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Ashley Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ashley Care Centre is a care home service with nursing, providing personal and nursing care to 43 people aged 65 and over at the time of the inspection. The service can support up to 49 people.

The care home has three units. On each unit people have their own bedroom and can choose to spend time in the communal lounge and dining area within that unit. There are communal bathrooms and toilets on each unit with a main kitchen and laundry.

People's experience of using this service and what we found
Records of care provision for pressure relief and continence care showed they were not always being provided as often as people's care plans stated they should be. This put people at an increased risk of developing pressure sores. Some areas of risk had not been identified or risk assessed, and some care plans lacked information.
Infection control practices were inconsistent and while people had been supported to isolate and staff had been cohorted. Basic hygiene practices during lunchtime were not implemented. Staffing levels had been maintained during the COVID-19 outbreak by using regular agency staff and the registered manager had worked alongside staff to provide direct care to people when needed.

The registered manager monitored the service through communicating regularly with people, staff and relatives. Management meetings helped to review the service and identify changes in people's needs. However, these did not always pick up on the daily provision of care and look at whether this was being met.

The service had recently had an outbreak of COVID-19. The registered manager and staff acknowledged this had been a difficult time which had impacted on care provision and record keeping. Feedback from relatives was very positive about staff's approach with people and how they were kept informed. The service had worked closely with external professionals to help monitor people's health and gain advice and support in relation to managing the service during COVID-19.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 7 January 2020) and identified two breaches of regulation. The provider completed an action plan after the last inspection to tell us what they would do and by when to improve.

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

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The inspection was prompted in part due to concerns received about infection control, moving and handling, personal care, pressure care, support with nutrition and the care of people with COVID-19. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. 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.

We found no evidence during this inspection that people were at risk of harm from this concern. Please see the safe and well-led sections of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service remains the same. 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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashley Care Centre on our website at www.cqc.org.uk.

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 and hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Ashley 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 carried out by two inspectors, an assistant inspector and a specialist nurse advisor.

Service and service type
Ashley 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 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. 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 one person about their experience of the care provided. We spoke with five members of staff including the registered manager, the clinical lead, two care workers and the chef.

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

After the inspection
We contacted five relatives of people living at the service, three care staff and one nurse. We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies, care plans, risk assessments and records of the daily care provided by staff.

Requires Improvement

Is the service safe?

Our findings

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

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

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

At our last inspection the provider had failed to have an effective system where lessons were learnt when things went wrong. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection sufficient improvement had not been made and the provider was still in breach of regulation 12.

● Risks to people had not always been identified, assessed and managed. For example, despite previous issues and concerns raised around safe evacuation practice. People did not have personal evacuation plans in place and the information used to locate people in the building and evacuate them in an emergency had not been updated and gave staff incorrect information. Some staff had not taken part in a fire practice for several months or at all since starting their employment. This increased the risk to people during an emergency. The registered manager said he would create new plans for people. We informed the fire service of the risks found during this inspection.
● The gate and lock on the entrance to the kitchenette was broken. Furthermore, a hot water machine which dispensed instant boiling water and an unlocked cupboard containing cleaning products had not been assessed for their risk to people. Maintenance work had not been carried out in a timely manner and there was no plan in place for this to be repaired
● The service had experienced an outbreak of COVID-19. Some people were being cared for in bed and isolating in their bedrooms. This meant some people's care and support needs had changed. However, risk assessments had not been carried out to assess the risks to people's health. For example, people who were remaining in bed were at a higher risk of developing pressure sores and the impact of COVID-19 on pre-existing health conditions such as diabetes and epilepsy had not been assessed.
● Records used to update staff of minor injuries and the treatment of them were not always completed. During the inspection staff were unable to answer questions when asked about people's injuries. Furthermore, one person's catheter required changing every six weeks, however, records showed a nine week gap between changes. The manager felt that recording had been impacted during their COVID-19 outbreak.

We found no evidence that people had been harmed however, some risks were not identified, assessed and mitigated. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and

Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's weight was closely monitored and GP's were contacted if necessary. Staff told us "We have fortified food and milkshakes for the extra calories. We make sure they are eating and if they don't want something, we offer alternatives." Staff monitored fluid intake, one nurse told us "If the fluid intake is less, we encourage the staff to push the fluids for the residents".
● Staff were recording incidents around behaviours which can challenge, records identified possible triggers so staff could learn from these to help avoid incidents in the future.

Systems and processes to safeguard people from the risk of abuse
● Some staff did not know where to access information on whistleblowing or safeguarding, however, staff said they had received safeguarding training and would report concerns. One staff member said "Any marks, if you witnessed it or had any concerns on any staff, anything verbal you would go to team leader, then nurse, then manager. If it was serious and nothing was being done, go to your Local authorities."

● The manager understood their responsibilities in notifying CQC of safeguarding concerns and carried out internal investigations without delay, When a concern was raised with them which implicated staff, disciplinary action was taken when required.
● Staff and relatives said they thought people were safe. When asked, one relative said "Absolutely, I can come home and know he is so cared for".

