Hinckley Care Limited

The Ashton Care Home

Inspection report

John Street
Hinckley
Leicestershire
LE10 1UY

Tel: 01455233350

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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 56 people.

People's experience of using this service and what we found
People did not always receive a service that ensured their safety.

Risks to people's health and wellbeing had not been effectively assessed, monitored or mitigated. Risk assessments did not provide sufficient information and guidance to enable staff to respond consistently when supporting people. Systems and process to manage control and prevent infections, including COVID-19, were not consistently followed by staff. This exposed people to significant risk of harm.

People were not consistently protected from the risk of poor nutrition and dehydration. Staff recording was not always accurate and therefore an accurate picture of support could not always be determined.

People were not protected from abuse or improper treatment. We observed occasions when people were left unsupervised and unsupported for lengthy periods of time. We also observed staff using improper and unsafe methods when providing care and support.

Analysis of incidents and accidents were not always effective. Timely action was not consistently taken to identify root cause and immediate measures that could reduce the risk of further incidents of harm for people.

The service was not well managed. Systems and processes to assess and monitor the service were not effective or completed accurately. Audits, although completed, were not effective in accurately capturing information or driving improvements. There had been a lack of effective oversight of the service by the provider. The lack of robust, effective quality assurance meant people were at risk of receiving poor quality care.

Following our inspection, the provider took immediate action to make significant improvements in the service and had put in place an interim management team to make this happen. Following the inspection, we were provided with evidence that demonstrated improvements were taking place.

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

Rating at last inspection
The last rating for this service was Good (published 17 April 2020).

Why we inspected
We received concerns in relation to the management of people's care needs, how people were protected from the risk of infection, harm and abuse and a lack of leadership at The Ashton Care Home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvements. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. Please see the safe 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.

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 have identified breaches in relation to safe care and treatment, safeguarding people from abuse or harm and governance systems. 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. 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating. In addition, we will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will 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?

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 as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
This inspection was carried out by two inspectors and a specialist advisor nurse.

Service and service type
The Ashton Care Home is a 'care home' with nursing. 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.

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 took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We also spoke

with three relatives by telephone and received feedback from one relative after the inspection visit. We spoke with nine staff including the deputy manager, head of care, nurse in charge, care staff and housekeepers. We observed care and support provided in communal areas and during the lunchtime meal.

We reviewed a range of records. This included five people's care plans and health monitoring records. We also reviewed a sample of medicines records. A variety of records relating to the management of the service including CCTV footage and governance audits were sampled and reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found around people's care.

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 Good. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

● People were at significant risk of infections and COVID-19 because staff were failing to follow safe infection control procedures and current government guidance.

● Throughout our inspection visit, we observed a large number of staff who did not wear personal protective equipment (PPE) such as gloves or aprons when providing care and support. Staff did not wear gloves when supporting people to eat and drink, often moving between people to offer support without washing their hands. A nurse did not wear gloves or sanitize their hands when administering medicines to people.

● We reviewed CCTV footage of communal areas between the dates of 8-11 August 2020 inclusive. We observed 63 occasions when staff were not wearing the appropriate PPE for the support they were providing. Support included providing personal care, assisting people to move and transfer and assisting people with food and drink. Staff were seen in insufficient PPE or wearing PPE inappropriately, such as face masks around their necks. On three occasions we observed staff administering medicines directly into people's mouths without wearing gloves, aprons, or washing hands. This placed people at significant risk of harm from infections and increased the potential risks from COVID-19.

● People were supported to isolate if they showed symptoms associated with COVID-19 or were particularly vulnerable due to a health condition or had recently been discharged from hospital. One person who had recently returned from hospital had no infection control prevention plan in place to provide the guidance and support staff needed to keep the person and others safe from COVID-19. We raised this with the deputy manager who told us they would implement a plan immediately.

● We saw, where people were isolating in their room, doors had been left open and there was no PPE available outside the rooms to enable staff to don PPE before entering. There was no receptacle to place inside the room for used items after doffing PPE before leaving the area.

● We observed a member of staff walk into a person's room who was isolating for 14 days and provide support without wearing any PPE.

● Sufficient resources were not always available to support staff to follow safe infection control procedures. PPE was not always available in toilets and bath/shower rooms and some hand sanitizer units were faulty.

● The provider had an infection control and prevention policy in place. This did not provide specific guidance for staff on the measures they needed to take to reduce the risk of COVID-19.

