Atlas Care Homes Limited

Aster Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Aster Care is a care home which provides nursing and residential care for up to 102 people. The service supports younger people, older people and people assessed as requiring a period of recovery in its residential reablement unit. People are supported in three separate units, each of which has separate adapted facilities. At the time of this inspection 54 people were using the service.

People's experience of using this service and what we found
Risks to people were not always effectively assessed or monitored. Medicines were not always managed safely. Fire safety systems were not always effective. The provider's recruitment processes were not always followed. Staff had not always received the training needed to support people effectively. Quality assurance processes were not effectively monitoring or improving the service.

Effective infection prevention and control systems were in place. People were safeguarded from abuse.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People were supported to access healthcare appointments.

Staff spoke positively about the leadership of the manager. People and relatives said they had good communication from staff at the service. The manager was working to develop and strengthen links with external professionals and agencies.

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 17 May 2019) and there were three breaches of regulation. The provider completed an action plan after that inspection to show what they would do and by when to improve. The service was inspected again in August 2020. The rating was not considered but two ongoing breaches of regulation were identified. A Warning Notice was issued following that inspection.

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

Why we inspected
We undertook this focused inspection to check whether the Warning Notice we previously served in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. This report only covers our findings in relation to the Key Questions of Safe, Effective and Well-led.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Aster Care 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 medicine management, risk management and training. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Aster Care

Detailed findings

Background to this inspection

The inspection
This was a focussed inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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
Four inspectors (including a medicines inspector), a specialist advisor nurse and an Expert by Experience carried out this inspection. 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
Aster Care 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 but they were not 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
We gave the provider 24 hours' notice of the inspection. This allowed the provider time to let people know we would be contacting them for feedback and provide us with records for review as part of the inspection.

What we did before the inspection
We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within

required timescales. 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 six people and four relatives about their experience of the care provided over the telephone. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 13 people's care records and eight medicine administration records. We spoke with 11 members of staff, including the nominated individual, manager, nursing and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training information, medicine and care records and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider had failed to manage medicines safely. 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.
• Medicines were not always administered as prescribed.
• Records for topical medicines were inconsistent. Staff were not aware of where to record application of topical medicines and we found these medicines were not always applied as prescribed.
• Care plans for were in place to support staff when caring for people with a percutaneous endoscopic gastronomy (PEG). However, we found these were not always followed.
• Audits were taking place within the service but they were not always effective at identifying or addressing issues.

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 continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
At our last inspection the provider was not effectively assessing or managing risk. 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.
• Risks to people were not always effectively assessed or addressed. Action was not always taken to manage known risks to people.
• Safety checks of people were not always carried out in accordance with their care plans.
• Required test and safety certificates were not always up to date.
• Fire safety systems were not always effective. For example, not all staff had participated in effective fire drills.

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 continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider carried out pre-employment checks before staff were employed. However, some staff had worked unsupervised before all of these checks were completed.

We found no evidence that people had been harmed however, systems were not in place to ensure all staff had the qualifications, competence, skills and experience to provide care safely. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staffing levels were regularly reviewed by the manager to ensure enough staff were deployed.
• People and relatives spoke positively about staffing at the service. One person told us, "Staff are all great here, they are always around."

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Action was not always taken to learn lessons from incidents. For example, effective monitoring was not always put in place to see if improvements could be made to keep people safe.
• Systems were in place to safeguard people from abuse, though not all staff had completed safeguarding training. The manager was planning further safeguarding training.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• Staff had not always received the training needed to support people effectively and safely. This included training in people's specialist support needs.
• Staff knowledge and competence was not always effectively monitored to see if they needed additional support to provide safe care to people.

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

• At the time of our inspection the manager and provider were arranging additional training for staff. Staff told us they had been offered extra training.
• The manager was developing a new system for supervisions and appraisals to improve the support staff received.

Supporting people to eat and drink enough to maintain a balanced diet
• People who needed specialist support with eating and drinking did not always receive this.
• Monitoring food and fluid intake was not always effective, which meant people were at risk of not receiving the support they needed. One person had become dehydrated after failing to consume enough fluids.

This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People who were not on specialist diets received appropriate support with eating and drinking and spoke positively about this. One relative told us, "The food is good, which is important for [named person] as they are very fussy."

Staff working with other agencies to provide consistent, effective, timely care; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before they moved into the service but where these changed effective plans were not always put in place.
• The service did not always work effectively with other agencies to help people develop and achieve outcomes for their care.

• People said they felt in control of the support they received. One person said, "I like the staff and they do what you want.

Supporting people to live healthier lives, access healthcare services and support
• People were supported to access external healthcare appointments and said this had improved since the manager joined the service.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• Consent to care was obtained and recorded. MCA assessments and best interest decisions were used when people were unable to consent themselves.
• DoLS were appropriately sought

Adapting service, design, decoration to meet people's needs
• The manager was reviewing the layout of the service and its units to ensure they met the people living there.
• People's rooms were customised to their own needs and preferences.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection the provider had failed to ensure good governance processes were in place. 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.
• The provider had not met the requirements of the Warning Notice we served following the previous inspection and remained in breach of regulation.
• The manager and provider carried out a range of quality assurance audits to monitor the service. These had either not identified the issues we found at this inspection or had failed to address them. These issues included the unsafe management of medicines, ineffective risk assessment and management and a failure to ensure all staff had the knowledge and skills needed to provide safe support.

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 continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
• The manager joined the service in November 2020 and had not applied for registration with the Care Quality Commission by the time of our inspection. This is a ratings limiter for the well-led key question.
• Staff spoke positively about the leadership of the manager and the changes they had made since joining the service. One member of staff said, "You can approach [manager] and have a chat."
• People and relatives said the service was open and transparent, and described communication from the manager as good. One person said, "The manager gets around the building, comes and finds you and has a chat with you."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Feedback was sought from people, relatives and staff and the manager was working on ways to improve

this. Plans included developing a 'resident charter' with people to ensure they were aware of all of their rights at the service.
• People, relatives and staff said their opinions and feedback was sought. One relative said the manager told them, "I welcome any feedback so it will be more easy for me to develop or improve the service."

Continuous learning and improving care; Working in partnership with others
• The manager was working on developing and strengthening link with external professionals and agencies. This included making referrals to other professionals where needed.

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 Risks were not always effectively assessed or monitored. Medicines were not always managed safely. Regulation 12(1)

The enforcement action we took:

We imposed conditions on the provider's registration requiring action to be taken to improve the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems did not effectively assess, monitor and improve the quality and safety of the service. Regulation 17(2)(a) and (b)

The enforcement action we took:

We imposed conditions on the provider's registration requiring action to be taken to improve the service.