Ashurst House Limited

Ashurst House

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
Ashurst House is a residential care home providing personal care to 8 people with a learning disability.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
The model of care setting did not maximise people's choice, control and Independence.

Right care:
Care was not centred around people to ensure they had control over all areas of their life. People were not supported to be as independent as possible and were not always treated with dignity.

Right culture:
The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people could lead confident, inclusive and empowered lives.

People's views had not been used to develop the service and there was no evidence to demonstrate concerns they raised had been addressed. Other stakeholders including staff and relatives had not been invited to share their views of the service. The manager and provider lacked oversight of the service and shortfalls had gone unnoticed. There had not been a registered manager at the service for eighteen months and there was a lack of strong leadership.

People told us they did not always feel safe at the service. Some people's behaviour scared other people and staff at times. Staff did not know what caused people to become anxious or frustrated or how to support them to remain calm. The manager had not notified us about safeguarding concerns so we could check action had been taken to keep people safe.

People were not supported to develop their independence and take risks. They were not involved in planning how risks were mitigated. Sufficient guidance had not been provided to staff about how to manage some risks. Action had not been taken to learn lessons when things went wrong. People's medicines were not always managed safely.

People were not involved in recruiting the staff who supported them. New staff had not been recruited safely and in accordance with the provider's recruitment process. There were not enough staff on duty each day to support people in the way they preferred.

Records about people's care and support were not accessible to them. They were not always accurate and completed or written when things happened. Electronic records were not easily accessible to staff due to poor Wi-fi.

People were protected from the risk of infection.

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 24 May 2019).

Why we inspected
We received concerns in relation to the management of medicines and people's care needs. 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. We did not inspection the other key questions. 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 changed from good to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. 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.

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.

We have identified breaches in relation to protecting people from abuse, managing risks to people, medicines management, staff recruitment and deployment, poor record keeping, ineffective checks and audits and a failure to act on people's views.

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 overall rating for this service is 'Inadequate' and the service is therefore 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.

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.

Ashurst 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 completed by two inspectors.

Service and service type
Ashurst 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 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. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke with nine members of staff including the nominated individual, who is responsible for supervising the management of the service on behalf of the provider, the manager, senior support workers and support workers.

We reviewed a range of records. This included multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including safety checks and financial records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two staff and reviewed five people's care plans, risk assessments and accident/incident records.

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People told us they did not always feel safe living as Ashurst House. One person told us, "I like [person's name], they are my friend, but I am scared of them sometimes". Some staff told us they were also scared of the person. Action had not been taken to support people and staff to feel confident in the person's company and there was a risk the person would be isolated.
- One person shouted at and hit staff at times. We observed the person strike out at, but not hit, another person. The person had been supported by the positive behaviour team who had provided written up guidelines for staff to follow to help them remain calm. These were not available to staff and staff did not know what may trigger the person's behaviour. Following our inspection, the manager put guidelines in place to support the person. However, these told staff to remain at a safe distance from the person but did not tell them how to safely provide the person's personal care.
- There had been an incident between two other people in January 2021. This had been reported to the local authority safeguarding team for their consideration. However, CQC had not been notified of the incident so we could check how the provider had acted, to keep everyone as safe as possible. Following the inspection, the manager sent us a notification, however this did not include the action taken to keep the person and others safe.
- Staff had completed safeguarding training and knew how to raise concerns with the manager and provider. Information was not available to people, in a format they understood about how to keep themselves safe and raise any concerns they had.

The provider had failed to operate effective systems and processes to effectively prevent abuse of service users. 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.

