safety incidents that had either not been reported or had not been adequately acted on to ensure people were protected from the risk of harm.

●Staff were not supported through de-briefing post incidents and were not provided with the opportunity to identify different, more effective approaches with managers when things went wrong.

Preventing and controlling infection

● At our last inspection we found the provider did not have effective systems in place and staff were not followed safe practices in protecting people from the risk of infections, including COVID-19. At this inspection we found the provider had made required improvements.

● There were infection control measures in place to prevent visitors from catching and spreading infections immediately upon entry to the building. All visitors were required to fill in a contact sheet. Hand sanitiser and masks were available, and staff took the temperatures of anyone entering the building.

● We observed staff wearing Personal Protective Equipment (PPE), such as face masks, gloves and aprons which were freely available and regularly changed. Staff told us, "We didn't know what to do before and were given the wrong information. Now we have been given really good training and understand why and how we need to wear PPE."

● Although we observed most staff following current guidance in terms of protecting people from infections, we saw one staff member moving between people's rooms without changing their face mask. We raised this as a concern with the interim manager who told us they would address this with staff.

● Staff followed safe practices where people needed to isolate, ensuring doors were shut and notices placed on doors advising of dates of isolation. PPE stations were outside people's rooms; we advised staff to ensure

all people had individual PPE stations outside their rooms rather than shared.

● People were supported to maintain contact with their friends and families. The provider has recently installed a dedicated visitor room with intercom system to support people to communicate through a clear floor to ceiling screen. Bookings were being taken for visits at the time of our inspection.

● People were admitted safely into the service, with testing beforehand and a period of isolation once they had been admitted. Staff and residents were tested regularly in line with government guidance.

● The provider had recently reviewed their infection prevention and control policy to ensure it was in line with current guidance and requirements.

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 inadequate. At this inspection this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- At the last inspection we had found that the provider was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 12,13 and 17 in relation to safe care and treatment, protecting people from abuse and improper treatment and good governance.
- We had specific concerns around people being exposed to the risk of harm, including risks from infections and COVID-19. We also had concerns around poor, ineffective leadership and management and a lack of support and oversight by the provider. We had imposed conditions telling the provider they must ensure risks to people are managed; care records reflect people's current needs; care plans are updated in a timely manner and systems and procedures to assess and monitor the quality of care provided are implemented effectively. We asked them to send us monthly action plans to tell us how they were doing this.
- The imposition of conditions had not been effective in driving improvement or preventing repeat themes of concern re-occurring in relation to people's safety or the quality of care at The Ashton Care Home.
- At this inspection we found areas around the prevention and control of infections had improved. However, we found risks to people who required support for their behaviours that may challenge were high and their needs were not being met safely or effectively.
- There were repeat breaches of regulations 12, 13 and 17. We found there was a new breach of CQC Registration Regulations 18 regarding failing to notify the CQC of incidents.
- The failures in people being exposed to potential and actual harm had not been recognised or prevented by the provider prior to our inspection. We needed to request immediate assurances of action the provider would take to reduce the risks to these people.
- Systems and processes to assess, monitor and improve the quality and safety of the service were still not operating effectively.
- The service manager and clinical lead carried out a variety of internal audits to check the quality and safety of the support people were receiving.
- The management and staff at the service had received consistent additional support from an interim management team to help assure the delivery of good quality and safe support for people.
- These quality assurance systems and processes had not identified or prevented significant safety issues occurring or continuing at the service.
- Where issues had been identified, these had not always been effective action to maintain or improve the quality and safety of the support being delivered.

●Staff accountability had not been managed effectively. Staff continued to not always have the right skills, knowledge or experience to manage risks and deliver safe care for people.
● There was not always an accurate and contemporaneous record in respect of each person in place. People's care plans, risk assessments and monitoring forms regarding behaviours that may challenge were not accurate, complete or up to date.

The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved. This was a continued breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Working in partnership with others
● The local authority and local NHS partnership trust provided feedback staff had not always acted when they made recommendations to improve people's support.
●Some relatives felt staff communication with them about their family member's support could be improved. Two relatives felt they had not been kept informed or involved in changes to their family member's care and were not regularly informed of incidents involving their family member. Some relatives were not assured that their family members were receiving the care and support they needed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●Staff said they cared about any issues affecting people living at the service and wanted to make improvements. We observed staff supporting some people in a positive and friendly manner during our inspection visits.
●The culture of the service was not fully person-centred as staff were focussed on the tasks they needed to complete.
●Staff had not empowered to provide fully personalised care through consistent, effective leadership. People's views were collated on an ad-hoc basis and were not used to drive improvements or developments within the service.
●The nominated individual and the provider's senior management team told us they were currently undergoing an internal review of their structure and approach to delivering support, to try and make improvements in safety and quality across their organisation.

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 failed to notify the Care Quality Commission of events and occurrences within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment for people.

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 The provider had failed to ensure effective systems and processes were in place to protect people from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained and service performance was evaluated and improved.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs.