Ashgables House Limited

# Ashgables House

## Inspection report

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## Ratings

| Overall rating for this service | Inadequate |
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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Ashgables House is a residential care home providing accommodation and personal care for up to 26 people living with diagnoses including mental, physical health and learning disability needs. At the time of this inspection 21 people were living at the service. The service had three units, one unit was for male service users only and the other two units were of mixed occupancy.

People's experience of using this service and what we found
At the time of this inspection people were put at increased risk from unsafe infection prevention control management. People were not being appropriately protected against risks and action had not been taken to prevent the potential of harm. Internal audits did not reflect an overview of incidents in the service in considering patterns and future prevention measures. Medicines were not always managed safely.

At the time of this inspection the service did not have sufficient levels of trained staff to meet people's needs.

People were not always supported to have maximum choice and control of their lives and the systems in the service did not support this practice.

During the first inspection visit we observed some examples of undignified practice.

There was a lack of governance in assessing monitoring and improving the quality and safety of the service.

The service was not always able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Right support:
• People's support needs were not always correctly recorded to ensure they received the most appropriate care. This included information around risks to people, continence care and how to maintain their skin integrity.
Right care:
• Care practices did not always uphold or respect people's dignity. We saw examples of punitive responses recorded to address people and observed a lack of respect for people's home.
Right culture:
• The culture in the service was impacting negatively on people's experiences and care support. There was a lack of effective leadership and governance at the service. Systems in place were not being reviewed appropriately to promote positive changes for people.

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

Rating at last inspection
The last rating for this service was good (31 October 2018).

Why we inspected
The inspection was prompted in part due to concerns received about the management of a COVID-19 outbreak at the service. The concerns included infection prevention control measures and low staffing levels. A decision was made for us to inspect and examine those risks.

We planned to undertake a targeted inspection. CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We inspected and found there was further concerns, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective, caring and well-led only. No areas of concern were identified in the responsive key question, therefore we did not inspect this. Ratings from previous comprehensive inspections for that key question were used in calculating the overall rating at this inspection.

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

During the inspection we were made aware of a specific incident in which a person using the service was taken to hospital following a fall. This person was found with unrelated significant indicators of neglect and has since sadly died of Covid-19. This incident is currently being explored separately to this inspection under CQC's specific incident protocols.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the four key question sections of this full report.

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. 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.

A positive condition has been applied to the providers registration. This requires the provider to submit a monthly improvement plan to CQC so we can regularly monitor the service and ensure timely action is taken to improve this service.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the

provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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 caring?**

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

# Ashgables House

**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
On the first day of this inspection one inspector visited the service alongside a member of the local public health team. On the second visit two inspectors attended the site visit.

A medicines inspector reviewed medicine management away from the site. A third inspector undertook calls to staff following the site visits.

Service and service type
Ashgables 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 at the time of this inspection. This means the provider was solely legally responsible for how the service was run and for the quality and safety of the care provided at this time.

Notice of inspection
This inspection was unannounced on both visits.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return prior to this inspection. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection
Due to 16 out of the 21 people having tested positive for Covid 19 at the time of our inspection, we did not spend time chatting directly with people. People were being encouraged to isolate in their rooms and we observed people from a distance. We spoke with eight members of staff including the organisation's positive behavioural support lead (PBS) who had offered managerial support to the service at this time.

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

After the inspection
To reduce time at the service due to the current pandemic and service outbreak, we continued to seek clarification and documents from the provider to validate evidence found. We received feedback from three health and social care professionals who have visited the service.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

● At the time of this inspection people were put at increased risk from unsafe infection prevention control management.

● On arrival to the service measures to ensure visitors were received safely were not followed. This included temperature checking and signing in to ensure details were taken for track and trace purposes.

● Personal protective equipment (PPE) was not being stored safely. We saw PPE exposed and draped over banisters, towel rails and windowsills which people who had tested positive for Covid-19 were in contact with. We raised this with the positive behaviour lead (PBS) who then took steps to store this securely.

● There was an outbreak policy in place which contained guidance on the Covid 19 pandemic. However, we saw that this was not always consistently followed.

