Ashberry Healthcare Limited

Heathercroft Care Home

Inspection report

Longbarn Lane
Woolston
Warrington
Cheshire
WA1 4QB

Tel: 01925813330
Website: www.ashberry.net

Date of inspection visit:
25 February 2021

Date of publication:
07 May 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Heathercroft Care Home is a 'care home.' The service is registered to provide nursing and personal care for up to 88 older people across two purpose-built units; Heathercroft unit is for people with nursing and personal care needs and the Ashberry unit is for people living with dementia. Following our last inspection, we imposed conditions to remove the nursing element of the location's registration. At the time of our inspection there were 41 people being provided with accommodation and personal care.

People's experience of using this service and what we found
People's health, safety and wellbeing were sometimes put at risk due to a number of concerns identified during this inspection. Risk management was not always consistent, and people and family members did not always feel assured about their safety. Staff did not always have the right skills, knowledge or experience to carry out their role safely and effectively.

There were not enough assurances that the service consistently met current national guidance and standards in relation to infection prevention and control (IPC). Staff had limited knowledge about some IPC procedures, including the removal and disposal of PPE. There was limited assurance that staff were taking part in regular COVID-19 testing. The provider did not always make sure that adequate measures were in place to prevent the spread of infection; particularly in relation to COVID-19.

The service had experienced a long history of inconsistent management and poor compliance with regulations. This had lead to low staff moral and poor team cohesion. Family members told us communication from managers was poor, and people spoke negatively about the constant change in management. Staff felt the service was disorganised due to lack of consistent management and provider support.

There were widespread, significant shortfalls in the way the service was led which had resulted in multiple and continued breaches of regulations. Governance systems were not robust enough to identify issues and drive improvement. Staff did not feel involved, appreciated or engaged with.

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

Rating at last inspection and update
The last rating for this service was inadequate (report published 29 October 2020) and there were multiple breaches of regulations.

Why we inspected
This inspection was prompted in part due to concerns received about staffing, lack of staff training and inconsistent management. A decision was made for us to inspect and examine those risks and to follow-up on concerns identified at the previous inspection and to check whether any improvements had been made.

This report only covers our findings in relation to the Key Questions Safe and Well-led. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

The provider took some actions following the inspection to mitigate some risk.

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 to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified repeated breaches in relation to Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 18 (Staffing). We have also identified a new breach of Regulation 13 (Safeguarding people from abuse).

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 service remains in special measures'. 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

This service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

This service was not well-led.

Details are in our well-led findings below.

Heathercroft Care Home

Detailed findings

Background to this 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
This inspection was carried by two inspectors, an inspection manager and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. This meant the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service and 14 family members about their experience of the care provided. We spoke with 12 members of care staff, the deputy manager, Director and Chief Operating Officer and Quality and Compliance Director.

We reviewed a range of records which included six people's care records, multiple medication administration records from across the different units, and five staff personnel files in relation to recruitment. We also reviewed a variety of records relating to the management and governance of the service, including policies and procedures.

After the inspection
We continued to review evidence that was sent remotely as well as seeking clarification from the provider to validate evidence found. We looked at audit and governance data, as well as infection prevention and control 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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At the last inspection the provider had failed to ensure that identified risks were managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvements been made and the provider remained in breach of Regulation 12.

● Whilst risk assessments had been completed, staff did not always have access to relevant information and guidance in order to safely manage people's identified risks. This placed people at potential risk of harm.
● Where people required regular monitoring to reduce risks associated with poor skin condition, it was not always clear that tasks were being completed by staff within the timescales instructed in care plans.
● Where people had identified risks such as diabetes and behaviours that challenge, care plans lacked information and guidance for staff to follow in order to respond to and manage associated incidents.
● From records reviewed, we could not always be certain that people were receiving adequate amounts of fluid, specifically those with risks associated with poor skin condition.

The provider had failed to ensure that identified risks were managed safely. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relevant checks had been completed on the environment and equipment used to ensure it remained safe.

Preventing and controlling infection

At the last inspection the provider had failed to ensure robust measures were in place to prevent the spread of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvements had been made and the provider remained in breach of Regulation 12.

● Whilst the home appeared clean, we could not always be assured that infection prevention and control guidance was being robustly implemented and followed to prevent the spread of infection.
● Some cleaning schedules were in place for staff to follow. However, these did not include regular cleaning

of communal areas and high touch surfaces. Where daily cleaning tasks were allocated, gaps in records suggested these were not being completed when required.
● We could not always be assured the provider was following guidance in relation to regular staff testing of COVID-19. Records provided showed not all staff had been tested weekly as advised within national guidance.
● Some staff were observed not always following correct procedures in the use of masks and did not always maintain social distancing whilst in office areas. This increased the potential risk of spread of infection, such as COVID-19.
● Some staff told us they had not received training in relation to infection prevention and control (IPC) and were not confident in the correct procedures for the use and removal of PPE.

