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 responsive?	**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 11 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 required improvement, 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 always sufficient numbers of competent staff deployed to ensure the service was safe. Lessons had not been learned following the last inspection or input from other professionals.
The service was not well-managed, and quality assurance, monitoring and oversight systems were either poor or not in place. We found significant shortfalls identifying the provider had not met the objectives and requirements since our last inspection and was not compliant with the Warning Notices issued. 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.
People had very few meaningful activities on a day to day basis. 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 received some positive feedback from relatives that staff were kind and caring, however the care was not always attentive, and staff did not have time to spend with people.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about service supporting people with a learning disability and autistic people and providers must have regard to it.

The service could not show how they met the principles of Right support, right care, right culture,

Right Support:

● The service was made up of two detached bungalows which could accommodate six people in each one.
● People had their own rooms which had been personalised.
● Information in peoples care plans was out of date and therefore did not reflect their current needs.
● People were not always actively supported in maintain their own health and wellbeing. Health plans were either not in place or lacked detailed information.

Right Care:
● The service did not have enough appropriately skilled staff to meet people's needs.
● People were not always sufficiently protected from the risk of harm. Although staff had completed safeguarding training they had not always recognised or reported poor care.
● People did not always receive good quality care, because staff training had not been embedded in practice.

Right Culture:
● People were not always involved in planning their care. Care plans were not person centred.
● The registered manager did not have robust systems in place to monitor the quality of the service and people's care documentation did not reflect their current health or care needs.

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 19 August 2021).

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, responsive 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 remained 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, responsive 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, risk management and person centred care. The provider had also failed to notify the Commission of incidents as required by law, including abuse or allegations of abuse.

Follow up
The overall rating of this service is inadequate and the service remains in 'special measures' as one of the key questions remains inadequate.

This means we will keep the service under review. Since this inspection the provider has put a notification into the commission to cancel their registration. We will continue monitor the service until this process is complete.

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 always safe

Details are in our safe findings below

Is the service responsive?

Inadequate

The service was not responsive

Details are in our responsive 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
Two inspectors visited the service on two separate occasions. An Expert by Experience supported this inspection by carrying out telephone calls to relatives for their feedback about the service. An Expert by Experience is a person who has personal experience of using or caring for someone who used this type of service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 11th February 2022 and ended on 14th February 2022.

What we did before the inspection
We reviewed information about the service since the last inspection. We sought feedback from the local

authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and nine relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager and the deputy manager.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data. We spoke with other professionals who have regularly visited the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as inadequate. At this inspection, although there has been some improvement in the environment this key question has remained inadequate due to continuous breaches that have not been met. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection
At our last inspection we identified significant shortfalls in how the provider and management team were responding to the COVID-19 pandemic. They failed to have robust systems in place to ensure infection outbreaks could be effectively prevented or managed to protect people from the risk of harm from the spread of infection. This inspection found very little improvement had been made and the provider is still in breach of regulation 12.

- 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 not wearing face masks, masks worn under a staff member's chin. No effective measures or supervision was in place to support staff to improve their practice.
- Risk assessments were not in place for staff who were vulnerable or who were not able to wear a face mask for medical reasons.
- Staff were not competent in asking inspectors for proof of a negative LFT test or screening for signs and symptoms of COVID-19 when in the building despite there being senior staff on shift. There was a delay in carrying out the necessary actions and the paperwork required was not readily available. We were not asked as per their COVID-19 policy for proof of vaccination status.
- The premises were clean and odour free. However, areas of the home did require refurbishment. One shower room had been refurbished. The registered manager told us plans were in place for the other bathroom to be refurbished shortly. Staff told us there was no dedicated cleaning team, and we saw no clear evidence of infection and prevention control (IPC) audits being completed.

Assessing risk, safety monitoring and management
At our previous inspection we found the provider did not have effective systems in place to identify, monitor and mitigate risks to people's safety. During this inspection sufficient action had not been taken to address these concerns and risks to people were still not being effectively monitored.
This inspection found a lack of improvement and the provider was in breach of regulation 12(1) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- 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. Staff provided contradictory information as to whether this person had periods or not.

● Fluid monitoring charts were being completed to ensure people received adequate hydration. However, there was no oversight by management to query any discrepancies. One person's record was partially completed with entries that had been crossed out with no explanation. Another person had entries showing they had two drinks one 250ml and one 300ml within ten minutes.
● People's fluid charts had no entries after 8pm. We questioned this with staff who told us, "People have their medication at 8pm, that is when they have their last drink." There was little evidence of people having any additional fluid or food offered to them after this time. In one bungalow people had been given their dinner at 5pm. During our visit we did not see any snacks or fruit being offered and none were available for them to help themselves to up until they went to bed at 8pm.
● One person's relative told us they were concerned about their loved one's weight. Although monthly weight charts were in people care plans these were not being completed on a regular basis. The last entry on one person's weight chart who was at risk of putting on weight was dated August 2021. When we spoke to this person, she told us, "I have to be careful what I eat, I don't have breakfast I just have a drink." There was no documentation in their care plan to show that staff were having conversations with them about a healthy diet or explaining food choices. We asked them if the staff helped them with their food choices and were told, "Yes the staff make my meals for me." When we looked at menu plans they contained little evidence of healthier options. Staff told us people choose between two meals however there was no evidence of this on the menu plans.
● Epilepsy care plans were not in place or had not been reviewed for some time. Staff had not signed to say they had read and understood how to mitigate the risk to someone living with epilepsy. When staff were spoken with, they showed little understanding of how to mitigate the risk to people living in the service who had epilepsy.
● 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. The registered manager told us they were going to have some support from a consultant in putting all care plans on the electronic system but had decided to do this gradually themselves. However, during this inspection there was only one care plan on the electronic system other care plans contained out of date information.