● The provider's outbreak policy stated that regular oxygen saturations should be taken for people who were identified as Covid positive, however there was no evidence that this monitoring had been completed. Oxygen saturations monitor oxygen in the blood and can indicate when a person may be experiencing complications associated with Covid 19.

● We saw that the service was not being cleaned as regularly as it needed to be in light of the outbreak. One agency staff member was cleaning on two of the units and the other unit did not have cleaning staff. We were told it was hoped other staff were completing it, but it was not known or recorded.

● Cleaning signs were displayed on doors saying bathrooms should be cleaned every four hours and door handles every two hours and that this must be recorded. We reviewed the recording of these and saw most only had entries from 2020. Another cleaning entry only had two signatures for 2021. One staff member told us they believed it was cleaned but staff failed to sign it.

● The provider's outbreak policy stated that regular cleaning of high touch points should take place to reduce risk of Covid transmission, however we saw no records of this being completed, the management team told us this was being completed but not always recorded.

● Areas of the home, in particular the bathrooms and toilets needed maintenance and repair which made it difficult to effectively clean. For example, we saw one toilet was leaking out onto the floor, flooring in toilets and bathrooms was chipped and needed re-grouting.

● We observed that clinical waste was not always being managed appropriately. There were several occasions where we saw clinical waste bins without lids on or where lids had been left up following staff discarding their used PPE. This was not safe practice in reducing the spread of infection. We asked the PBS lead to address this with staff.

● Staff were working across the units due to staff shortages. This meant the risk of transmission was increased and put people at potential harm.

● We reviewed the training matrix for staff. We saw that 14 out of 23 staff had not received updated infection

control training in light of the current pandemic. The previous manager who left in January 2021 and one other staff member had not completed it at all. This meant that the majority of staff had been working for nearly a year during the pandemic without appropriate training provided. The provider informed us following this inspection that some webinars had been undertaken, but this had not been evidenced.
● Staff told us they had not always felt supported during the recent outbreak or throughout the pandemic. Comments included, "I haven't felt supported during the pandemic" and "I always use PPE and there has been enough for everyone, but I have not felt supported during the pandemic. Not at all. I have not felt safe because some of the staff are not always following PPE guidelines."

The failure to take adequate precautions to prevent and control the spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following this inspection, the PBS lead informed us of the actions they were implementing to address these concerns. This included specific infection control training for all staff and daily cleaning checklists for the senior staff to complete to ensure cleaning had been undertaken.
● We observed that staff were wearing the appropriate levels of PPE. There was adequate stock of PPE in place.
● Staff were taking and recording temperatures for people that would allow this to be undertaken.
● Not everyone in the service understood the requirement to socially distance and isolate due to having tested positive for Covid-19. This meant people were still walking around and in close contact with others. Staff were observed reminding people to wear masks and asking that they return to their rooms. Some communal areas had been closed to stop people gathering in these areas and reduce transmission.
● Visitors prior to the outbreak had been able to visit their relatives. A dedicated room had been created for this purpose with a separate entry that did not go through the home and a protective Perspex screen in place.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;
Using medicines safely
● People were not being appropriately protected against risks and action had not been taken to prevent the potential for harm. Risks to people had been identified and a risk assessment put in place however, we saw there was not always sufficient guidance in place to manage risks.
● Some people in the service were at risk of developing pressure sores and needed support to maintain their skin integrity. We observed that the recording and monitoring of this was not consistent and there was no formal skin monitoring in place. Following our inspection, the PBS lead implemented skin integrity folders for each person to ensure this was monitored daily by staff. We saw these charts however were being kept in a communal area and not kept confidentially.
● One person had returned from hospital with the directive to be supported to change position every two hours. We saw staff were recording positional changes on a scrap of paper. At times this person had not been supported for a period of three hours which was not in line with their needs. This increased the risk of this person obtaining a pressure sore. Another person had a long-standing ulcer on their leg. They required support from staff to wash. We saw in January 2021 this person had no personal care support recorded for three days.
● Prior to this inspection there was an incident in December 2020 in which a person threw a boiling hot water urn onto the floor and in the process spilled hot water onto their foot. During our inspection we saw one kitchen door was open with a chain across. We were informed that this was to prevent people going in due to risks around hot water. Staff were not available to monitor anyone going into the kitchen and the chain was not enough to prevent a person accessing the kitchen if they wanted to. We raised this with staff, but they weren't able to provide an answer about how this risk was monitored. The PBS lead said they

would address this risk.