Staffing and recruitment
Prior to our inspection we received concerns around moving and handling practices
● Staff had up to date training in moving and handling and catheter care, however, staff's on-going competency was not formally assessed. In other areas staff lacked training, the service had people who were at risk of weight loss and experienced behaviours which could challenge but staff had not received training in these areas.
● Records demonstrated that nurses addressed issues directly with staff when they witnessed practice which was not in line with moving and handling training and this was fed back to the manager. However, this did not always lead to further training or assessment of staff.
● Safe recruitment practices were followed and staff had all the necessary checks in place before they started working with people.
● Staff absences had occurred due to COVID-19 but were managed by using regular agency staff during the pandemic
● Staffing levels were based on people's needs and additional staff were deployed to provide care at busier times to help ensure people received the support they needed. Staff acknowledged they did not have time to read care plans and said that if they were short staffed care could sometimes be delayed.

Using medicines safely
● People received their medication as prescribed.
● Staff had training in handling medication and records to show the administration of medication were accurate.
● People's health was monitored by nursing staff and medication was reviewed when necessary.
● Protocols were in place for PRN medication. This helped to ensure medication was only administered when necessary. Staff understood that some medication was only to be used as a last resort. One nurse told us "First we need to try to redirect and reassure people".

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 admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● The service had supported people to isolate in their bedrooms and created zones with consistent staff working with them to prevent COVID-19 spreading. However, some areas of practice did not support good infection control.
● During lunchtime bread to have with food was placed directly on to tables rather than using plates.
● Evidence to show staff temperatures were taken before every shift were not always recorded.
● Social distancing was not always implemented in communal areas. Four people were sitting round a dining table with staff supporting them which meant people were not 2 metres apart.
● Staff were not washing their hands or changing their PPE [personal protective equipment] in between supporting different people to eat and drink. People were not supported to wash or sanitise their own hands before eating.
● Signs for handwashing, social distancing and PPE were not displayed in most areas of the home.
● Cleaning schedules did not detail high touch points or show additional cleaning of these. In some areas, clothing, equipment and PPE were not stored appropriately. This created a risk of cross contamination.

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

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At the last inspection the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations. There had been a failure to notify CQC of some events within the service, which the provider is required to by law. At this inspection we found that the provider was no longer in breach and was appropriately referring to CQC when required.

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

● We looked at three people's pressure relief and personal care records. Gaps in recording showed that people were not receiving care in line with their care plans. Some Care plans and staff were unclear around how often people should be supported. One staff member said "They are supported all the time". Other staff acknowledged that pressures from COVID-19 such as staff sickness had impacted on care provision.
● Monthly management meetings held with nursing staff showed what actions needed to be completed and who's responsibility it was. This helped monitor staff performance and quality of care. However, despite audits and management meetings, actions to improve infection control had not been completed, competency assessments and training had not been implemented and gaps in records for people's care and support were not identified by nursing staff.
● Complaints were responded to in a timely way with an apology and concerns around quality of care were passed on during meetings for nurses to monitor. However, issues raised did not lead to changes for improvement and issues identified during the inspection showed there was still a risk of issues re-occurring.
● We found some significant safety risks during this inspection which the registered manager had not identified or addressed. More detail of these can be found under the safe section of this report.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff understood their own role and responsibilities and that of others in the home. This meant staff knew who was accountable and who to speak to if they had concerns. This helped to create an open culture where staff said they felt able to speak up about poor practice.

● The registered manager was aware of their responsibilities in keeping the CQC informed about the service.

● The CQC rating from the providers last inspection was displayed as is legally required.
● Feedback about the staff was positive, one relative said "lovely staff, they feel like extended family". When asked about the registered manager people said "He is a brilliant manager, he has kept us in touch with everything."

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; Continuous learning and improving care
● The registered manager kept people and relatives informed about accidents and injuries.
● People and relatives were informed when people had tested positive for COVID-19 and were kept informed about the measures the service was taking to keep people safe.
● Relatives were asked for their feedback. One relative told us "A couple of months ago, they did a survey to see if there was anything they needed to improve on". The feedback was then analysed to look for individual issues or common themes that may need addressing.

Working in partnership with others
● The registered manager worked closely with external professionals. One professional told us "I find him to be open and honest and readily available when I ring".
● The registered manager and staff worked with relatives to provide person centred care by gathering detailed information during the assessment process. Relatives told us the registered manager and staff knew people well.
● The team worked together with health professionals. One staff member told us when they had concerns "The nurses come straight away, do their assessments and observations, ring [health services] and follow the advice". The GP rang weekly to discuss people's progress and the manager had been sharing information and taking advise from the local infection control team.

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
● The registered manager told us the shared aim within the team was to "to provide compassionate care in a professional manner, putting people's emotional feelings and well-being at the centre of what we do".
● Feedback from relatives explained how this was put in to practice "We rang yesterday and [Name of staff], was holding his hand, it is like a family to them. He is so happy there." Another relative told us their relative has difficulty communicating "but occasionally they are quite alert and staff call me on those occasions, I managed to have quite a conversation with her. It is absolutely marvellous for the home to ring me and to say she is quite alert today".
● The registered manager promoted an open culture amongst the team by discussing whistleblowing in meetings with staff. Staff had access to a box which they could leave written feedback in if they wished.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.

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
Treatment of disease, disorder or injury	Lessons were not learnt and risks were not always identified, assessed and managed

The enforcement action we took:

Warning notice requiring an action plan