Knighton Care Services Limited

Ashdown House

Inspection report

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Daventry
Northamptonshire
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Tel: 01327879276

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03 March 2021

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ashdown House is a residential care home providing personal care to up to 24 people aged 65 and over. At the time of the inspection 12 people were being supported.

People's experience of using this service and what we found
We found provider had not made sufficient improvement to provide a safe service. Risks to people had not always been identified or managed effectively. In some instances, risk assessments were not always completed.

Records were not always kept up to date. We found gaps in records for example records relating to the daily wellbeing checks and to monitor health conditions, repositioning checks of people nursed in bed, pressure mattress settings, cleaning records and food and fluid records.

Care plans did not always contain sufficient information to support staff to understand people's individual needs. Staff had not always completed up to date training for their role.

The environment required improvement. We found wardrobes that had not been secured to the walls to prevent harm and exposed pipes that posed a risk of scalding. The provider had already submitted an action plan to the local authority regarding concerns with décor, carpets, kitchen units, plug sockets and the leaking roof.

The service did not a registered manager, although the provider had appointed a manager who was due to start working in the service
Oversight and governance systems had not previously identified the concerns we found during this inspection. People, relatives and staff had not been asked for their feedback or suggestions to improve the quality of the service.

Infection, prevention and control required improvement. Issues raised at the IPC inspection had not all been rectified or completed.

We received mixed views regarding staffing levels. We were told that people had to wait for support due to limited staff being available, however people told is that staff were kind and caring.

People received their medicines as prescribed by staff who had received training and had their competencies checked.

The provider was working with external agencies to improve the quality of the service. However, systems and processes had not been implemented at the time of inspection.

Staff made referrals to healthcare professionals as required to ensure people's health needs were met.

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 requires improvement (18 September 2019).

The last inspection for this service was published 9 March 2021. The inspection was an infection protection control (IPC) inspection and did not rate the service. However, they were found to be in breach of regulation 12.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the environment, staff recruitment, PPE use and person-centred care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

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 breaches in relation to assessing risk, records, environment, infection control and oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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.

Ashdown House

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 one inspector.

Service and service type
Ashdown House 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. This means that 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report.

During the inspection
We spoke with three people who used the service and one relative about their experience of the care provided. We spoke with nine members of staff including the provider, deputy manager, and care workers

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staffing, complaints and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

- Not all risks to people had been assessed or mitigated. When people could not use their call bell or used specific equipment, we found that not all risk assessments were in place. Environmental risks had not been identified. For example, when people were at risk of falling wardrobes had not been secured to the wall and not all radiators had protective covers on them to reduce the risk of scalding. This meant people were at risk of harm.
- One person required daily checks to monitor their feet due to a health condition but these checks were not completed daily. This put the person at risk of deteriorating health conditions.
- One person with a specific health condition did not have the information required recorded in a care plan or risk assessment associated to monitoring risks related to their health. Another person who required their urine output monitored did not have the required information recorded in their care plan or within a risk assessment for staff to follow. This put people at risk of not receiving the support they required for health care needs.
- People at risk of pressure damage to their skin did not have the pressure mattress setting recorded or repositioning charts consistently completed. We found that two people's pressure mattresses were set at a different setting to their weight and gaps within repositioning checks. This put people at risk of skin damage.
- People at risk of dehydration did not have the required fluid intake targets logged, or amounts tallied consistently. When the required 'fluid intake target' for people was not met this was not always reported or actioned.
- People at risk of malnutrition did not always received the required fortified diet. For example, two people required a set amount of nutritional supplements every day. Records evidenced that staff had not consistently offered the required amount daily. This put people at risk of malnutrition.
- Although accidents and incidents were looked at, we found no evidence of recorded trends or patterns. For example, the majority of falls for the period October 2020 to January 2021 occurred at night and were unwitnessed. We saw no additional night checks completed or actions taken to mitigate these risks.

