Hinckley Care Limited

The Ashton Care Home

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
The Ashton Care Home is a purpose-built residential home providing personal and nursing care for up to 72 people. The service supports a range of needs including older and younger adults and people living with dementia across three separate floors. At the time of the inspection the service was supporting 41 people over two separate floors.

People's experience of using this service and what we found
Staffing levels were not sufficient provide safe care to people. People with dementia were seen being left unsupervised by staff. Staff told us staffing numbers continued to be unsafe at the service. The providers tool used for determining safe staffing levels at the service was inaccurate. This meant people did not receive the care they needed to keep them safe from harm.

Medicines were not managed safely. People did not always receive their medicines as prescribed and medicines had not been ordered prior to running out. Staff continued to make medication errors. The provider had not identified an issue with the service's electronic medication system. This meant four people did not receive their medicines over a four-day period which meant they were put at risk of harm.

People were at risk of harm due to poorly managed health conditions such as diabetes. A person was at increased risk of developing chronic complications as there was no indication of diabetes for staff on the care plan; a diabetic specific care plan was not completed despite health advice. This increased the risk of chronic complications developing which can lead to serious damage.

The service was not well-led. The management team had undergone changes but still did not have oversight or awareness of concerns, risks and incidents that had taken place. Quality assurances and processes were not always robust or effective at identifying areas of concern, and improvements to the service were not always made.

The provider failed to ensure adequate leadership or oversight. The provider failed to create an open culture, so staff did not feel safe to speak out and report issues or concerns.

The provider failed to operate effective systems to assess, monitor and improve the service. They failed to review audits affecting the safety and quality of the service. Because of this, people were placed at an avoidable risk of harm.

The provider had not fulfilled their legal responsibilities. Breaches of regulations were found at our inspections of December 2020 and our inspection in August 2020. This demonstrated the lack of lessons learned and limited action had been taken to improve the service as further breaches of regulations were found at this inspection.

At the time of inspection, one person was being isolated due to testing positive for COVID-19. Infection prevention and control practices had improved at the service, and staff were using Personal Protective Equipment (PPE) in accordance with national government guidance. The provider ensured staff and people living in the service were tested regularly for COVID-19, in line with government guidelines.

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 inadequate (published 1 March 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

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 COVID-19 and other infection outbreaks effectively.

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.

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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.

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

Enforcement
We 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 staffing, 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.

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 meet with the provider following this report being published to discuss the next steps. We will work with the local authority. If we receive any concerning information we may inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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 of 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.

The Ashton Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted 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.

Service and service type
The Ashton Care Home 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 that 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. We focused our inspection planning on concerns we had received in relation to people's safety, in order to assess if the service was safe and well led. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service to gain their views. We also spoke with eleven members of staff including eight care staff, one nurse and two managers within the interim management team. We carried out observations within communal areas to help us understand people's experience of care and support. We reviewed electronic care records for seven people which included care plans, risk interventions, behaviour and incident charts, food and fluid records for seven people. We also reviewed staffing rotas, accident and incident reports and a range of records relating to the management of the service, including audits and checks.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed information around staffing, dependency levels and staff training. We also spoke with five relatives and one health and social care professional by telephone to gain their views about the care provided.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection the provider had failed deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a breach of Regulation 18 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 18.

● There were still insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. Inspectors observed staff leaving people unattended on the dementia unit whilst they assisted other staff with personal care.
● Staff members told us they felt there were not safe staffing levels at all times. One staff member said, "There are never enough staff. It's always two on this unit. We are asked to call in someone if we need help, but there isn't always someone to come across. Today there is someone floating between the areas, but that's not normal."
● The manager told us the provider had just reduced the staffing numbers as of a week ago due to combining floors and closing off the third floor of the home. When inspectors asked what do staff do if they need more help, the manager told us they tell staff to ask the domestic staff to watch people if they are busy. Inspectors asked if the domestic staff are trained to support people with distressed behaviours. The manager replied, "I don't know, I don't think so".
● Training records were reviewed, and domestic staff are not trained in caring for people with complex needs.
● We reviewed the provider's new dependency tool. This was not fit for purpose, as the scoring mechanism was not accurate and did not meet the needs of the people using the service. This did not keep people safe at all times. This was discussed with the manager and we were advised this would be reviewed immediately.

● Staff told us, and staff records showed us that staff still had not received supervisions and the support they needed to keep them and others safe.

The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to safely meet people's needs. This is a continued breach of Regulation 18 (1) Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

● Processes to safely recruit staff were followed.

Using medicines safely

● At our last inspection medicines were not always managed safely. At this inspection we found that medicines were still not being managed safely by the provider, as people had not received their prescribed medications.

● A weekly missed medication management report was seen for the previous week showing that four people were without some of their prescribed medicines for between one to four days. The missed medications included medications for serious health conditions including Parkinson's Disease and Angina, meaning people were at risk of harm if their medications were missed or delayed.