Using medicines safely
At our last inspection 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.This inspection found little improvement had been made and the provider was still in breach of regulation 12.

● Medicine Administration Records (MARs) were not always completed in line with best practice guidance. For example, we found there were gaps in the MARs where they not been signed to confirm the person had received their medicine. No refusal or reason for this had been recorded on their MAR and this discrepancy had not been identified by oversight systems in place.
● Staff had not signed handwritten medication entries. This meant potential medication errors would be difficult to trace.
● The providers PRN (as required medication protocols) were not robust enough. It was unclear where staff would record why a PRN medication was given and monitor its effectiveness.
● The provider had not carried out any medication audits carried and therefore the concerns we found had not been identified.
● Medicines were stored safely and securely.

Systems and processes to safeguard people from the risk of abuse
At our last inspection we found 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.

At this inspection we found little improvement had been made and the provider was still in breach of regulation 13.

● The Local Authority (LA) had carried out safeguarding visits following concerns raised about the service. The registered manager had been consistently made aware when they should raise safeguardings. However, the LA told us the registered manager continued to fail to recognise some incidences as safeguarding concerns which left people at risk of abuse not being recognised and mitigated.
● Where safeguarding had been reported, records showed the registered manager had not taken effective action to address any potential triggers, or to minimise the risk of it happening again. This included a person who had been injured by another living at the home where risk triggers had been previously identified. These risks had been discussed at the previous inspection including what action the provider should take. At this inspection and following the incident, the provider had not taken the identified actions to minimise the assessed risk.
●The provider had not provided new staff with safeguarding training as part of their induction.
● Staff were not able to tell us what constituted a safeguard and who they would contact if they had concerns.
● Despite support from other professionals' around documentation and how to use templates and forms to identify and manage people's needs, staff, including managers, were still not completing these effectively. For example, fluid charts were put in place on the outcome of a safeguard however, these were not checked for accuracy or to highlight any concerns.
● Whilst some relatives told us they did not have concerns about the safety and quality of care, there were still some concerns about how some people's anxieties and needs impacted on others living in the service. The management team had still 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. One relative told us, "There has been some altercations with another person everyone is aware of it they have been stuck indoors for two years we understand it."

Staffing and recruitment
At our last inspection the provider failed to have enough numbers of staff with the right skills and competencies to provide the right level of care and meet people's needs safely and effectively. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found very little improvement had been made and the provider was still in breach of regulation 18.

● We were not assured that staff had the appropriate skills and competency to support people with behaviour linked to anxiety, distress or other factors. Although the training matrix showed staff had training in this area in August 2021, staff did not appear competent in supporting people who might exhibit distress and frustration in a manner that posed risks to others.
● Staff responses to people were not always dignified. During our inspection one person was seen to be pacing and looking out of the window. Staff repeatedly told this person to "go to your room."
● At our last inspection, several people at Eight Ash Court were living with epilepsy. There was not always a member of staff available during the night shift trained to give rescue medication if required. At this

inspection at times night shifts to be covered by staff who had not received this training. This placed people at risk of not receiving timely emergency treatment which could result in poor health outcomes.

● During our last inspection there was one only one member of staff assigned to work at each bungalow during the night. On this inspection staffing numbers had increased and one staff member was now working during the night in each bungalow with an additional staff member working between both bungalows. However, staff told us they felt there were not enough staff on shift to enable them to meet people's needs. One staff member told us, "The people that live here have all got old therefore their needs had changed they need more support."

● During our inspection we observed that most people only received the basic care needs due to not enough staff being on shift. Staff did not spend time talking to people. Most care given was 'task' led. The provider still 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. There was still no tool in place to check staffing levels were correct.

● Senior staff spoken to were not able to demonstrate they had the knowledge to be able to support the rest of the staff team. They were unsure about safeguarding procedures and not able to tell us how to mitigate the risk for someone living with epilepsy.

● We received mixed feedback about staffing levels and consistency. One person's relative told us, " I have been concerned about the levels of staff, although things do seem to of calmed down recently." Another person's relative told us, " I do worry about agency staff and whether they know [name of relative] and what help they need?"

● There was 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 staff spent their time cleaning rather than spending time with people to meet their needs. Staff told us, "We have to spend so much time cleaning we don't get a chance to spend time with people."