● At the start of our inspection we were informed that no one in the service demonstrated behaviours that warranted a behaviour care plan being in place or regular monitoring of their behaviour. This demonstrated a lack of understanding about behaviour support and what staff were managing on a daily basis. For example, people in the service had behaviours including physically aggressive behaviours. The occurrences of aggressive behaviours were not consistently recorded or reviewed. This meant the service was not always evaluating incidents and using these to improve care and mitigate risks.

● When we arrived at the service, we contacted the service to gain entry. There is a gated entrance with a keypad entry system due to the risks associated with the busy main road and a person who would make frequent attempts to leave the premises. No one was answering the call, but we spotted a staff member through the gate and we called out to them. They told us they did not know the code and would have to find someone else. If this had been paramedics attempting to gain entry in an emergency situation this would have delayed treatment and was not a safe approach.

● We reviewed information recorded about the evacuation support that people may need in the event of an emergency. We saw incorrect information was recorded about people who smoked. A review had been due in June 2020, but this had not been done. The PBS lead confirmed it needed to be updated.

● The service did not always monitor environmental risks. Water temperatures in people's rooms were not regularly checked, this meant there was an increased risk of scalding. The Health and Safety Executive recommends checks are conducted in health and social care settings to ensure water accessible to vulnerable people does not exceed 44 degrees centigrade.

● Internal audits did not reflect an overview of incidents in the service in considering patterns and future prevention measures. For example, one person had left the service unsupervised eight times during 2020 and 2021 and made repeated other unsuccessful attempts to leave. The risk assessment did not provide detailed information on how staff were to manage this risk. On one of these occasions the person had used public transport and the incident form recorded this now increased the risk to very high as they could travel further. However, the risk assessment had not been updated to reflect this and no additional measures had been put in place to mitigate this.

● Staff spoke about how challenging it was and how unsupported they felt trying to manage the risk for this person. One staff member said "It has been very stressful trying to cope with [person's name] leaving and the challenging behaviour. The main issue was that when [person's name] 'left' [home manager] would tell the staff to go out and bring them back." The staff added this should have been done by the police and that some days they dreaded coming into work as they were always going out to try to bring the person home. Another staff member told us "There were no individual positive behaviour plans for each person in place, so it was very general." This staff continued to say they felt, "Very unsupported with [person's name] leaving unsupervised."

● Medicines were not always managed safely. Staff used Medicines Administration Records (MARs) to record when medicines had been administered. The MARs we reviewed showed that medicines were being given as prescribed, however when MARs had additional handwritten entries the process outlined in the provider's medicines policy was not being followed. We saw these had not been signed by the member of staff who had transcribed them, or a second member of staff to confirm their accuracy.

● The minimum and maximum fridge temperatures were not being recorded so the records could not provide assurance that medicines requiring cold storage were kept at appropriate temperatures. We also saw that opening dates were not being recorded on creams to ensure they were discarded within an appropriate timeframe.

● When medicines incidents arose, we saw that they were being recorded. There were limited details on what was being done to prevent them re-occurring. Daily stock checks were being completed on medicines, but a medicines audit recently completed had not identified the issues we found at the inspection.

The failure to provide safe care and treatment to people by mitigating risks, safely managing medicines and learning from previous incidents was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recorded details of incidents and accidents that occurred.
● Following this inspection, the PBS lead told us they planned to complete a behaviour competence framework for the service when a new manager was in post.
● During our inspection we looked at the systems in place to manage medicines. Records showed that the regular staff members had been trained and were competent to undertake the tasks asked of them.
● Medicines were stored securely, and access was restricted to appropriate individuals.

