Ashcroft House Care Services Limited

Ashcroft House - Leeds

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashcroft House - Leeds is a residential care home providing personal care for up to 32 people in one adapted building. At the time of our inspection 25 people were using the service.

People's experience of using this service and what we found
People told us they were happy living in the home and overall, people received personalised care from staff who knew them well. However, risks were not always properly assessed, planned for or well managed, and medicines were not always managed safely. Not all concerns had been reported to the appropriate bodies in a timely way.

Recruitment and selection procedures were in place to make sure suitable staff were employed.
Some people would have benefitted from more social interaction. We have made a recommendation about staffing.

Management records and audits were not always kept up to date, and staff did not always receive supervision and support. Although most people had appropriate care plans and risk assessments in place, audits were not effective in picking up shortfalls in areas such as people's risk assessments and care plans and the management of medicines. When things went wrong, lessons learned were not always communicated effectively in the team or used to improve the service.

The provider's checks and audits had failed to identify some shortfalls in the safety of the environment and equipment and, additional cleaning of frequently touched surfaces was not adequately recorded.

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.

Rating at last inspection
The last rating for this service was good (published 8 August 2017).

Why we inspected
The inspection was prompted in part due to concerns received about the admissions process, medicines, the Mental Capacity Act 2005 and deprivation of liberty safeguards, record keeping, safeguarding people, staff training, and learning lessons when things go wrong.

The inspection was prompted in part by notification of a specific incident, following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident. The information CQC received about the incident indicated concerns about care planning, risk assessment, responding to people's changing needs and illness or injury. This inspection examined all of these risks.

As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall 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.

The overall rating for the service has changed from good to requires improvement. This is based on the findings of this inspection. Please see the safe, effective and well-led sections of this full report.

We have found evidence that the provider needs to make improvements. We have identified breaches of regulation in relation to the safety and management of the service.

You can see what action we have asked the provider to take at the end of this full report.

The provider had taken some action during the inspection to mitigate risks and continued to liaise with the inspectors after the inspection to advise of further improvements scheduled and carried out.

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 will take further action if needed.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Ashcroft House - Leeds

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.

We undertook this inspection at the same time as CQC inspected a range of urgent and emergency care services in West Yorkshire. To understand the experience of social care providers and people who use social care services, we asked a range of questions in relation to accessing urgent and emergency care. The responses we received have been used to inform and support system wide feedback.

Inspection team
Two inspectors carried out the inspection.

Service and service type
Ashcroft House - Leeds 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.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority commissioners and safeguarding team, and professionals who work with the service. 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.

During the inspection
We visited the service on 4 May 2022. We spent time with people living at the service, observing interactions. We spoke with eight people who used the service and three visitors. We spoke with seven staff, the provider and registered manager. We reviewed a range of records. This included four people's care and medicines records. We looked at records relating to the management of the service including records of safeguarding, complaints, meetings and staff records.

After the inspection we requested further information and evidence from the provider, including staff training records, audits, care plans, and reports. We continued to seek clarification from the provider to corroborate evidence found.

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 rated inspection this key question was rated as good. At this inspection this key question has changed to requires improvement. 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

- One person did not have risk assessments or a care plan in place. Another person had gaps in their risk assessments and care plans. This meant the identified risks associated with their care were not properly assessed or planned for. One person was at risk of falling. Their pre-admission information showed they needed to be checked by staff on an hourly basis to help manage this risk. There was no evidence to show any checks had been carried out for their first four weeks living in the home.
- Two people did not have personal emergency evacuation plans (PEEPS). PEEPS guide staff on how to support people to safely evacuate the building in an emergency.
- We found areas of the environment where there was increased risk that people could be harmed. There were three uncovered radiators, leaving hot surfaces exposed. The stair lifts in use in the home were not checked as often as required by safety regulations. One high window did not have a window restrictor in place.
- In most cases, learning was identified and used in a timely and effective way. However, we saw some instances when information was not shared effectively within the staff team when incidents had taken place. In one instance, this had resulted in one person leaving the building and coming to harm.

