Ashgate Care Limited

Ashgate House Care Home

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
Ashgate House is residential care home providing personal and nursing care to up to 45 people. The service provides support to adults of all ages and people living with dementia. At the time of our inspection there were 35 people using the service.

Ashgate House Care Home accommodates people across two floors in one adapted building. Ashgate House has communal areas and bathrooms as well as providing ensuite facilities in most bedrooms.

People's experience of using this service and what we found
People were not always protected from the risk of abuse, actions had not always been taken following incidents and accidents to reduce the risk of reoccurrence. We found risks relating to people's skin had not been safely managed as wounds and active skin conditions had not been included in people's care plans. This placed people at increased risk of harm as staff did not have any recorded strategy to follow. Medicines had not been safely managed as they had not always been in stock, expired medicines had not been disposed of appropriately. We also identified that medicines had not always been administered in accordance with the prescriber's instructions and medicines that posed a risk to people had been left in communal areas. This placed people at increased risk of harm.

Care plans did not always provide person centred direction to staff. Where people's choices and preferences had been recorded, care records showed staff had not consistently followed this information. Training records evidenced not all staff were up to date with training this placed people at risk of receiving unsafe care. People's care plans clearly detailed their eating and drinking needs. We saw that people's food and fluid intake was monitored when appropriate.

The provider had not always ensured they had adequate oversight of the service. Action plans in place did not identify or address all of the issues found during this inspection. The service worked in partnership with other professionals such as speech and language therapists to support people to access healthcare when they needed it.

People were not always supported to have maximum choice and control of their lives and staff did not consistently support people in line with their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at

Rating at last inspection
The last rating for this service was good (published 4 September 2021).

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 COVID-19 and other infection outbreaks effectively.

We received concerns in relation to the management of medicines, infection control and staffing. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. You can see what action we have asked the provider to take at the end of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashgate House 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding people from abuse, safe care and treatment, dignity and respect, staffing and the oversight of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan 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 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? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Ashgate House 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 Health and Social Care Act 2008.

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 three inspectors. One inspector specialised in medicines.

Service and service type
Ashgate House Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ashgate House Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
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 not 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 since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with two people who use the service, 11 members of staff including the operations director, deputy manager, nurses, nurse associates, senior care assistants and care assistants. We also carried out phone calls to six relatives about their experience of the care provided. Following our visit, we continued to seek clarification from the provider to validate evidence found. We looked at training, and quality assurance information and further policies and procedures.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse. We found several recorded incidents of where a person had assaulted other people. These had not been investigated or reported to the relevant authorities.
- Actions had not always been taken following incidents to reduce the risk of reoccurrence. This placed the people at risk of harm.
- Not all staff had received training in safeguarding. Training records showed only 65% of the staff team were up to date in this area. However, staff were able to tell us of the actions they would take if they had a concern about a person's safety, but we could not see this had been consistently applied as not all incidents had been appropriately referred to the relevant agencies. Following our site inspection, the provider sent us evidence which demonstrated staff had now completed this training.

People were not always protected from the risks of 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.

The provider told us they would review the incidents and refer them to the relevant agencies, the provider also informed sent us an action plan which addressed the staff training.

Using medicines safely

- People did not always receive their medicines as prescribed. Records evidenced multiple instances medicines had not been in stock, this meant that people had not always received their medicines as prescribed.
- People were at risk of harm as medicines were not always stored safely. We found a prescribed thickening agent in a communal lounge and prescribed topical creams in a person's bedroom and communal bathroom. These medicines posed a risk of harm to people if ingested.
- Medicine administration records did not accurately record reasons to changes in medicine administration. We found one person's pain-relieving patch had not been applied with the correct time between doses and another person's pain-relieving patch had been changed early, however the reason for this was not recorded. The provider told this was a system and staff error.
- Expired medicines had not been disposed of in a timely manner, this increased the risk of medicines errors. We found medicines in stock that had expired. The expired medicines were stored in the medicine cabinet and medicine fridge and may not have had the required effect if administered.
- Medicine administration records were not consistently in place for people who were prescribed topical medicines. This meant there was no record of people having prescribed creams applied to their skin. This posed a risk to people's skin health and integrity.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● People were at risk of skin damage as risks had not been safely managed. We observed several people had wounds and active skin conditions, these injuries and conditions had not been included in people's care plans. This placed people at increased risk of harm as staff did not have any strategy to follow.
● Care plans and risk assessments were not always reflective of people's current needs. We found that risks to one person's mobility had been identified, however there was insufficient information on how staff were to support this person. We also identified two people who had lost weight. Their care plans did not provide any evidence of investigation or actions taken to mitigate the risk this presented. The provider told us of the actions they would take which included reviewing people's care plans and risk assessments.
● Personal emergency evacuation plans had not been kept up to date and contained incorrect information. This posed a risk in the event people needed to leave the building in an emergency. The provider updated these during our inspection, however they continued to provide incorrect information for one person.

Preventing and controlling infection
● People were not always protected from the risk of infection. We observed some staff not wearing their face masks correctly causing them to be ineffective.
● The reception area floor and a communal bathroom were visibly unclean and high touch cleaning was not recorded.

The provider failed to manage medicines safely, assess and mitigate risk and learn from accident and incidents. 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 sent us an action plan following our inspection telling us the improvements they would make to address these issues.
● 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 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.

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

Visiting in care homes
● The provider ensured visiting was facilitated safely and in line with people's preference and choice. This had been risk assessed and appropriate safety control measures were found to be in place.

Staffing and recruitment
● Staff were recruited safely. The service followed safe recruitment processes to ensure the staff recruited were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● There were sufficient numbers of staff deployed to support people, the majority of relatives we spoke with felt the service was adequately staffed, however one relative told us, "At weekends, they need more staff as there doesn't seem to be the same amount available as in the week."