People were not protected from the risk or spread of infections, including COVID-19. The provider had failed to ensure staff followed safe procedures to control the risk and spread of infections. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

● Housekeeping staff were responsible for maintaining the cleanliness of the home. There was a cleaning

schedule in place and records showed this was followed throughout the day. Staff told us cleaning had been increased in line with current guidance around the management and prevention of COVID-19.
● The service presented as clean and free from malodours.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse
● People were not effectively protected from risks associated with their health conditions such as malnutrition and dehydration. We reviewed fluid monitoring charts for seven people between 3-10 August 2020 inclusive. We found 21 days where seven people had not received their daily baseline fluid intake. For some people, this involved consecutive days. For example, one person had failed to achieve their daily fluid target of between 1000-2000mls on every day between 4-10 August 2020. Daily monitoring records had not been reviewed or had been reviewed over 24-hours later with vague guidance, such as 'push fluids' or 'encourage fluids'. This meant timely action had not been taken to protect the person from the risk of dehydration.
● A second person had not achieved their daily fluid target intake in four out of seven days. Two days had been reviewed with instructions for staff to 'push fluid's' whilst two records had not been reviewed. The person had continued with reduced fluid intake despite the monitoring chart reviews.
● We monitored the fluid intake for two people for the duration of our inspection visit. We saw one person had a beaker of 150mls of cold tea in their room. Fluid monitoring charts completed by staff twenty minutes after our monitoring recorded the person as having consumed 150mls of tea. We identified that the person had only consumed 50mls and the remaining tea was still in the beaker 90 minutes after staff recordings. A second person had 150mls of fluid in a beaker. Shortly after our monitoring, staff recorded that the person had consumed the 150mls of fluid. We checked the fluids periodically over a two hour period and found no fluids had been consumed since our initial monitoring began. This demonstrated people were not received the fluids they needed and records had not been completed accurately.
● During our inspection visit, we observed people left with untouched food in front of them at breakfast. When we raised concerns with staff for one person, they immediately began to assist the person to eat cold porridge. CCTV footage later shows staff stopped assisting the person when the inspection team left the area and the person was not offered any alternative. This put the person at risk of poor nutrition.
● One person had an in-dwelling (inside the body) catheter. Their care plan stated 'the catheter needs to be cleaned daily" "staff to measure urine passed" "staff to measure in-put and out-put" and "staff are to report any concerns to the nurse'. The care plan did not state what the early signs of infection were and/or blockage and retention; concerns that would require reporting. Records did not evidence that the care plan was being followed and appropriate daily catheter care had been provided. For example, between 8-11 August 2020 inclusive, records showed the person's output had only been recorded on four occasions over 72 hours. There were no recordings to confirm the catheter had been checked as per care plan. Recording the out-put is important as reduced out-put can be an early indicator of infection, blockage or retention.
● A second person had an in-dwelling catheter that was overseen by external health professionals. Their care plan did not contain information on early signs of infection, blockage or retention in order to alert the district nurses in a timely manner of potential problems that may arise in between the routine changes.
● People's care plans included personal emergency evacuation plans (PEEPS) to provide staff with information to support the person to evacuate the building safely. Plans did not detail the level or type of support each person required or equipment needed to help them evacuate in an emergency. Plans stated that all staff had received fire training, but a training record for one nurse showed they had not received any fire training since they started employment early 2020.
● People were not always protected from abuse or improper treatment, including neglect. Our review of CCTV footage between 8-11 August 2020 inclusive revealed several incidents where people, including those at risk of falling, were left between 30-60 minutes without staff supervision or support in communal areas.

● On one occasion staff are observed to support a person to transfer using a hoist. Staff are seen to leave the person suspended in the hoist mid air for over 30 seconds whilst they 'chat' with each other. The person is then hoisted into a wheelchair using an unsafe transfer. The person is then left alone with the hoist sling still around them for over 45 minutes.
● On another occasion, a second person is seen to be handled roughly by a staff member who is supporting them to eat and drink.
● CCTV footage showed numerous occasions where staff were seen to be on their mobile telephones, ignoring people or using their phone whilst supporting people.

The provider had failed to take timely, effective action to mitigate risks for people as far as is reasonably practicable. People were not protected from abuse or improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment and Regulation 13: Safeguarding service users from abuse and improper treatment.

● Staff who we spoke with demonstrated they understood safeguarding procedures and how to raise concerns outside of the service. Some staff felt concerns had been acted upon whilst other staff felt concerns had not been resolved.

Using medicines safely
● Not all aspects of medicines management were safe.
● One person who received their medicines through trans-dermal methods (direct to skin) did not always receive their medicines at the prescribed time. We found six occasions between 6 June 2020 and 8 August 2020 where the person's medicine was between two and five hours late being administered due to 'ward busy' or nurse 'waiting for witness'. This demonstrated medicines were not always administered efficiently or effectively.
● Some care plans lacked information about people's medicines for staff to understand why people were prescribed their medicines or how to support people effectively with these. We also found contradictory information in care plans. For example, one person was described as being able to take their medicine in one area of their care plan, whilst another section described them as 'non-compliant' with their medicines. The medicine care plan advised staff that the person should avoid certain foods and drinks due to risks associated with their medicines, these were not detailed. The care plan also advised staff that the person had a preference as to what they wanted to take with their medicine; this preference was not recorded.
● We observed the nurse in charge administer medicines as part of their medicines round. Whilst the nurse ensured people received their medicines correctly and as prescribed, they did not wash their hands or sanitise between administration.
● Medicines were stored safely. There were effective systems in place for ordering and disposing of medicines safely.