The above demonstrates systems were not always effective in assessing, monitoring and mitigating risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed risk assessment were now in place, the identified risks had been mitigated and suitable checks of equipment were in place.

Using medicines safely

- Medicines were not always managed safely.
- The system of recording the receipt and/or disposal of these medicines was not effective. There had been recent errors involving controlled drugs. Controlled drugs are drugs controlled under the misuse of drugs legislation due to being especially addictive or harmful. This included two instances of controlled medicines thought to be missing. In addition, these incidents were not investigated or reported to the appropriate bodies in a timely way.
- We found one person's topical eye medicine was being administered to them when out of date.
- Some people did not have protocols in place to guide staff on the use of medicines prescribed as and when needed (often referred to as PRN medicines). Where there were protocols in place for people's PRN

medicines, there were not always effective processes in place in relation to monitoring and recording the effectiveness of these medicines.
● Where people were prescribed PRN medicines in variable doses, staff did not keep an adequate record of the times or doses of the medicines administered.

The provider had not ensured medicines were managed safely and administered appropriately to make sure people were safe. This is a breach of Regulation 12 (2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Staff we spoke with told us they had completed a range of training in safeguarding people. They were aware of how to whistle blow if they witnessed any poor practice.
● People we spoke with said, "I do feel safe. I didn't realise it at first, but the staff here really are all about helping you." and "They [staff] look after me and are there when I need them." Visitors we spoke with felt their family members were safe. One relative said, "It's the safest place for [person]" and "[Person] is safe and settled."
● Management systems and processes had not always worked effectively in relation to responding to and reporting safeguarding concerns to the appropriate bodies. This is reported further under the well led section of this report .

Staffing and recruitment
● The provider carried out recruitment checks to make sure only suitable people were employed.
● Staff we spoke with said they had undergone checks prior to working in the service. This was confirmed by the records we saw.
● The registered manager told us they used a dependency tool to calculate safe staffing levels staff at busy times to enable individualised support to be maintained.
● Staff said there were usually enough staff on duty to maintain people's safety. However, they said there were times of the day when it was difficult to meet people's individual and social needs.
● We saw times when people were left unsupported in communal lounges while staff undertook other care duties. Some people did not require support, while others would have benefitted from more social interaction. This suggested some people were not provided with enough opportunities for meaningful activities and social engagement.

We recommend the registered provider consider their staffing requirements to ensure all aspects of the service are operating in line with current good practice guidance.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas, such as bath hoist chairs needed cleaning. The cleaning schedule did not show how frequently 'high touch' areas should be, or, were cleaned. We have also signposted the provider to resources to develop their approach.
● 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 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.

Visiting in care homes
Visitors to the service followed current government guidance.

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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.
- Overall, the service was working within the principles of the MCA.
- In most cases the correct procedures had been followed when people's liberty needed to be restricted for their safety. People had been referred to the DoLS team for assessment.
- There had been a delay in applying for a DoLS authorisation for one person when they were admitted to the home. The registered manager showed us they had set up better tracking systems to avoid delays of this kind in the future.
- People were asked to consent to their care, and this was reflected in their care plans and records. We saw staff seek consent from people regarding their everyday care needs. People confirmed staff sought their consent before carrying out personal care tasks. One person said, "[Staff] know me. They get to know what you want, but they still ask me."
- Staff we spoke with understood the requirements of the MCA and DoLS and were aware of good practice guidance. They confirmed they had been provided with relevant training. This included the process for making decisions in people's best interests. Staff were mindful of supporting people in the least restrictive way.

Staff support: induction, training, skills and experience
- Staff told us they received the training they needed to keep people safe and meet people's needs. They spoke of the disruption caused by the COVID19 pandemic and told us recent training was mostly online,
- Some staff felt they would like more time and support to help them in completing training online.
- Records showed staff had not always received regular supervision to review and discuss their

performance, practice, and training needs. The registered manager told us some of the senior staff, whose roles had included supervising staff, had left in recent months. This had made it difficult to provide all staff with regular supervision. The registered manager said new senior staff had been successfully recruited and were coming into post. This would help make more regular staff support and supervision achievable.