The provider had failed to ensure that all strategies to mitigate risks had been completed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was open to feedback and put strategies in place to mitigate the risks, update and implement care plans and risk assessments following the inspection. The provider was working closely with the local authority and consultancy firm to identify and mitigate any risks to people.

Preventing and controlling infection
At our last inspection the provider had failed to ensure infection control procedures protected people from the risk of infection. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulations.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found gaps in the cleaning records. For example, that whole days had no records completed for cleaning including the high touch areas had not been completed as cleaned after 2pm on numerous days.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The training matrix evidenced that not all staff had completed training on infection control practices.

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

These issues were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.

Using medicines safely
● Medicine administration record's (MAR) were signed accurately to indicate medicine had been administered to people as prescribed. However, one medicine, a prescribed thickener had not been signed for consistently. The deputy manager agreed to ensure this MAR was completed immediately following the inspection.
● When staff administered an 'as required' medicine, records were clearly kept regarding the reason the medicine had been administered.
● Staff responsible for administering people's medicines received appropriate training, which was updated when required. Staff knew what action to take if they made an error.

Staffing and recruitment
● Not all people and staff felt there were enough staff to give people the time and attention they required. One person said, "I am not able to have a shower when I want one due to lack of staff." Another person said, "There is not enough staff, so I have to wait as staff are too busy." However, people said when they rang the call bell staff did respond in a timely manner.
● Records evidence not all staff had completed the mandatory training in moving and handling and dementia. However, staff told us the training was sufficient, but some staff felt they were not offered additional training to further their knowledge.
● Staff were recruited safely. The provider completed pre employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe. One person told us, "Staff make me feel safe."

● There were procedures in place to keep people safe. All staff had training on safeguarding and understood their role in identifying and reporting any concerns.

● When an incident occurred, the relevant people were informed including the local safeguarding team and CQC. When required investigations were completed and shared.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Systems and processes were not robust enough to identify the issues we found during the inspection. For example, we found gaps in the recording of repositioning charts, hourly checks, food and fluid charts and health checks. These audits would support a manager to have an overview of the care being delivered.
- We found no evidence of audits being completed on daily charts, care plans risk assessments, cleaning schedules or health and safety.
- Care plans were not person centred, lacked guidance for staff to follow and had not always been kept up to date. For example, one person who required support with a catheter care did not have any information recorded in their care plan, another person's care plan stated in one section that they walked with the help of one carer another part stated they were bedbound. This showed people remained at risk of receiving unsafe and inappropriate care and support as information was not readily available to staff.
- We found no evidence that the concerns found on this inspection regarding the environment had been identified through the provider's internal audits. For example, wardrobes not being secured to the walls, radiators not all being covered and exposed pipe work. These put people at risk of harm from scalding or furniture falling on them.
- Meeting minutes evidenced that issues with equipment had been raised and discussed for two consecutive months but the records did not have any actions completed. The maintenance log evidenced work had not always been completed in a timely manner.
- People, staff and relatives had not been asked to feedback on the service and care plans did not consistently evidence people's involvement.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. These are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Good governance.

At our last inspection the provider had failed to notify CQC of serious injuries to service users which, in the reasonable opinion of a health care professional, required treatment by that, or another, health care professional. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents. At this inspection we found the provider was now meeting this

regulation.

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 responded to previous complaints appropriately. The provider had not needed to complete a duty of candour; however, they understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.

Continuous learning and improving care; Working in partnership with others

● We saw evidence of referrals made to external professionals such as speech and language therapists, dietitians and occupational therapists. The staff liaised with their GP as required.

● The provider was working with an external consultancy firm to review all aspects of the documentation and implement a better governance system to ensure a better oversight of the service. However, these had not been implemented at the time of inspection.

● The provider was working with the local authority to ensure actions required to the environment were implemented.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that all strategies to mitigate risks had been completed. The provider had failed to ensure infection control procedures protected people from the risk of infection.

The enforcement action we took:

Positive conditions on registration. Monthly action plans to be sent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

Positive conditions on registration. Monthly action plans to be sent