Learning lessons when things go wrong
● The provider had systems in place to monitor incidents and accidents, and to identify trends and patterns. There was evidence these were analysed and actions taken post incident to prevent further risk of harm. For example, referral to external health professionals or review of equipment. However, records did not detail any interim measures had been put in place pending review/assistance from external professionals. Accident records did not always include the detail needed to enable effective analysis and intervention.
● Care plans lacked sufficient guidance to enable staff to support people with distressed behaviours. For example, we found one person's care plan identified they could become distressed during care and support but did not identify actions staff should take to reduce this risk or suggest appropriate interventions. There were no post incident analysis to ensure staff were responding appropriately and learnt from each incident.

Staffing and recruitment

● People told us there were enough staff to meet their basic care needs. However, we observed staff had very little time to spend with people and some people were bored and under-stimulated.

● We observed sufficient staff to meet people's needs on the day of our inspection visit but they were not always deployed effectively across the service. For example, some staff were engaged in time consuming tasks such as inputting data into the electronic care system, leaving them unable to provide care or support. There was a limited staff presence in communal areas due to staff supporting people in their rooms, including people who required more than one staff member to meet their needs.

● The deputy manager told us they strived to maintain planned staffing levels but there were times these were not consistently achieved. The service relied heavily on agency staff covering short falls in staffing. This meant the service could not respond effectively in the event of short notice staff absence. There were occasions when there were insufficient staff deployed in the service to keep people safe. People told us, on these occasions, they had to wait for assistance. CCTV images showed there was a lack of staff supervision of communal areas when staffing levels were low, putting people at risk of potential incidents and accidents.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Whilst audits were completed these did not always highlight issues or concerns we found during the inspection. Systems and processes were not embedded in working practices to demonstrate improvements could be sustained to support positive outcomes for people.
- For example, care plans had been reviewed but did not always reflect people's current needs or provide guidance to support personalised care.
- Audits had failed to identify and implement improvements needed to manage risks for people as described in the safe domain of this report.
- An electronic care system was in place but was not used effectively or accurately to monitor and ensure people received the care and support they needed.
- The deputy manager told us 'discussion chats' were held with staff to support their understanding and compliance with PPE requirements. Our observations and review of CCTV footage showed these had not been effective in ensuring staff complied with infection control and prevention to manage risks, such as those from COVID-19.
- The service had a manager registered with the Care Quality Commission. They were absent from the service at the time of our inspection. We received mixed feedback on their leadership and oversight of the service.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider and interim managers sent us an action plan detailing how they would improve the governance of the home. They told us of their plans which included taking immediate action to ensure full compliance with current PPE guidance and infection control and prevention and on site management and support to ensure continued oversight and compliance.

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

- Whilst the deputy manager and staff team tried to ensure good outcomes for people, our inspection visit

found these were not consistently achieved. Care plans and records were not personalised to reflect people's specific support needs and wishes.
● People were not consistently supported to engage in meaningful interaction and experiences. Staff spent little time with people and care was observed as task focussed in the main.
● People felt there were limited opportunities to share their views as part of the development of the service. However, people and relatives we spoke with during the inspection process told us they were happy with the service provided. They felt the staff were caring and provided support in a respectful and dignified way.
● The provider and interim managers provided us with an action plan following the inspection which outlined how they would improve the culture of the service.

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 registered manager made notifications to relevant agencies when something went wrong in the service.
● Although correspondence when a specific incident occurred was transparent, outcomes of the investigations were not always clearly detailed and risk assessments were not always updated in a timely manner. In most cases, the person or their representative had been given the opportunity to liaise with the care manager about the incident.

Working in partnership with others; Continuous learning and improving care
● Effective systems were not in place to allow continuous learning and improving care. More details can be found within the safe domain of this report.
● Records showed staff sought support from other agencies to improve the quality of care people received, for example, health care professionals. However, health monitoring charts did not evidence that advice and guidance was consistently followed.
● Following our inspection, the provider recognised improvements in the service were needed and took immediate action to improve people's safety and care and review the management and governance of the service.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people were protected from the risk or spread of infections, including those that are health care associated.

The enforcement action we took:

Letter of intent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were protected from abuse or improper treatment

The enforcement action we took:

Letter of intent

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 failed to operate effective systems to assess, monitor and improve the service.

The enforcement action we took:

Notice of Proposal to impose conditions on the provider