S.J. Care Homes (Wallasey) Limited

Aynsley Care Centre

Inspection report

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Date of inspection visit:
03 December 2021

Date of publication:
19 May 2022

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
Aynsley Care Centre is registered to provide accommodation and personal care for up to 28 people. There were 19 people were living there at the time of the inspection, some of whom were living with dementia.

People's experience of using this service and what we found
The systems in place to monitor the quality and safety of the service were not effective. They were not in place for all aspects of the service and did not identify the risks to people that we highlighted during the inspection. When audits identified that actions were required, it was not always clear if they had been addressed.

Risks to people were not always effectively assessed or managed, such as those regarding smoking, emergency evacuation and COVID-19. Care files did not all contain sufficient information to ensure staff knew people's needs, including their medical needs and not all staff had completed training to ensure they had the knowledge required to support people safely.

The environment was not always well maintained. There were several repairs needed around the home and records were not available to evidence that all required internal and external safety checks had been completed recently.

Medicines were not all managed safely and although staff had completed training, records showed that not all staff had had their competency assessed to ensure they could administer medicines safely. Temperatures of the storage areas were not monitored regularly, stock balance checks were inaccurate, and records showed that medicines were not always administered as prescribed. The provider was in the process of improving the medication systems prior to this inspection.

Appropriate infection prevention and control measures were not in place to prevent the spread of infection. Processes in place to ensure safe visiting procedures were not effective and visitors in the home were not wearing PPE. There was no evidence to reflect that staff were undertaking COVID-19 testing in line with government guidance and people living in the home did not have their temperature monitored in line with the guidance. There was no evidence that all staff and professional visitors entering Aynsley Care Centre had received two doses of the COVID-19 vaccination, or were exempt, as required.

There was no system in place to establish how many staff were required to meet people's needs. Not all staff felt there were sufficient numbers of staff, although people living in the home did not raise any concerns regarding this. The provider agreed to review their systems. All staff had had a disclosure barring service (DBS) check prior to commencing in post, however, risk assessments were not available for potential risks identified in the recruitment process.

Feedback regarding care provided was very positive and people told us they felt safe living in the home.

Relatives agreed that it was a safe place to be, although they had not been asked about their views of the service. Staff had undertaken safeguarding training and knew how to raise any concerns they had. Accidents and incidents were recorded, however a concern was raised as to whether safe procedures were always adhered to following falls.

The manager and business managers were responsive during the inspection and took timely actions to address concerns raised. The provider submitted an action plan following the inspection to inform us of further actions they would take to ensure improvements were made.

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 28 September 2018).

Why we inspected
This was a planned inspection based on the previous rating and our current inspection methodology.

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 the management of medicines, infection prevention and control, the management of risk and the governance of the service. 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

Special Measures
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.

Aynsley Care Centre

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 undertaken by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Aynsley Care Centre 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 quality and commissioning teams.

We used the information the provider sent us in the provider information return. This is information

providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with the manager, deputy manager, two business managers and four other members of the staff team. We also spoke with five people that lived in the home and eight relatives, most of which were via the telephone.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found during the visit and that sent electronically following the visit.

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.

Assessing risk, safety monitoring and management;
- Risks to people were not always robustly assessed or managed.
- People's individual risks had not all been considered and mitigated effectively. For example, there was no risk assessment for one person who smoked, to ensure this could be managed safely. Personal emergency evacuation plans did not all provide accurate information regarding people's needs and risk assessments in relation to COVID-19 were not person specific.
- Records showed that recommendations and advice provided by other health professionals was not always followed to ensure people's needs were safely met.
- Not all staff had received the training necessary to ensure they had the knowledge and skills to effectively support people.
- Care files did not all contain sufficient information to ensure staff knew people's needs, including their medical needs. For example, there was no diabetes care plan for a person that had diabetes and not all staff had been made aware of people's diet and fluid needs. One person had been given fluids without them being thickened as required due to swallowing difficulties, placing them at risk of choking. We shared this concern with the local safeguarding team.
- The safety of the environment was not always well maintained. There were several repairs needed around the home, one room posed a fire risk due to it being overfilled with boxes and furniture and regular internal checks were not always completed, such as fire safety and water safety checks.
- Records were not available to evidence that all required external safety checks had been completed recently, such as fire alarm and emergency lighting inspections.

Failing to effectively assess and mitigate risk to people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider submitted an action plan following the inspection to advise how the risks identified would be mitigated and several issues had already been addressed.

Using medicines safely
- Medicines were not managed safely. They were stored within a locked clinic room, however the temperature of the clinic room and fridge were not monitored daily. When records showed the temperatures were not in range, there was no evidence of any action taken.
- Records showed that medicines were not always administered as prescribed.
- The stock balance checks we completed showed that records regarding administration were not accurate, as not all of the balances were correct.

● There was insufficient information available to staff to ensure people who were prescribed medicines as and when required (PRN), received them consistently and when needed.
● Although staff had completed training, records showed that not all staff had had their competency assessed to ensure they could administer medicines safely.

Failure to manage medicines safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was in the process of improving the medication systems in place prior to this inspection and continued to make necessary changes to reduce risks to people in relation to medicines management.

Preventing and controlling infection
● Appropriate infection prevention and control measures were not in place to prevent the spread of infection.
● Systems in place to ensure safe visiting procedures were not effective. Visitors in the home were not wearing PPE.
● Records regarding staff COVID-19 testing, did not evidence that staff completed testing in line with current government guidance.
● People living in the home completed COVID-19 testing as recommended, but there was no evidence they had their temperature monitored twice daily as required.
● Cleaning schedules were in place to help ensure all parts of the home were cleaned regularly, however they had not been completed accurately and so could not be relied upon.