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 our last inspection we rated this key question good. At this inspection the rating 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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care plans did not always provide person centred direction to staff. For example, a care plan stated "[Person] is to sit in the communal lounge," this did not promote the person's choice.
- Where people's choices had been recorded in their care plans, we found staff had not consistently followed this guidance. For example, one person told us they did not like been woken up during the night, their care plan also stated this, but their care records evidenced that staff regularly checked the person during the night.
- People were not consistently treated with dignity and respect. We observed several instances of staff not responding to people when they required support to maintain their dignity. For example, we observed one person experiencing discomfort and asking for help and they then experienced a fall, their care plan directed staff to ensure the person was visually seen at all times. Staff were unaware the person had suffered a fall until an inspector alerted them to this.

The provider had failed to ensure that staff consistently treated people with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- There was insufficient numbers of trained staff deployed. Training records evidenced that not all staff were compliant in training such as moving and handling, end of life care and fluids and nutrition this placed people at risk of receiving unsafe care.
- Staff were not up to date with safeguarding training, this impacted upon their practice as they had not always recognised and referred unexplained bruises or abuse.
- Staff did not demonstrate the required skill and competence during our inspection. Inspectors had to prompt staff on several occasions to respond to people who needed support. For instance, we observed a person to be asleep with their head on the dining table, staff in the area had failed to identify this or to support the person until prompted.

The provider had failed to ensure sufficient numbers of suitably competent and skilled staff were deployed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The provider sent us an action plan following our inspection telling us the improvements they would make to address these issues.

● Staff told us they felt supported in their roles and received regular supervision.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink a balanced diet. Where people needed support to eat and drink, we saw this was provided. We observed people being supported to eat and drink with care and patience.
● People were provided with choices of what they would like to eat and drink. Menus were available in pictorial formats and people told us they enjoyed the meals provided.
● People's care plans detailed the level of support they needed to eat and drink. We saw that food and fluid intake charts were completed and monitored appropriately.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to access healthcare. Records showed appropriate referrals had been made when people were experiencing swallowing difficulties and a relative told us how the service had supported a person to source physiotherapy.
● Guidance had been sought from external health care professionals where people required additional support with eating and drinking or risks such as choking had been identified. The guidance external professionals provided had been included in people's care plans and risk assessments.

Adapting service, design, decoration to meet people's needs
● People had personalised their bedrooms with pictures and items of their choice and people were provided with the opportunity to put forward their views on the décor of their bedroom and communal areas.
● Technology and equipment was used to promote people's independence such as specialist mattresses and sensor-controlled lighting.
● Signage and decoration to orientate and inform people was found to be in place throughout the service which met people's needs.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions

relating to those authorisations were being met.

● Staff were unable to locate a mental capacity assessment or best interest decision to demonstrate the need to administer one person's medicine covertly. This information is required to demonstrate this had been assessed as necessary and was in the person's best interests.
● In other areas, mental capacity assessments and best interest decisions in place had been completed in line with best practice.
● The service had made appropriate DOLS applications and monitored and followed up on the progress of these applications.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Continuous learning and improving care

- Auditing systems were ineffective for medicines and infection, prevention and control as they had not identified the issues we found during this inspection.
- Systems and processes were not robust in ensuring documentation regarding accidents and incidents had been fully completed. We identified records that did not document any investigation or follow up actions taken by the management of the service. This meant that lessons were not always learnt as information gathered about these events had not been thoroughly analysed.
- Systems and processes to ensure information was up to date were not robust as it had not been identified that records of how service users could be evacuated from the building in an emergency contained out of date information.
- The provider had not always ensured they had adequate oversight of the service, action plans in place did not identify or address all of the issues found during this inspection.

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 provider's systems and processes had failed to ensure that all care plans were up to date and reflective of people's needs, this placed people at risk as staff did not always have guidance on how to meet people's needs.
- The provider's systems to ensure staff training was kept up to date were ineffective as staff had been deployed without up to date training to support people using the service.
- The provider understood their responsibility to keep people informed when incidents happened in line with duty of candour, however records evidenced this had not always happened.

The provider had failed to have robust systems and processes in place to ensure the safety and monitoring of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan following our inspection telling us the improvements they would make

to address these issues

● This service is required to have a registered manager. At the time of our inspection a registered manager was not in post, the provider had interim management arrangements in place whilst they recruited for this role.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives told us they had not been asked to provide feedback on the service for some time. The service had a relative's meeting planned, however one relative told us "I think communication could be improved, I only found out there was a relative's meeting by chance as I spotted it on the notice board."

● Staff told us they felt they had regular opportunities to engage with the management of the service. One staff member told us, "The manager attends handover and listens, they deal with anything staff need help with."

● The provider told us of their approach to ensure people using the service had opportunity to feedback their views and opinions this involved providing information to people in their preferred format such as by using pictures and flash cards.

Working in partnership with others

● Relatives told us they the service kept them up to date by staff when their relative had been unwell. One relative told us "They were brilliant when [person] went into hospital, they were very good at ringing me and giving updates."

● The service worked in partnership with other professionals such as speech and language therapists to support people to access healthcare when they needed it.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from the risk of abuse.

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	The provider failed to ensure people received safe care and treatment and that risks were mitigated. The provider failed to ensure the safe management of medicines.

The enforcement action we took:

We issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to demonstrate effective governance, including assurance and auditing systems or processes.

The enforcement action we took:

We issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had not ensured that training was kept up tp date, staff did not always demonstrate the required skills and competence for their roles.

The enforcement action we took:

We issued the provider with a warning notice.