Staffing and recruitment
● At the time of this inspection the service did not have sufficient levels of staff to meet people's needs. The majority of regular staff were off having tested positive for Covid-19 and the provider had failed to source staffing by other means in order to run the service safely.
● During the outbreak the manager gave their immediate resignation and the staff at the service were left largely unsupported. This resulted in the deputy manager also having some time away from the service due to the increased pressures. One staff said, "There has been only two staff with 15 people who had all tested positive. The management team were aware of this and [previous manager's name] only arrived late in the afternoon and stayed in the office. There have been many days with no management or staff available or assessed to administer medication on site."
● Staff told us staffing issues were not just as a result of the outbreak, but that the service had struggled for some time due to the complex needs people had. Comments included, "There's not enough staff to support people safely" and "My job role is to make time to support people safely, sometimes it can be difficult because of a lack of staff or untrained staff." One health and social care professional told us, "The general consensus is that at times the home appears understaffed when there appears to be a lot of noise and commotion from residents requiring some form of assistance."

The failure to maintain sufficient numbers of suitable staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following this inspection, we were informed that regular staff had begun to return from their isolation periods and the service was being appropriately staffed.
● A member of staff with a different role in the organisation had stepped in to support the service. A second manager seconded from another region is now also supporting the service.

● We reviewed staff recruitment files and saw that appropriate employment checks were not always recorded correctly.
● We saw that identification documents had not been signed or dated when the originals had being viewed in line with Schedule 3 (Schedule 3 sets out categories of information required to be kept by providers about all persons employed in the provision of services).
● Records showed that checks had been made with the Disclosure and Barring Service (criminal records check, DBS) to make sure people were suitable to work with vulnerable adults. However, we saw that one staff's DBS started in 2017, despite the staff having begun their employment in 2014. We were informed that no log of a DBS prior to this time could be found and that once they expire, they are destroyed. However, DBS do not have an expiry date and there was no other information to show a renewal had been completed. Following this inspection the provider has told us one was completed but there was no record of this kept.

The failure to demonstrate that appropriate pre-employment checks had been completed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff told us they understood their responsibilities in recognising and reporting any safeguarding concerns and had received training in this area.

● Staff told us, "It is to protect myself or someone else from any harm or danger. I would always report anything heard, seen or suspected to my manager and feel it would be taken seriously and looked into" and "It's about keeping the vulnerable person safe. I would report any issues of concern to the manager but have never had to do this yet."

● A safeguarding protocol was in place, but this stated it had been due a review in May 2019. An updated copy has not been received.

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 now deteriorated 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 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 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.

- The service was not always working within the principles of the MCA. We saw evidence that restrictive interventions were in place without a mental capacity assessment. One person's care plan advised that staff should confiscate a person's cigarettes and limit the person's smoking to a certain amount per hour if they appeared to be smoking too heavily. There was no mental capacity assessment or documented consent to ascertain whether this person had capacity to decide how often they would like to smoke.
- We saw that people had capacity assessments in place for decisions including consent to receive care and treatment at Ashgables and for support with medicines. However, the assessments did not evidence how people were supported to make this decision and how the information was presented to them.
- People were not always assessed for capacity around decisions that had potential to harm their health. This meant that the service had not always fully considered the person's mental capacity and the best way to support them to manage risk of harm.
- We saw that some people were unable to leave the service without a staff member to support them. Although some DoL's applications had been applied for prior to and following this inspection, we could not see supporting mental capacity assessments for these decisions.

The failure to ensure people's consent was appropriately gained was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We saw evidence that DoLS had been applied for appropriately, however the provider was still waiting for some of these to be approved by the Local Authority.

Staff support: induction, training, skills and experience
● At the time of this inspection the service did not have sufficient levels of trained and competent staff to meet people's needs.
● Agency staff that had been called upon, were not all trained to complete manual handling or administer medicines. A regular member of staff who lived nearby was coming in between working shifts and sleeping to administer people's medicines. One staff told us, "What I find concerning is the agency staff who are here don't know our service users who are highly complex."
● We were informed at the time of this inspection there was only one staff member able to safely transfer people until 11am. Up to five people required support to be transferred safely, this meant their needs could not be met at this time. One staff said, "People are safe in respect they are being cared for, but I'm concerned about the hoisting and that they are being left in certain positions."
● Staff did not always receive all relevant training to their role. For example, we saw that the majority of staff had not received training on Covid 19. Where staff had received training, this had been completed in January 2021.

