South West Care Homes Limited

Ashfield

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

Ashfield is a residential care home providing personal care to 14 people aged 65 and over at the time of the inspection. The service can support up to 25 people.

Why we inspected
This inspection took place on 4 March 2020 because of the time that had passed since the last inspection, based on the previous rating. However, due to the Covid-19 pandemic we were unable to complete the inspection as it was initially planned. Therefore, our inspection was based on our findings from the visit on 4 March 2020. Due to the necessary changes made to the planned inspection process, the inspection was converted from a full Comprehensive inspection, that would have normally been completed over two days, to a one-day Targeted inspection.

Targeted inspections do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections cannot change the rating from the previous inspection. This is because they do not assess all areas of a key question. Therefore, the overall rating for this service has to remain inadequate, as not enough areas were inspected in order to change the rating. We plan to return in the near future to carry out a further inspection which can potentially change the rating of the service.

On 4 March 2020 we identified areas which placed people at risk from unsafe care. We raised these concerns with the nominated individual, and they are taking further actions to address these concerns. The provider completed an action plan after the last inspection to show what they would do and by when to improve. Improvements had been made but the provider continues in breach of regulations.

In September 2019, a new nominated individual began working for the provider. Their role includes Director of Operations, they have a staff team with their own quality assurance responsibilities. CQC met with this new team in October 2019 and has continued to regularly meet with them. CQC have worked closely with the local authority, including the commissioning team, to monitor the quality of care at Ashfield. Since this inspection dated 4 March 2020, Ashfield is no longer under a safeguarding process due to improvements at the service based on feedback from health and social care professionals.

Areas relating to care needed to be improved, including inconsistencies in care plans. There were gaps in staff training and supervisions for staff were not up to date. Staff said most people's risk assessments were up to date but a range of risk assessments for three people with complex needs had not been updated. The organisation was reviewing how staff were trained in completing electronic care records but due to the Covid-19 pandemic some training had been delayed. Staff were not always recording safeguarding concerns formally and therefore alerts were not always made to safeguard people.

Staff said the manager was working tirelessly to make improvements to the quality of the care. The nominated individual said there was a temporary staffing problem, hindering further improvements, due to improvement action having led to the dismissal of some staff. They explained new staff had been recruited

and were awaiting DBS, but temporarily there was a heavy reliance on agency staff for both day and night shifts.

Staff praised the approachability of the manager despite the pressures the service was under. Since the last inspection, a number of environmental improvements had been made, including new furniture, carpets and décor in some areas of the home. New colour schemes and signage were planned to make the home a more accessible place for people living with dementia. Whilst there were no new admissions to the home, bedrooms were being decorated and refurnished.

Enforcement
We did not look at all the previously identified breaches of regulations due to the changed circumstances of this inspection. Therefore, these breaches must remain in place until we carry out another inspection. These breaches were regulations 9 and 15.

On 4 March 2020, we judged regulation 18 in relation to staffing as no longer in breach. We have made a recommendation for this regulation instead. We identified four on-going breaches in relation to safe care and treatment, protecting people from potential abuse, notifying the Care Quality Commission in line with statutory requirements, and ensuring systems were in place to monitor and manage the service.

Follow up
We will request a further action plan from the provider to understand what they will do to improve the standards of quality and safety. We will continue to work alongside the provider and 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below	**Inspected but not rated**
Is the service well-led? The service was not always well led. Details are in our well led findings below.	**Inspected but not rated**

Ashfield

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.

Inspection team
An inspector and an assistant inspector completed the inspection.

Service and service type
Ashfield 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 and we used this information to plan our inspection.

During the inspection
We spoke with four people living at the home to explain our role and observed how staff supported them. We spoke with a range of staff including the manager, operations manager, care staff and ancillary staff. We reviewed three care records, two staff files, training overview, records of accidents/ incidents, audits and quality assurance records.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse

● During the inspection, staff said there had been an incident where a staff member's actions had impacted on some people's dignity, as well as putting them at risk of pressure damage. Staff alerted the new manager, who took prompt action to protect people. They also informed the provider's operations team about the steps they had taken to keep people safe. However, there had been a delay in notifying the Care Quality Commission and making an alert to the local safeguarding team. A safeguarding alert was made following our inspection.