Assessing risk, safety monitoring and management

- Risk were not always managed to keep people as safe as possible and support them to take risks. Staff told us one person enjoyed making their own drinks and required support to reduce the risk of them scalding themselves. Detailed guidelines were not in place about the support the person needed to stay safe. Staff told us other people were able to make drinks and simple meals with support but were not enabled to do this because there were not enough staff to support them. Any potential risks had not been identified and support had not been planned with people to enable them to take risks and develop their independence.
- Some people were at risk of developing pressure ulcers and this had been identified using recognised assessment tools. However, care had not been adequately planned to mitigate these risks. People used pressure relieving equipment, but plans were not in operation to support them to regularly change their

position during the day and at night. Some staff did not know the signs that someone was developing skin damage and guidance was not in place for them to follow.
● Staff supported one person to manage their diabetes. They took the person's blood sugars twice a day and told us if they were "too low" they gave the person a sugary drink. However, staff were not able to tell us what 'too low' was. The person's care plan stated their usual blood sugar range was between 12 and 23 mmols. Records showed their blood sugar level was rarely above 12 mmols and had fallen below 4 mmols. The person had not been supported to see a health care professional to review their diabetes and planned support. There was a risk the person would become unwell.
● Risks relating to fire were not completely mitigated. Fire alarms were scheduled to be tested weekly; however, this was not completed consistently. There had been two tests in May 2021, one in April 2021, three in March 2021 and one in February 2021. People knew what to do in the event of a fire and told us, "Even the cat comes out". They had practiced evacuating the building during the day but not at night, when it may be cold, dark and staffing levels were reduced. Staff told us they were not confident they could evacuate everyone at night.

The provider had failed to assess and mitigate risks with people, to keep them safe while supporting their independence and development. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other risks had been mitigated. For example, when people needed help to move this had been assessed and detailed guidance was in place for staff. One person told us they felt safe when staff supported them to use a hoist. Regular checks were completed on the building and equipment.

Learning lessons when things go wrong
● Effective systems were not in operation to ensure lessons were learnt when things went wrong at the service. Accident and incident records were not completed in detail and could not be used to identify patterns, triggers or trends. Accident records were used to record other areas of people's care, including hospital admissions. An audit in March 2021 had identified the provider's 'lessons learned log' was not being used and staff did not know when it should be used. The log was not being used at the time of the inspection.
● Accident records did not always include important information, such as the time and date of the accident, where it had occurred and what happened. Accident records had been reviewed by the manager; however, action had not been taken to include all the required information. Their comments were not specific to the accident and had not been used to plan people's care. For example, one person had fallen on several occasions. Their falls risk assessments and care plan had not been updated to prevent the accidents happening again.
● The provider required staff to clearly record what happened before, during and after an incident. Records were brief and did not contain all the information needed to fully understand what had happened and why.
● Following our inspection, we reviewed records of an incident witnessed by inspectors. This was dated a week after the inspection and contained limited and inaccurate information about what had happened.

The provider had failed to operate effective processes to assess, monitor and mitigate risks relating to people's safety. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People's medicines were not always managed safely. Before our inspection a visiting professional found that people's 'when required' medicines were not always administered as prescribed. We found guidance

for staff around when required medicines, but this did not reflect prescribing advice. For example, several people were prescribed pain relief 'when required'. The dispensing label said to administer one tablet, guidance to staff instructed them to administer two tablets. There was a risk people would be given more pain relief than they were prescribed.
● Guidance around one person's emergency medicine was unsafe and instructed staff to give it to them when they were unresponsive. This placed the person at risk of choking. Information had not been provided about signs the person required the medicine. Staff were not able to tell us when and how they would administer the medicine. The person was not supported to take the medicine with them when they went out.
● Most medicines were stored safely in people's bedrooms and temperatures were checked daily. Temperature records showed medicines were frequently stored at 24°C at 8:30 am. Some medicines, including those to manage epilepsy, needed to be stored below 25°C. No consideration had been given to ensuring medicines were stored at a safe temperatures when the weather was warmer during the day. There was a risk people's medicines would not be as effective because they had become too warm. Products prescribed to thicken fluids for people at risk of choking were not stored securely. This posed a risk to people if they were eaten by mistake.

The provider had failed to ensure service user's medicines were managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they received their medicines when they needed them. This included 'when required' pain relief. When people preferred, they were supported to administer their own medicines. Before our inspection a visiting professional identified shortfalls in the recording of medicine administration. These had been addressed and we found administration records were accurate and stock balances were correct.