The failure to maintain sufficient numbers of suitably competent staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw that staff completed an induction when they started working at the service and staff we spoke with commented positively about the training induction they had completed.
● Following this inspection the provider informed us staff had taken part in Covid-19 webinars however, this had not been recorded. The provider confirmed that this would be documented on the training matrix in future.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were assessed prior to moving into Ashgables House.
● A care plan was developed to record their needs and how these were to be met.

Supporting people to eat and drink enough to maintain a balanced diet
● At the time of this inspection we were unable to observe people's dining experience at mealtimes. This was because meals were being served in people's bedrooms due to the Covid-19 outbreak. Only one kitchen was in operation due to one of the two kitchen staff members being off with a positive test result. Meals were being prepared in one kitchen and taken across to the other unit at this time.
● The service had a food hygiene rating of five which had been awarded in 2019.
● We saw that information about people's food preferences was recorded in their care plans.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's care records showed relevant health and social care professionals were involved with people's care.
● Health and social care professionals told us staff had communicated with them when needed about the people living at Ashgables.
● Staff recorded information about people's oral health care needs and the support offered.

Adapting service, design, decoration to meet people's needs
● At this time the communal areas of the home were closed due to a Covid-19 outbreak and people were encouraged to isolate in their bedrooms. We saw that some people continued to gather in corridors and some communal areas and did not understand or choose to follow this guidance.

● The service was in need of maintenance and repair. Some corridors had paintwork that was marked and dented, and some bathrooms had chipped flooring, discoloured and stained tiles. One health and social care professional commented, "The communal areas appear tired and I personally feel lack a sense of a home environment."

● The carpet on the stairs in one unit had holes in it which was a potential trip hazard for people. The positive behaviour lead informed us this had been due to be replaced but was delayed due to the current pandemic. We saw in another unit the roof was leaking water and a bin had been placed to catch the water. This had also been due repair prior to the service's outbreak. We saw this recorded on a maintenance report.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- During the first inspection visit we observed some examples of undignified practice. One person approached staff asking for an item of food that they had ordered. This person was repeatedly spoken to in raised voices by staff to return to their room and put on a mask. The person continued to return to ask for their food item. Instead of offering the person an alternative, staff continued to argue and tell the person they had to wait until another staff returned with the shopping list. This did not help alleviate the situation but caused anxiety for the person who continued to ask for the item and showed a lack of respect for the person.
- Staff were observed telling a person to return to their room to isolate due to the outbreak. A member of staff then raised their voice to the person saying that the visitors (CQC inspector and Local health member) needed to go down the corridor and the person needed to move out of the corridor. At this point we intervened and told staff that this person did not need to move, it was their home and we did not need to walk down that particular corridor at that time. The management of this interaction had not demonstrated respect for this person and their home.
- We saw that people's bedroom doors had their names written in pen on sticky labels, some of which were peeling off. This did not demonstrate a dignified approach in personalising people's private space.
- People's daily notes were not always written in a respectful manner. For example, we saw that one person's care plan stated "Staff have tried to explain to [person] the risks but he refuses to listen.
- Some people's care plans directed staff to manage behaviour with punitive actions, for example, we saw one person's care plan stated staff should 'remind [person] that they won't be able to go out and their family may not come to see them' when they presented with behaviours that challenged staff. This was not an appropriate or dignified approach to supporting people.
- We saw inconsistences in the way people were supported to manage their independence relating to continence care needs. For example, one person's care plan stated they were independent in this area, however during the inspection they were observed continuously approaching staff and saying they had been incontinent and needed help to change and shower. This person was frequently asked to return to the bathroom and take their time. After persistent requests a member of staff went with the person to get them some more continence aids. This was not reflected in the person's care plan, despite staff saying it was a frequent behaviour. This meant people's care was not always managed in a way that supported them to maintain their dignity as there was not appropriate guidance for staff about how to manage this person's continence needs.