Although the provider took action to begin addressing these concerns straight away, failure to ensure effective infection prevention and control measures were implemented in line with government guidance, is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider failed to ensure that the vaccination as a condition of deployment regulation was met. There was no appropriate system in place to ensure that all staff and professional visitors entering Aynsley Care Centre had received two doses of the COVID-19 vaccination or a valid exemption as required.
● Managers told us they had relied on verbal evidence given, which does not meet the criteria of the regulation.

This is a breach of Regulation 12 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Records showed that accidents and incidents were recorded and relatives told us they were kept informed. However, records did not always give sufficient detail to evidence appropriate actions had been taken. One person had three falls on the same day and although no injuries were sustained, there was no evidence recorded of actions taken to reduce further risks.
● A concern was raised as to whether safe procedures were always adhered to following falls. We shared a concern regarding this with the local safeguarding team.
● The systems in place to review accidents and incidents with the aim of identifying trends and reducing risks, had not been completed since September 2021.

Staffing and recruitment
● We observed there to be sufficient numbers of staff on duty during the inspection. There was no tool in use

to assist the provider in establishing how many staff were required based on people's needs and only two staff members were on duty overnight. Some people required support from two staff and those staff also administered medicines and served supper, so may not be available to support people at the times they needed it. The provider agreed to review this.

● People living in the home told us there were usually enough staff on duty to meet their needs in a timely way. One person said, "There's enough staff. I pull the bell and somebody always comes to help me." Feedback from relatives was mixed. One relative told us, "There always seems to be plenty of staff at the home" and another said, "My impression is they are very understaffed. People are busy. You don't see staff when you go in, they're just not around."

● Staff recruitment files viewed, showed that staff had a disclosure barring service (DBS) check prior to commencing in post, to ensure they were suitable to work in the care sector. We found however, that risk assessments were not always in place for potential risks identified in the recruitment process.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living in the home. One person said, "I've got company and I like it here. I feel safe where I am." Relatives agreed and told us, "[Relative] gets good care. She's happy there and we're very happy she's there."

● A safeguarding policy was in place to guide staff in their practice and records showed that staff had undertaken safeguarding training.

● Staff were confident in how to raise any concerns they had and were aware of the whistleblowing policy.

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.

Continuous learning and improving care

- The systems in place to monitor the quality and safety of the service were not effective. Although some audits were undertaken, they did not cover all aspects of the service, were not all accurate, completed regularly or followed up on, to help drive improvements within the service.
- The provider failed to ensure systems were in place to manage risks to people's safety and wellbeing; to ensure medicines were managed appropriately, and to ensure the building was maintained safely.
- The provider also failed to implement effective systems to meet the government guidance regarding COVID-19 testing and vaccinations in order to minimise the spread of infection.
- There was no oversight of the completion of records. For instance, there were gaps evident in people's temperature monitoring; cleaning schedules were not completed accurately and medication records were not always completed correctly or robustly.
- Although some actions had already been taken to improve the medication systems in place, the recent medication audit had not identified the significant concerns we highlighted during the inspection.
- When audits had been completed and identified actions for improvement, there was no evidence they had been acted upon. For example, the kitchen audit showed several issues that needed to be actioned, but there was no recorded evidence as to whether these had been completed. High risk actions identified in the recent external fire risk assessment, which required immediate response, had not all been completed to maximise safety.

Failure to ensure effective systems were in place to monitor the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider submitted an action plan to tell us what actions they would take to address the concerns raised during the inspection and some actions were completed straight away. The manager and business managers were responsive to the feedback provided and took timely action to rectify some of the issues.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Systems were not in place to gather regular feedback from people or their relatives regarding the service provided, to enable changes and improvements to be made as necessary.
- The manager told us they had a good relationship with local GP surgeries and had been supported well by them.

● People were referred to other health professionals for their expert advice when needed. However, records showed that the advice provided was not always followed.
● Relatives told us they had not been involved in any reviews of their family members planned care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and their relatives told us they felt the home was managed well, although not everyone was sure who the manager was. A relative told us, "I think it's run well. I'm very surprised how very relaxed they are. It's a nice and comforting atmosphere."
● Feedback from people and their relatives regarding the quality of care provided was positive. Comments included, "I have no concerns whatsoever. I'm more than happy with the home. The staff, they are so helpful", "I'd recommend it because of the way they talk to residents. They treat my [relative] with respect" and "It's wonderful. The food is good and they look after you."
● Staff told us there had been a lot of changes over the past few months, including a change in management and the type of support the care home provided and that not all of these changes were for the better. Not all staff felt supported and some staff felt they required more training to give them the knowledge necessary to meet people's needs.
● Measures had been taken during the COVID -19 pandemic to facilitate people having contact with their relatives.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There was no registered manager in place at the time of the inspection. There was an acting manager who was not fully aware of their regulatory requirements, but they were also being supported by two of the providers business managers.
● The Commission had been informed of all notifiable incident's providers are required to inform us about.
● The ratings from the previous inspection were displayed as required.

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
● Relatives told us staff informed them of any accidents or incidents involving their family members. One person's relative told us, "Staff have been very helpful on the phone. They are quite detailed in what they tell you."

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 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality and safety of the service were not effective.

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 Risk to people and the building were not always assessed and mitigated robustly. Medicines were not always managed safely. Infection prevention and control measures in place were not in line with government guidance. There was no evidence that all staff and professional visitors entering the home had received two doses of the COVID-19 vaccination as required.

The enforcement action we took:

A warning notice was issued.