● Improvement was needed in the recording of incidents. Daily care notes for one person showed at times they became agitated and frustrated. This could result in them swearing and hitting out at staff, and on one occasion trying to leave the home. Records did not show if a review or audit had been completed to assess what had triggered their behaviour.

● Staff said they had confidence in the new manager because they listened to their concerns about people's safety and well-being and took action. However, staff did not routinely report when care had not been documented as taking place even when this put individuals at risk of harm. For example, gaps in repositioning records. Following our inspection, we made a number of individual safeguarding alerts to the local authority as we were not confident some people were receiving the appropriate level of care to reduce risks to their health and well-being.

At our last inspection the provider had failed to safeguard people. 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● People who were in their rooms used call bells to request staff support. The noise of the call bell system was intrusive throughout our visit, particularly when it changed to an emergency sound if a bell was not answered within a set time. Following feedback during our visit, changes were made to the wiring of the front door bell, so it did not link in with the emergency call bell. Due to the age of the system, staff said they could not carry out audits on how quickly they were answered or how often call bells rang.

● Training was being reviewed by the operations team and an overview of compliance was being compiled. We were told the completion of mandatory courses, such as safeguarding training, was low. The training manager said this was due to be addressed in the next month but there was also acknowledgement of the

difficulties of scheduling training when there were staff vacancies.

Assessing risk, safety monitoring and management

● Care records were in the process of being reviewed and updated; this work had begun in January 2020. Staff said 11 had been updated out of 14 people's records. However, staff said there had not been an assessment as to which records should be prioritised based on people's risks. For example, records for one person with high care needs had not been updated or effectively reviewed. Another care plan had not been reviewed for five months despite several incidents where the person had become aggressive towards others. We raised concerns with the nominated individual about the quality and oversight of the person's care and requested their care was reviewed immediately to mitigate risks.

● Work had taken place to update risk assessments, but some were still not yet up to date and contradicted other assessment tools. For example, in the case of a person who was losing weight, an action was for them to be weighed weekly, but this was not happening. There was insufficient oversight as to whether agreed actions were effective. They had been prescribed food supplements drinks, but records contained gaps and it was unclear if the supplements had been drunk. Prior to the new manager starting, their weight was also poorly monitored with gaps of three months despite significant weight loss, but this was now being addressed.

● People had been assessed as being at risk of poor oral healthcare. Assessment outcomes contradicted the level of support they required. There were significant gaps in people's oral care records. Lack of oral health care potentially put people at risk of pain and decay and a reluctance to eat. This included people who were already experiencing unplanned weight loss.

● People assessed as being at very high risk of pressure damage had instructions in place for them to be repositioned by staff at set intervals to reduce this risk. According to records for two people this guidance was not followed with significant delays in providing care, putting them at increased risk of developing pressures sores. However, neither person had a pressure sore.

● Information in three people's care plans was out of date and gave staff inaccurate guidance about how to meet people's care needs. This placed people at risk of not having their needs met in a consistent or safe way. For example, one person's mobility assessment stated they could mobilise with the assistance of two staff and the use of a zimmer frame. Staff said this was no longer the case and they were now cared for in bed.

● Two people's personal evacuation plans had not been updated to reflect a person moving out of the home and another moving rooms. Both were immediately updated during the inspection.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Gaps in the records of people's weight took place before the new manager came into post and this issue was now being addressed.

● Following the inspection, the nominated individual confirmed people's personal evacuation plans had been updated, as had people's risk assessments. Audits had been put in place to oversee people's nutritional intake and the manager was checking people's re-positioning charts on a daily basis to ensure staff followed the outcome of risk assessments. All people had been weighed and records updated. One person who was particularly at risk of unplanned weight loss was referred to a dietician. Care plans had also been updated.