Staffing and recruitment
● People were not protected by safe staff recruitment. The provider's recruitment policy had not been followed to ensure staff had the skills, knowledge and experience required and were of good character. A full employment history, with a satisfactory written explanation of any gaps in employment had not been obtained for one staff member. Two written references had not been obtained for another. The dates on references for a third staff member did not match the employment dates supplied on their application form. Criminal record checks with the Disclosure and Barring Service had been completed.

The provider failed to operate effective recruitment processes to ensure staff were of good character and had have the qualifications, competence, skills and experience necessary to complete their role. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were not enough staff on each shift to meet people's needs and keep them safe. The provider did not have a system in operation to assess how many staff were needed to meet people's needs. The numbers of staff on each shift was based solely on the hours funded by local authorities. Commissioning authorities had not been asked for additional funding when people's needs had changed.
● Staff told us there were not enough staff. Three staff supported the eight people during the day. Each day two staff took one person to a local shop. This left one staff member to support the remaining seven people, one of whom needed two staff to support them with aspects of their care. Other people required the support from the staff to mitigate the risks, such as choking, scalding or falling. Following our inspection, the provider deployed an additional member of staff between 9am and 9 pm. A staff member told us this had

"made a massive difference" to the support they were able to give people.
● The manager had identified there were not enough staff on duty at night. However, they had not increased the number of staff on duty. All of the staff we spoke with told us they would not be able to meet some people's continence needs or support in an emergency at night. We spoke with the nominated individual during our inspection and they increased staff on site at night, to two staff. We will continue to monitor staff deployment to check there are always enough staff on duty to meet people's needs and keep them safe.

The provider had failed to deploy sufficient numbers staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was 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.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

● The service was clean, and people were supported with cleaning, laundry and tidying their rooms. Regular infection control audits were completed to make sure the service was clean and hygienic.

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 good. 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.

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

● The culture of the service did not reflect our Right Support, Right Care Right Culture guidance. People had not been offered the same choices, dignity, independence and good access to local communities that most people take for granted. People were not involved in decisions made at the service, such as the recruitment of staff who supported them. Meals for people at risk of choking were not prepared in a dignified way. All of the foods were pureed together, and people could not taste the flavour of individual foods.

● People were not encouraged and supported to be as independent as possible. People prepared their own breakfast with support but did not prepare other meals despite having the skills to do this. For example, at lunch time people were not supported to spread butter on their bread, this had been done by staff. Staff were doing 'for' people rather than 'with them.'

● The service's 'mission statement' noted, 'Ashurst House aims to provide a homely environment which enables each person to reach their own individual maximum potential, at a pace and level that that is appropriate for each individual's ability and needs'. In practice, this support was only provided when local authorities funded it specifically. The manager told us, "[Person] does cook. We have just asked for more hours [from the local authority commissioner] to support them more with this". Staff were preparing meals for people and had not considered whether they could be supported to do this themselves.

● We spoke with staff about the culture and ethos of the service. None of the staff we spoke with mentioned encouraging and empowering people to promote their independence. There were no plans to support people to become more independent and have maximum control over their life.

● The manager was not leading by example to develop a culture centred around people. The provider's care planning system included a section for 'My views and wishes'. This had not been completed for anyone. Shortly before our inspection one person's pet had died and the person was upset. The manager told the person, "You don't want another pet. You couldn't look after it could you". At our previous inspection we found the person was caring for their pet with support. Staff told us they had continued to do this and loved their pet very much.

Continuous learning and improving care

● Effective systems were not in operation to keep the quality of the service under review and identify any shortfalls. Several quality assurance checks had been completed but these had not identified the shortfalls we found.

● An audit of the service had been completed in March 2021 by the regional manager. This included, 'Are there suitable numbers of staff to keep people safe and meet their needs'. The report only noted the total

number of staff employed. There was no mention of the deployment of staff on each shift to consider people's needs and preferences.
● The provider's recruitment audit did not reflect the requirements of their recruitment policy. The policy required applicants provide a full employment history, in line with the Health and Social Care Act 2008. The audit required a ten-year work history. The audit had not been effective and identified the gaps in recruitment checks we found.
● The manager had been supported to check all areas of the service by a registered manager from another of the provider's services. An action plan had been developed to address the shortfalls found. However, some actions did not have a date for completion or identify who was responsible for completing the work. This made it difficult to check the action plan had driven improvements.