● The manager told us that medical advice had been sought as soon as staff identified the errors and reported that no harm had been done. However, the manager could not have known this, as the people affected could not always communicate their needs to staff due to their cognitive impairments. Prescribed medication for serious progressive diseases, is prescribed to relieve the symptoms and maintain quality of life for people.

● The manager advised that errors had taken place as staff had not noted the medication had run out on the medication system and staff had failed to request a repeat prescription five days prior to the medication running out. This put people at risk of harm.

● The provider had failed to identify that medications disappeared off the electronic medication system if staff had not extended the dates. There was no contingency in place to ensure adequate stocks of medicine were available and the provider had not utilised the electronic medication system to remind staff of when medication needed to be ordered. The provider had not taken all that was reasonably practicable to mitigate risks in relation to the management and administration of peoples prescribed medication.

The provider had not ensured people's medicines were managed and administered safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider rectified the issue on the electronic medication system, completed a stock check of all medicines in the service. A nurse on duty would now be the only one administering medication to ensure the safety of medication administration in the service.

● We observed a senior care worker administer medicines individually and complete the Medication Administration Records to confirm the medicines had been administered.

Assessing risk, safety monitoring and management

At our last inspection the provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment for people. This is a breach of Regulation 12 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.

● People's needs were not always safely assessed or managed. Inspectors observed several people in bed on the nursing unit, who were not able to use call bells to alert staff. No formal observation or checks on these people and their wellbeing were being conducted. Staff told us that during a night shift, people were routinely checked hourly, but during the day they were not.

● Care plans for these people did not identify any risks around not being able to use a call bell and alert staff and did not document the need for regular checks and observations. The manager told us these risks would

be assessed immediately, and checks would be implemented and recorded.
● One member of staff told us, "At times I feel [people] do not get what they deserve".
● Inspectors observed staff chatting in the dining room of the residential unit, whilst people were eating and drinking at lunchtime. Only one member of staff was seen supporting one person with their lunch, despite care plans for two other people stating they needed supervision and encouragement with eating and drinking, as they were both at risk of choking.
● Care plans did not meet the needs of people with diabetes, as they did not detail diabetic best practice guidance on nutrition. This meant staff would not know how to treat hypoglycaemia. The provider failed to ensure staff were supporting people as recommended to do so by expert advice. This put people at risk of harm.
● Two people had been involved in several incidents where their behaviour had escalated resulting in a high risk of harm to others. The provider failed to ensure they had specific risk assessments in place to capture distressed behaviours, triggers, and de-escalating techniques for staff to follow. These were the actions the provider said they would take with regards to improvements needed from the last inspection.

Learning lessons when things go wrong
● Lessons had not been learnt and opportunities to prevent incidents from occurring again were missed. Since the last inspection an incident had occurred whereby a person suffered a burn from a hot drink when they were left unattended by staff. There was also a delay in getting the person adequate healthcare following the incident. At the time of the inspection the provider was still in the process of completing the investigation with staff.
● Systems in place for staff to report, review and investigate safety incidents, and act to prevent them re-occurring were still not always effective. One member of staff told us they didn't think there was any point in raising issues as managers do not seem to care and that nothing changed. They said, "Things have got worse at [The Ashton Care home]".
● The manager told inspectors that staff had not always come forward to report the concerns they had. This increased the risk that incidents would not be investigated and acted on to prevent them reoccurring.
● During this inspection we identified issues relating to safety incidents that had either not been reported or had not been adequately acted on to ensure people were protected from the risk of harm. This placed people at risk of avoidable harm. It demonstrated the provider lacked oversight to improve the quality of care that people received.

The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to people. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure systems and processes protected people from abuse and improper treatment. 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

At our last inspection the provider had failed to notify the Care Quality Commission of events of occurrences within the service. This was a breach of Regulation 18: Notification of other incidents, Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 (Registration).

● Systems were in place for management to report safeguarding incidents. However, improvements were still needed to ensure lessons were being learned from incidents amongst the staff team.
● The manager had reported safeguarding concerns and completed safeguarding notifications to the Care Quality Commission (CQC) when appropriate. Incident records were reviewed by inspectors and these matched the notifications received.
● The provider still needed to ensure preventative actions were being taken by all staff, particularly for those people who become distressed, in order to identify potential abuse.

Preventing and controlling infection

At our last inspection the provider had failed to ensure staff followed safe procedures to control the risk and spread of infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection with regards to prevention and controlling infection.

● Staff were allocated to floors to minimise the risk of people and staff contracting and transmitting COVID-19. We found however, regular instances where staff were required to move between floors to administer medicines and provide support with personal care. The provider was reviewing their staffing dependency tool again to ensure staff did not need to 'float' to other floors due to staffing gaps.
● 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 preventing visitors from catching and spreading infections.
● We were assured that the provider's infection prevention and control policy was up to date.