The failure to ensure people were treated in a dignified approach was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● On our second visit to the service we did not witness any further incidents of this nature. We observed staff speaking to people respectfully and offering help and support. One staff member we spoke with knew people well and was able to speak easily about their needs. Another staff commented, "I love the residents, I think they are happy, the personalities of the residents and the staff really match, we all get on it is relaxed and chilled."
● Health and social care professionals we spoke with told us they had observed staff being caring towards people and commented, "The staff appear very caring and we have had no concerns to contradict this at any of the visits. The staff appear to have a good understanding of the residents we enquire about and answer any questions we may have."

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 Good. 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

- The service did not have a manager registered with the Care Quality Commission at the time of this inspection. We saw that the service had been managed since 29 June 2020 until 11 January 2021 by a manager who had not completed their induction training or submitted an application for CQC registration. They were not trained in a number of areas including infection control and quality assurance.
- We saw that concerns regarding the home manager's training had been identified in supervisions in November 2020, however no formal improvement plan had been implemented. We saw that senior management had increased video monitoring contact with the home manager following concerns, the date and time of conversations were recorded however there was no record of what was discussed or agreed during these calls.
- The manager had given their immediate resignation during the Covid-19 outbreak at the service. The deputy manager had also taken some time off due to the pressures and lack of support within the service. The provider's senior manager PBS lead had offered to step in and support the service at this time.
- During the two days of our inspection and the time the service had their outbreak, senior management who had oversight of the service were not visible on site to support the staff and service. Staff at the service informed us they were in touch on the phone, but no one had attended the service to offer support. Communication between the onsite staff and senior management clearly showed that they were distressed and in need of further support, but this had not been forthcoming.
- During professional meetings held with senior management, the deputy manager, the Local Authority, Commissioning and CQC regarding staffing levels during the outbreak, it was clear there was disparity between senior management understanding and the reality at the service.
- On the first day of our inspection there was a clear lack of oversight at the service. We were not able to gain assurances on how many people were at the service, how many had tested positive for Covid-19 and what their particular needs were. Although the PBS lead was now supporting the service they were open about their lack of knowledge of the service as they had not worked on site for some time commenting, "It's difficult as I have been brought in and don't know the full picture."
- The staff were understandably very anxious, frustrated and emotional during the inspection. There was a clear lack of visible leadership at the service to support and direct staff. Staff told us they felt unsupported by the senior management. One staff spoke about how they had tried their best to keep Covid-19 free and keep people safe but had no encouragement or support from head office commenting, "Head office staff are never heard of. Through the pandemic we didn't hear from them, there was no support. There is no official wellbeing, counselling or access to support from head office."

● Staff told us the issues with management had not been as a result of the outbreak but had been an ongoing concern since the last registered manager left in April 2020. Comments included, "The leadership is not good and there is no consistent managements visible in the service and things are not communicated well" and "Area manager didn't offer to be here and support in person, [PBS name] offered. No idea why senior management have not been here."
● The provider had quality assurance systems in place, however the scope of what these looked at was limited. We saw that when concerns had been identified in meetings, they had not resulted in improvements to the service or a robust action plan with reviewed timeframes for completion. The provider had a quality assurance process in place for area management to maintain oversight of the service, however we saw that a full audit or site visit had not been completed since June 2020. The audits completed did not pick up all of the concerns we identified during this inspection such as gaps in care records, staff recruitment and medicines records.
● We saw that the lack of analysing risks had been discussed in a manager meeting and set as an action, but this had not been addressed in a timely manner.
● The provider's business continuity plan to manage outbreaks of this nature stated staff should take additional infection control measures to reduce the spread of infection. This did not happen and placed people at further risk by not adequately managing the outbreak.

The failure to assess, monitor and improve the quality and safety of the service effectively is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt glad the positive behaviour lead had stepped in to support them and the home. A health and social care professional told us, "My colleague felt the stand in manager was very good and identified the more vulnerable residents and had performed a skin check. The home seemed much more settled with a presence of senior management."
● Since supporting the service from 13 January 2021, the PBS lead had started to implement documents for staff to complete around medicine management, infection prevention and people's skin monitoring. This had not previously been in place.