● Recruitment checks were undertaken on staff, including references from previous employment and Disclosure and Barring Service (DBS) checks. However, there was not always induction, supervisions, training or competencies in place and 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

● On our last inspection we found that 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. Upon discussion with other professionals we have found the provider still did not respond promptly to concerns raised.

● Concerns raised at the previous CQC inspection of the service had continued, including staff not being fully trained.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

During out last inspection this key question was rated as requires improvement. On this inspection the rating has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not receive care that was planned, personalised or responsive to their needs. There was a lack of clear guidance and key information for staff to enable them to consistently deliver the right support to people.
- Care plans did not reflect people's needs or strengths. Staff did not have information in how they should work with people to promote their independence. During the inspection we observed staff completing tasks without any engagement with people or encouragement for them to do the task for themselves. We observed staff moving someone from behind who was sitting in a wheelchair without asking the person if they would like to be moved or encouraging them to move themselves. We discussed our findings with the staff who told us, "We are always in a rush, it is quicker to do the task for someone".
- Staff did not spend time talking with people or engaging in positive interactions. This was observed during the inspection where a staff member was busy completing paperwork whilst sitting at the table with two people that live in the service, they did not engage with either person for over an hour. As soon as another staff member walked in, they stopped the paperwork and spoke amongst themselves. Neither staff member interacted with the two people. Despite one person's care plan reading, 'staff should engage in conversation with [name of person].'
- During the lunchtime people were not encouraged to make a choice or to make themselves something to eat independently.
- People did not have individual timetables most people went to day care four days a week there was little evidence that this was in the persons best interest or if they enjoyed going. One person told us, "I go to day care, I like it sometimes depends what I do there." Staff told us, "I don't know if they like it or not that is where they go, they always have." On the day of inspection we observed a couple of people coming back from a drive, one person was very excited and showed this by making noises he was immediately told by a staff member to 'calm down mate' rather than have any positive interaction about his ride out.
- Relatives told us they had been involved in discussions about different activities, but nothing much happened since. One relative told us, "[Name] goes trampolining. I was the driving force behind that. Other than that, they go to the day centre."

People did not receive individualised care which met their needs. This was a breach of Regulation 9 [Person - centred care] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Meeting People's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Care plans were not in an easy read format.

● People's care plans contained little information regarding how people like to communicate. However, staff were able to tell us when we asked how they were aware if someone was happy or sad or if they were in pain. One person had a tablet which we understood was used for communication. However, we received a mixed response from staff when we asked them how this was used. One staff member told us, "They use it to call their family, other than that they do not use it." Another member of staff told us they used it to communicate with staff. On our two visits to the service we did not observe the person using the tablet.

Improving care quality in response to complaints or concerns

● We had mixed feedback from relatives we spoke with regarding complaints, most people told us they knew how to complain and told us they would ring the manager. One relative told us, "I have the managers private telephone number. I would ring them if need be, I do feel they are approachable." Another person told us, "If there is anything we need to know, I think we are usually told; communication has not always been good."

● The service did not seek feedback from service users as information was not accessible to them.

End of life care and support

● People's care plans contained little information about their end of life care needs. If there was any information, there was no documented involvement from the person themselves.

● No people were reported to be on end of life at the time of this 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 the last inspection this key question was rated as inadequate. At this inspection this key question has not improved and remains 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.

At our last inspection the provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had also 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.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17 and Regulation 18.

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.

- 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.
- This inspection identified continued concerns in regards of the oversight of the service, and the provider's ability to identify risk, closed cultures due to the institutionalised task-led practise, for example people getting ready for bed straight after their evening meal at 6.30pm.
- The service was still 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 still 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.
- The registered manager was supported by a deputy manager who worked supernumerary hours in the office as well as working on shift when needed. The deputy manager was knowledgeable about the people the service supported but was aware their knowledge was not documented in people care plans. For example, we asked them about one person's epilepsy plan, the deputy manager was clearly able to tell us

how they supported this person and explained to us how they had input from various other professionals in order to give a diagnosis for this person. However, none of this information was recorded and senior staff were unable to give us any clear explanation on how they worked with this person. This meant this person was at risk of harm as the staff team worked in conflicting ways to support them.

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. This is 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, "I don't think some people enjoy 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.

● The provider had a set of policies and procedures in place for the running of the service. There was also a Statement of Purpose which sets out the ethos and purpose of the home. However, these did not reflect the experience of people using the service. There was 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 was still failing to ensure the service was being run with a focus for people with complex and changing needs and promoting the principles of Right support, right care and right culture guidance.

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 still not acted on warning notices issued at our last inspection and was still in breach of regulations. This showed a lack of improvement.

● During our last inspection the provider had not been working effectively with partner agencies to drive improvements and meet people's needs, deadlines had been missed and information was not returned in a timely manner.

● At this inspection external professionals continued to raise concerns that the provider did not understand the seriousness of the concerns raised about the quality of care; and that these were not responded to in a timely way.

● During meetings with safeguarding and the local authority the registered manager acknowledged they did not have safe systems in place. The registered manager told us during our inspection. "We know we have a long way to go we just need the time."

● 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.

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.