Staffing and recruitment

● Recruitment to cover staff vacancies was a significant issue at the home; operational staff said it was hard to recruit in the local area. There was a daily reliance on staff from different agencies, both to cover day and night shifts. Some confirmed they had worked at the home before and their interactions with people showed they knew their names and preferences. However, one agency staff member had not previously worked at the home; they were not provided with people's names or care needs either electronically or on paper. They had been partnered with a permanent member of staff but were completing some care independently, such as supporting a person to eat a meal. The manager said they had intervened on these occasions to remind them to work in a pair. The nominated individual has confirmed action has been taken to improve the handover of information to agency workers and how information is shared between shifts. Whilst this was not in place on the day of inspection, we saw that an alternative arrangement was used by the manager to promote people's safety.

● We checked the recruitment records for a new staff member, which contained references, interview notes, training qualifications and identification information. The manager said they had ensured they were paired with experienced day and night staff as part of their induction before working with agency staff. Rotas confirmed this arrangement. However, no competency or performance feedback had been recorded; this was despite several incidents with one person living at the home. An induction record had not been started.

We recommend the provider introduces new measures to judge the competency of new staff, including staff from recruitment agencies.

● The training manager said the induction process was being restructured, including for managers. This was because there were gaps in the induction, including in the use of electronic care records.

● Operations staff identified there were a lack of strong role models in the team, which could impact on how shifts were organised and run. The manager has taken on additional tasks due to staff vacancies; they said they had arranged for additional agency cover on these occasions, which was the case on the day of our inspection.

Preventing and controlling infection

● Rooms in the building were clean and free from odour, except one. Staff explained how they were supporting one individual whose behaviour impacted on others because of an infection control issue around their incontinence. The nominated individual said the person's care needs had been referred again to external health and social care agencies for further advice and support.

● Staff said they had equipment in place to manage the control of infection, for example aprons and gloves. Records showed staff had been reminded to take immediate action when communal areas needed cleaning, including shared toilets. Despite Covid-19 advice at the time of our inspection, there was no hand gel near the front door for visitors to use when they entered and left the building. We were told this was an oversight due to the hall being decorated. Following the inspection, the nominated individual said this had been addressed.

● One person had recently moved out; staff deep cleaned the room during our visit and a new carpet was planned. Staff said since the last CQC inspection, this was now normal practice before a new person moved into a vacant room.

● The laundry had been moved to provide more space, infection control measures were in place, including the red bag system for soiled laundry. There was no sluice. However, new guidance had been introduced for staff on how to clean and empty commodes safely.

Using medicines safely

● Due to a lack of staff trained in medicine administration, the manager with the support of two other staff

members needed to cover four medicine rounds a day. On the day of the inspection, they were still administering morning medicines for 14 people in the late morning. Action was being taken to train more staff in medicine administration, which would enable the manager to concentrate on their specific managerial duties.

● Records showed the manager was proactive in contacting health professionals to have medicines reviewed. During the inspection, they met with a local pharmacist to resolve issues they had identified.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the parts of the key question we have specific concerns.

We will assess all of the key question at the next comprehensive inspection of the service.

In September 2019, a new nominated individual began working for the provider. Their role includes Director of Operations; they have a team of staff with their own quality assurance responsibilities. CQC met with this new team in October 2019 and has continued to regularly meet with them. CQC are also working closely with the local authority, including the commissioning team, to monitor the quality of the care at the provider's homes.