The provider had failed to operate effective processes 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others:
● There was a lack of clear leadership at the service and this had impacted on the quality of the support people received. The previous registered manager had left in November 2019. Another manager had been employed but had not been registered with CQC. The current manager had begun working at the service in January 2021. They had not applied to be registered as the manager of this service or deregister as the registered manager at their previous service.
● Records of the care people received were not accurate, contemporaneous and complete. Staff told us they were not confident with the electronic records system despite receiving training. Staff completed records for each other and did not always complete them at the time the support was provided. Records did not include all the information required to review and plan people's support. Staff were only able to access electronic records in one room due to poor Wi-Fi connection. The provider had attempted to address this, but the issue had not been resolved.
● The manager had begun to review and rewrite people's care plans and risk assessments when they began managing the service. This process was not yet complete and information about some people was inaccurate. People's care had not been planned with them or by staff who knew them well. They did not have access to information about themselves in formats they could easily understand.

The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each service user. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a lack of evidence of continuous learning. For example, there was no overview of accidents and incidents. Each accident report was reviewed by the manager and signed to note the review. These reports lacked detail and were inaccurate. One recent record included details of a different person. Shortfalls identified by the regional manager in March 2021, such as on overview of accidents and the use of a lessons learned log, had not been addressed.
● The manager had not worked in partnership with health care professionals to ensure people received timely treatment. There had been a delay in referrals being made to the speech and language therapists and dentists. This had placed people at risk and impacted on their privacy and dignity.

The provider had failed to operate effective processes 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.

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

● People's views had not been used to improve the service. People took part in regular meetings with the manager and staff to talk about their experiences living at the service. They had raised concerns, but these had not been acted on. Five concerns relating to one member of staff, had been raised, these included people feeling they were shouted at. We asked the manager what action had been taken to address this. The manager did not provide a response to reassure us action had been taken to ensure people were always treated with respect.

● People's relatives, staff and health care professionals had not been asked for their views of the service. The provider had missed this opportunity to gather feedback on which to make any required improvements.

● Each person was allocated a key worker. A key worker takes the lead in making sure people's changing needs are met and keeping their loved ones informed. The manager had identified that key workers needed to spend more time with people. This was not included in their action plan and, other than discussing it at a staff meeting, no other action had been taken.

The provider had failed to seek and act on feedback from service users, staff, relatives and other stakeholder for the purposes of continually evaluating and improving the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Services that provide health and social care to people are required to promptly inform us of important events that happen in the service. This is so we can check appropriate action had been taken. The provider had failed to notify CQC of allegations of abuse so we could check action had been taken to protect people from further risks.

The provider had failed to notify CQC of allegations of abuse. This was a breach of regulation 18 (Notification of other incidents) of the of the Care Quality Commission (Registration) Regulations 2009.

● The manager told us they understood their responsibility to follow the duty of candour to provide an explanation, and when required an apology, if something has gone wrong or could have been done differently or better.

● The provider had displayed the current CQC rating in the service and on their website.

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 of allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to operate effective recruitment processes to ensure staff were of good character and had have the qualifications, competence, skills and experience necessary to complete their role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of staff to meet people's needs.

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 assess and mitigate risks with people, to keep them safe while supporting their independence and development. The provider had failed to ensure service user's medicines were managed safely.

The enforcement action we took:

We applied conditions to the provider's registration.

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 operate effective systems and processes to effectively prevent abuse of service users.

The enforcement action we took:

We applied conditions to the provider's registration.

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 operate effective processes to assess, monitor and mitigate risks relating to people's safety. The provider had failed to operate effective processes to assess, monitor and improve the quality and safety of the service. The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each service user.

The enforcement action we took:

We applied conditions to the provider's registration.