Continuous learning and improving care
● We saw that some actions for improvement or work outstanding had been discussed between the previous manager and senior management. However, this did not record timeframes for completion or state who would be responsible for ensuring the work was done. This meant the level of accountability for driving improvement was not effectively monitored.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture in the service was not positive. There had been ongoing staff conflicts dividing the team which was impacting on their practice. This had also been picked up by external professionals visiting. Although this had been known for some time and discussed in meetings, there was a lack of proactive action and measures taken to reduce and manage this conflict in practice.
● Staff told us, "The managers have not been strong enough. We all try our best, but it needs to be equal. If the day co-ordinator was on the floor more, overseeing the staff team it would be better", "There are some colleagues who were not caring or respectful. I don't feel valued and supported. Policy and procedures have not always been followed. Equality at times has been noticeably absent", "I also feel upset when I get treated with disrespect. The morale with staff is not nice at the moment and there always seems to be tension or some staff snapping at other staff or gossiping making some staff including myself feel uncomfortable coming to work."

● Staff felt that some team members did not communicate well and would neglect their responsibilities by spending time in the office. One staff told us they were never sure what was going on with people as they were not informed, and this was also confusing for the people in the home. One staff commented, "There is a day Co-ordinator who is supposed to have oversight of the floor, but they spend most of their time in the office and we don't have access to their communications. Communication is lacking and teamwork is lacking." Another staff member told us, "How some staff treat other staff, I do not think they treat them with respect or care. Team leaders have different rules and ways of working, which is understandable, but staff don't know what they should be doing or not and this changes regularly."
● Although the senior management were aware of the ongoing staff conflict, we raised these concerns with them again about how their staff team were feeling and the negative impact this was having for people living at Ashgables.

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 management details for people to contact was incorrectly displayed on the provider's website. The manager shown had not worked at the service since June 2020.
● A complaints procedure was in place to manage concerns raised. We did not review complaints received at this inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We saw that the last people satisfaction survey had been completed in November 2019. Some of the participants were unable to provide their feedback but the majority gave positive responses to questions asked. We saw mixed feedback had been given on how much of a say people felt they had in the daily running of the service. There were no available actions recorded following this survey to improve people's experiences.
● We reviewed the last staff meeting minutes in June 2020 in which only two staff attended and the staff survey from November 2019 in which mostly positive experiences were shared.
● People and staff had been offered a 1-1 interview with a quality assurance officer and a Covid-19 related questionnaire to complete in September 2020 which looked at the understanding of the pandemic, if appropriate PPE was worn and if people had been supported to maintain contact with their families.

Working in partnership with others
● The service worked with a variety of different health and social care professionals in order to meet people's needs.
● We received mixed feedback on the effectiveness of these relationships from professionals we spoke with.

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 10 HSCA RA Regulations 2014 Dignity and respect<br><br>During the first inspection visit we observed some examples of undignified practice. Documentation was not always recorded in a respectful manner.<br><br>Regulation 10 (1). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The service was not always working within the principles of MCA.<br><br>Regulation 11 (1). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had failed to ensure that employment checks were completed as required.<br><br>Regulation 19 (1) (a) (3) (a). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>At the time of this inspection the service did not have sufficient levels of trained staff to meet people's needs. |

Regulation 18 (1).

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<br><br>People were not being appropriately protected against risks and action had not been taken to prevent the potential of harm.<br><br>Medicines were not always managed safely.<br><br>There was a failure to maintain adequate levels of cleanliness of premises and equipment to keep people safe.<br><br>Regulation 12 (1) (2) (a) (b) (g) (h). |

**The enforcement action we took:**

A positive condition was imposed on the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There was a failure to assess, monitor and improve the quality and safety of the service for people.<br><br>Regulation 17 (1) (2) (a) (b) (f). |

**The enforcement action we took:**

A positive condition was imposed on the providers registration.