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 inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care; 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

At our last inspection the provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved. This was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

● At the last inspection we had found that the provider was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 18 (Registration), 12,13, 17 and 18 in relation to notifications of other incidents, safe care and treatment, protecting people from abuse and improper treatment and good governance and staffing.
● We had specific concerns around people being exposed to the risk of harm, including risks from infections, staffing levels, falls and how people were supported when they become distressed. We also had concerns around poor, ineffective leadership and management and a lack of support and oversight by the provider. We had imposed conditions telling the provider they must ensure risks to people are managed; care records reflect people's current needs; care plans are updated in a timely manner and systems and procedures to assess and monitor the quality of care provided are implemented effectively. We asked them to send us monthly action plans to tell us how they were doing this.
● The imposition of conditions had not been effective in driving improvement or preventing repeat themes of concern re-occurring in relation to people's safety or the quality of care at The Ashton Care Home.
● At this inspection we found areas around the prevention and control of infections had improved along with notifications of other incidents and safeguarding. However, we found risks were high with regards to staffing levels, how medicines were being managed by the provider, for people being nursed in bed, for people with diabetes, for those at risk of choking and for people who required support when they became distressed, as their needs were not being met safely or effectively.
● There were repeat breaches of regulations 12, 17 and 18.

● The failures in people being exposed to potential and actual harm had not been recognised or prevented by the provider prior to our inspection. We needed to request assurances of action the provider would take to reduce the risks to these people.
● Systems and processes to assess, monitor and improve the quality and safety of the service were still not operating effectively.
● The manager and regional manager carried out a variety of internal audits to check the quality and safety of the support people were receiving. These quality assurance systems and processes had not identified or prevented significant safety issues occurring or continuing at the service. Where issues had been identified, these had not always been effective action to maintain or improve the quality and safety of the support being delivered.
● Managers voiced to inspectors that staff needed accountability, yet the provider had not ensured staff were provided with the supervision and support that was necessary for them to carry out their roles and responsibilities. Or had addressed poor performance issues amongst the staff team.
● People's care plans, risk assessments were not complete or up to date. The provider told us care plans and risk assessments for people who demonstrated distressed behaviours on a regular basis had been re-written. Care records were seen for two people who had a number of recent serious incidents whereby staff had been hurt, but their care records had not been rewritten to capture distressed behaviours, triggers, and de-escalating techniques for staff to follow. This put people and staff at risk of harm.
● The implementing of new person-centred care plans for people had still not been carried out by the provider. Progress had been slow, as senior care staff had been requested to do this, on top of their roles at service, at the same time as staffing hours on the units had been reduced. The manager advised that staff had been given extra hours to do this work, off the units. However, staff were only still receiving the training on how to do this. Only two out of forty-one care plans had been completed, meaning staff and health care professionals did not always have the most up to date information to follow for people.
● The manager advised that a 'resident of the day' system had just been implemented to ensure each care plan is reviewed monthly.
● A registered manager was not in post when we inspected. The provider had appointed an interim manager. The regional manager told us a new manager had been recruited and that they would be starting shortly. The regional manager said they would continue to have oversight of the home with the interim manager.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The service was not well-led. Measures were in place including daily meetings and team meetings. Changes to the management structure had occurred again since the last CQC inspection, but the interim management team in place still did not have an oversight of the service despite these measures being in place. For example, the management team were not aware of staff concerns or of the staffing shortfall on the units. This meant that not all the risks or concerns were not known and opportunities to improve care were missed.
● Quality assurance processes were not robust and did not address areas where improvements could be made due to lack of oversight. For example, the medication errors that occurred due to an issue with the electronic medication system and dates entered, was raised because of the CQC inspection rather than being identified previously by the management team. Changes that were required to improve practice did not occur in a timely manner at The Ashton Care Home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Information was shared with relatives via telephone calls and emails, including a weekly email update to

those relatives who had requested it. Monthly Microsoft Teams meetings had been introduced with the relatives in February 2021. However, some relatives felt information was not always consistently shared about what was going on during COVID-19. One relative told us, "[The provider kept us up to date] after the last CQC visit but that then died off".

● Staff told us they were not always supervised, and the provider had not raised any concerns about their performance. Staff did not always follow procedures. One staff member told us, "[There is] no structure or set of rules" and "I'm lower in the pecking order. The problems are higher up". Another staff member told us how things were always changing, with new 'to do' tasks, but staff were not told about them. So, changes were not communicated.

The manager said a staff meeting was planned for the day after the inspection and they were hoping this would help staff feel more settled following recent changes at the service.

Working in partnership with others

● Partner agencies told us improvements had not taken place or become embedded at The Ashton Care Home despite them supporting the provider and its staff for a significant amount of time to improve the standards of the service.

● The provider did not always ensure that managers and staff implemented recommendations or guidance from health professionals in relation to the improvements needed at the service or to people's health needs. This meant that measures to improve people's care was not always considered a priority and implemented in a timely manner.

There were ineffective systems and processes to ensure effective management oversight of the quality assurance of all aspects of people's care to demonstrate the regulatory activity was effectively managed. This was a continued breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. The manager advised that the nursing and dementia unit would now become one unit on the same floor and staffed accordingly. All medication administration would be now only be carried out by the nurse on duty. The provider would also review the services dependency tool to ensure staffing hours reflected peoples' needs at The Ashton Care Home.