The provider had failed to ensure that robust measures were in place to prevent the spread of infection. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At the last inspection the provider had failed to ensure there were enough staff to safely meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvements had been made and additional concerns had been identified. The provider remained in breach of Regulation 18.

● There were not always enough suitably skilled and experienced staff deployed to meet people's needs.
● Training records showed that not all staff had received the training they needed to carry out their role. In addition, we found that some newly recruited staff were shadowing inexperienced staff who had not received training in relevant areas.
● Staff rotas showed inconsistencies in staffing numbers, with some days showing levels below what the service had identified as being safe.
● People told us there were not always enough staff to support them. Comments included; "There's never enough staff. I call for help and they don't come, I am waiting ages" and "No, there isn't enough staff. I feel sorry for them [staff] always rushing around."
● Staff told us there were not enough staff on duty and did not always feel that all staff had the right skills and knowledge to support people. Comments included; "There's not enough staff. We're losing staff. Turn-over is terrible" and "Staff levels are low. We are losing team leaders. Agency usage is really high."

The provider had failed to ensure there were enough suitably skilled and experienced staff to meet people's needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● We could not always be assured that people were protected from the risk of harm or abuse.
● Whilst safeguarding incidents were reported to the local authority, managers and staff failed to act on actions set following safeguarding investigations. This placed people at risk of potential harm.

The provider had failed to ensure people were safeguarded from the risk if abuse. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received training in relation to safeguarding and knew how to identify and report incidents of abuse.

Learning lessons when things go wrong
● Systems were not in place to review and analyse incidents in order to prevent them reoccurring.
● Where people had identified risks in relation to behaviours that challenge, incidents were not recorded or reviewed to look for patterns and trends. This resulted in staff not always being aware of how to prevent or respond to incidents of concern.
● Some issues found during this inspection showed evidence the provider had failed to learn from previous inspection findings and implement changes to ensure they did not occur in the future.

The provider had failed to ensure that robust systems were in place for the recording, review and analysis of accidents and incidents. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Whilst medicines were managed safely by trained staff, we could not be certain their competency was being regularly assessed by staff with the relevant training to do so.
● Electronic medicine administration records (eMARs) showed that people received their medicines at the right times. However, some stock levels were not accurate and no explanation could be provided regarding these errors.
● Care plans provided guidance for staff to follow in the safe use of 'as required' (PRN) medicines to ensure these were only administered when needed.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

At the last inspection, the provider had failed to implement governance systems robust enough to identify issues and make improvements to the quality of care provided. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and additional concerns were identified. The provider remained in breach of Regulation 17.

Continuous learning and improving care

- Governance and quality assurance systems were not effective at driving necessary improvement.
- The provider had identified a number of issues through their own audits and reviews completed after our previous inspection. However, action had not been taken to address these issues and make necessary changes.
- Audits and checks were not completed by managers on a regular basis and those that had been, failed to identify a number of the issues we found during inspection.
- Evidence showed that no improvements had been made to the service and overall delivery of care since our last inspection.

The provider failed to implement robust and effective governance systems which had resulted widespread, significant shortfalls in the way the service was led. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Numerous changes in management and senior care staff had resulted in low staff morale, poor team cohesion and inconsistent care and support.
- The most recent manager had resigned from their post shortly before our inspection. The newly appointed deputy manager was acting as interim manager and being supported by the Director and Chief Operating Officer and Quality and Compliance Director.
- Staff told us they did not feel supported by managers or the provider and felt the overall management of the service was poor; Comments included "It's a shambles. Owners don't support staff or managers. Managers aren't allowed to make decisions. There's no structure at all," "Managing directors don't let managers make decisions. There's been a lot of changes in managers. Staff morale is low and if inspections

go wrong it's on our heads" and "No managers to support you. Staff are leaving because of decisions directors are making."

● Family members told us there were constant changes in management which impacted on the continuity of care their relative's received. Comments included; "There have been lots of managers, they seem to have a new one every six months or so" and "Senior management have the wrong ideas and seemingly do not treat their managers right and the structure is clearly inadequate. There is no management communication and absolutely no continuity."

● The provider had not always notified CQC of events as required by regulation.

● A positive, person-centred culture was not always promoted within the service and we could not always be assured people received quality care. that was safe and effective.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Staff told us they did not feel engaged with by managers or the provider and did not feel involved in the running of the service. Comments included; "There are no night meetings at all. They [managers] only really call meetings to announce things," "We never know what's going on" and "I've raised issues to management but nothing gets done about them."

● Family members provided mixed feedback about the levels of engagement from managers and staff. One family member told us "They [managers] never contact me to tell me when things have happened. I got a call last week to tell me about a fall my mum had had several weeks ago."

● Regular reviews and surveys were completed with people to obtain their views of the service.

● The service worked in partnership with external agencies where required.

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 had not always complied with their duty of candour responsibilities. Family members told us they were not always notified of incidents within a timely manner or given information regarding outcomes to incidents.