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

- There is currently no registered manager at the service; a new manager has been in post since January 2020. They have not applied to register as a manager with CQC yet. We were told the service's care quality and compliance manager, managers from other homes in the group and the nominated individual were supporting them.
- In the last year, there had been four different managers at the home, which staff said had been unsettling. The new manager was busy on the day of our inspection, so we were unable to spend time with them to discuss how they were being supported in their new role. This was because they were working as part of the care team and administering medicines.
- Audits, for example on the quality of record keeping and the management of risk, had not taken place to check risks to people's health were being managed effectively. Staff said the manager was working tirelessly to make improvements to the quality of the care. The nominated individual said there was a temporary staffing problem. Further improvements were hindered as the manager worked alongside staff to provide additional cover, including administering medicines and delivering care.
- The previous CQC report highlighted weaknesses in the service which needed to be addressed to keep people safe. The operations team had provided CQC with verbal updates at regular meetings and submitted an action plan for the service, which was updated every two months. The outcome of this inspection showed that improvement had been made but that further improvement was needed.
- A planned new tool to monitor the quality of care records was not yet in place at the time of the inspection, although care plan reviews had begun. The Nominated Individual has confirmed the new care planning tool has been implemented since the inspection visit. Staff did not routinely check each other's practice and did not routinely report if there were gaps in the records. This indicated staff did not understand the potential impact of people not being re- positioned at regular times.
- The new operations team had been in place for six months and they said their aim was to embed improvements across all the homes owned by the provider. They had made changes to improve the

management of risks to people's health and well-being through improved monitoring and auditing of events in the home. Our inspection identified areas for improvement which had been highlighted in an internal audit in November 2019. Risks to people's health and well-being were not being consistently safely managed at Ashfield. Due to additional responsibilities, the manager said they had not had time to audit records, including incidents at the home.
● Training issues identified last year were still not fully resolved with more work taking place to collate what training had been completed by staff and what was still outstanding. Staff supervision was not up to date. Inductions and competency checks were not completed in a timely way.

At our last inspection the provider had failed in their governance of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Following the inspection, we asked for reassurances as to what steps had been taken to improve people's safety, which we reviewed. We requested further detail, and this was provided by the nominated individual. These included care records and risk assessments being audited remotely by the operations team. They said pressure mattress checks were now being recorded, an improved communication book was in place for staff and the manager, and a clinical manager was overseeing the completion of nutritional records to ensure risks were being managed.
● An external auditor has audited the environment and building; the operations team said the outcome had been delayed by Covid-19. We have requested a copy of the report. An internal audit was completed in November 2019 to audit the care and quality of the service. Further audits took place in December 2019 to audit nutrition and medicines, and the nominated individual said weekly falls analysis began in February 2020 as well as a care plan review.
● The provider had identified changes in the complexity of needs of two individuals. They had involved health and social care professionals to review them and support them to move to services where their increased needs could be met.

● Registered providers and registered managers have a legal responsibility to inform us (CQC) about any significant events that occur in the home including any serious injuries or safeguarding events. The provider had failed to ensure this had happened for several safeguarding incidents that had occurred. However, a social care professional has given feedback that the home escalated concerns in a timely way. We were told about people displaying behaviours that could be challenging to others, but we could not be confident these were identified or recorded consistently.

At our last inspection the provider had failed to notify CQC of other incidents. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4): Notification of other incidents

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

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

● People generally looked relaxed and at ease with staff.
● Staff told us they had confidence in the new manager to address issues of poor practice and to make changes to improve the quality of care people received. They said the introduction of a well-being staff member and more social activities was benefiting people living at the home. Staff said the manager listened to them, which they said had not always been the case in the past.
● The manager and staff were reviewing people's needs and updating people's care records to provide more detailed and person-centred information.
● Since the last inspection, improvements had been made to communal areas. This included a dedicated dining room, which had been decorated and refurnished and the creation of a quiet lounge. However, there was limited seating in the main lounge, which we saw made a few people anxious about losing their seat and being reluctant to move.

Continuous learning and improving care; Working in partnership with others
● The senior management team were currently reviewing how all their services were supported. A review of staff training needs and skills was underway, and a number of training events had been planned.
● The manager had consulted with health and social care professionals to seek guidance about how to meet some people's care needs. However, we were told there had been delays to getting responses to their requests for help, which meant they had then had to escalate their request for some people to be re-assessed and moved.