Adapting service, design, decoration to meet people's needs

- Work was ongoing to redecorate the home. The provider had begun to make the décor and facilities more suitable for people living with dementia.
- The environment was accessible, with a range of adaptations and equipment to meet people's needs.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law and Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Overall, people's care and health needs were assessed and kept under review. People's care plans included their healthcare needs.
- The service supported people by working with healthcare specialists. This included GPs, district nurses. dieticians and the speech and language therapy team.

Supporting people to eat and drink enough to maintain a balanced diet

- People's needs were met by a varied and nutritionally balanced diet.
- People gave us positive feedback about the choice and quality of the food.
- Staff were aware of people's dietary needs and people who required specialist diets were supported appropriately.

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 good. At this inspection this key question has changed to requires improvement. 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.

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

- There were processes in place to monitor the quality and safety of the service. However, some systems of communication, monitoring and review were not effective, or were not sufficiently robust.
- The provider's oversight and audit systems did not identify or address the issues found during this inspection. These included shortfalls related to cleanliness, risk assessments and care planning, medicines and the environment and equipment.
- We were not assured checks to the building were always robust. For instance, we identified radiators that were uncovered. This exposed people to a risk of burns. The provider's audit systems had failed to identify or mitigate these risks. .
- There were gaps in some management and monitoring records. This included monitoring information about incidents, safeguarding and medicines. This meant managers were not always aware of significant incidents that had taken place in the service. Staff training records were not kept up to date or audited regularly to maintain best practice standards.
- We received feedback from the safeguarding authority of some allegations of abuse that had not been referred to them by the service. During the inspection we found instances when communication between members of the senior team had not been effective. We also saw cover arrangements had not been robust in the absence of the registered manager. This meant some safeguarding incidents were not referred to the local authority and not notified to CQC. Registered providers are legally obliged to inform the CQC of certain incidents which have occurred. These statutory notifications are to ensure CQC is aware of important events and play a key role in our monitoring of the service. We asked the registered manager to notify us of the identified incidents retrospectively.

- Recent audits of people's care plans, risk assessments and care records had not been completed to ensure people needs were being met and they were receiving safe care.
- The registered manager had not always used learning in a timely way to improve the service. For instance, here had been a discrepancy in controlled medicines records. Medicines systems were not reviewed or improved in response, and a similar concern had arisen some weeks later.

The provider had not ensured systems and processes operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and to improve the quality and safety of the service provided. This is a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and registered manager were open about the identified failings and told us they would ensure there would be improved systems to prevent a re-occurrence. The provider began to take immediate action to mitigate the identified risks and make improvements where needed.
● The registered manager told us the senior staff who had not communicated well in the team had since left the service. The registered manager said they were introducing improvements to the systems of communication in the staff team. This would help to ensure there was no omissions of this nature in the future.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider did not always take the opinions and views of people, staff and other stakeholders on board to make improvements.
● The more formal methods of communication and consultation, such as quality assurance questionnaires and resident's meetings had lapsed in the 12 months before the inspection.
● Staff responses regarding the culture of the home were mixed. Several staff said they were not listened to. Some staff said they had worked hard for a long time, to help maintain the service to people throughout the pandemic. They felt this was not recognised, and they often felt undervalued and unsupported by the registered manager.

The provider had not always sought and acted on feedback from people using the service, those acting on their behalf, staff and other stakeholders, so that they can continually evaluate the service and drive improvement. This is a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback from people and their relatives was positive regarding day to day communication with the service. One person said, "Staff do talk to you and listen to you and the owner comes in."
● Over the course of the inspection we observed staff working well as a team and saw warm and caring interactions between staff and people using the service.

Working in partnership with others
The service worked with other professionals to meet people's needs. This was facilitated, in part, by senior staff attending regular online meetings with a team of healthcare professionals known as the multidisciplinary team (MDT).

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
● During the inspection, the registered manager acknowledged the shortfalls identified during this inspection and stated their intention to put better processes in place to ensure people were safe and protected from harm.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health safety and welfare of people and had failed to ensure the proper and safe management of medicines. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems and processes operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and to improve the quality and safety of the service provided. Regulation 17 (1) (2) (3) (5)