Ashley Community Care Services Limited

Ashley Care

Inspection report

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12 October 2021
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15 October 2021
18 October 2021

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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
Ashley Care is a domiciliary care service providing personal care to people in their own homes. At the time of inspection, the domiciliary care service was providing support to 142 people.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Information relating to people's individual risks were not always recorded or did not provide enough assurance that effective arrangements were in place to keep people safe. People were often not informed if staff were running late and call preferences were not considered or followed. The monitoring of missed and late calls was not robust, and this resulted in some people not having their care and support needs met. Not all staff had up to date mandatory training, with many courses seemingly completed over a one or two-day period. Not all staff had been trained to provide safe catheter and stoma care. Lessons were not learned, and improvements were not made when things went wrong. Staff had not always been given up to date information or training about COVID-19 or warned where people tested positive for the virus.

The leadership, management and governance arrangements did not provide assurance that the service was well-led, that people were safe, and their care and support needs could be met. Quality assurance and governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. There was a lack of understanding of the risks and issues and the potential impact on people using the service. The lack of effective oversight of the service has resulted in continued breaches of regulatory requirements and the Warning Notice issued following our last inspection in November 2020, was not complied with.

Improvements were noted relating to some aspects of medicines management and staff recruitment practices.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published January 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of Regulation 12 [Safe care and treatment], Regulation 17 [Good governance] and Regulation 18 [Staffing].

Why we inspected
We received concerns relating to missed and late visits and the impact this had on the overall delivery of

care. As a result, we undertook a focused inspection to review the key questions of Safe and Well-Led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashley Care on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, staffing and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Ashley Care

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. We also checked whether the provider had met the requirements of the Warning Notice in relation to Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection team consisted of three inspectors 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
This service is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
We gave the service 24 hours' notice. Inspection activity started on 12 October 2021 and ended on 18 October 2021. Two inspectors visited the office location on 12 and 13 October 2021. The Expert by Experience made telephone calls to people who used the service and relatives. On 15 October 2021 telephone calls were made to staff by three inspectors.

What we did before the inspection
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 sought feedback from the Local Authority and reviewed all of the information we held about the service. We took this into account when we inspected the service

and made the judgements in this report. We used all information to plan our inspection.

During the inspection
We spoke with 23 people who used the service or their relative about their experience of the care provided. We spoke with the registered manager and the manager responsible for overseeing the organisations staff employment and training.

We reviewed a range of records. This included six people's care records and numerous Medication Administration Records [MAR]. We looked at six staff files in relation to recruitment, training, supervisions and 'spot checks'. A variety of records relating to the management of the service were viewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff training data, quality assurance information, MAR forms, timesheets and people's care records. We sent a text to 30 members of staff and spoke with 17 members of staff about what it is like to work at Ashley Care. We also spoke with a further two people who use the service and one relative on 18 October 2021.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

At our last inspection in November 2020, not all risks relating to people using the service were recorded and improvements were required to medicines management. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and this was a continued breach of regulation.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

- Not all risks for people using the service were identified and recorded. Where these were in place they primarily related to people's environmental and moving and handling risks. Risks relating to people's health and wellbeing, for example where a person had a catheter or stoma fitted, were living with the medical condition of diabetes, were at risk of developing pressure ulcers or had poor skin integrity, had not been considered or recorded.
- We could not be assured that people's risk assessments were accurate or up to date. For example, the risk assessments for three people recorded these were last completed in October 2019, December 2019 and August 2020.
- Although not all people using the service required medication to be administered at a specific time, not all people using the service received their medication at consistent times.
- Where people continuously refused their medication, records did not show that staff had taken any action in response to this such as referring this to a healthcare professional.
- We were not assured the provider was preventing people [staff] from catching and spreading infections or making sure infection outbreaks could be effectively prevented or managed. Staff told us they had not always been made aware where people using the service had tested positive for COVID-19. This placed staff at risk of getting COVID-19 or transmitting the virus to others.
- Not all staff had up to date infection control training. Not all staff had received specific training relating to COVID-19 or 'donning and doffing'. The latter relates to the correct order for the putting on and taking off of Personal Protective Equipment [PPE].

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014

- Improvements were noted relating to the completion of people's Medication Administration Records

[MAR].
• Staff confirmed they had enough supplies of PPE. People and relatives provided an assurance staff were using PPE effectively and safely when staff visited their home. One person told us, "[Name of staff member] has got their own aprons, gloves and masks. When they've finished, they roll them up and put them in the bin." A relative told us, "[Carer] is very good and always wears them."

Staffing and recruitment
• Variable comments were recorded by people who used the service or those acting on their behalf relating to call times. Where positive comments were recorded people told us, "I have one call in the morning for 30 minutes and I have the same staff most of the time", "I have one call, 20 to 30 minutes, different staff but not every day. I'm lucky to have the same person twice a week" and, "I think they [staff] call within a reasonable parameter of time."
• Where less favourable comments were made, people told us they were not always contacted by Ashley Care if staff were running late or where there was a change of carer. People told us they usually received the same staff in the mornings but at teatime and in the evenings, this varied considerably and was particularly worse at weekends. One relative told us, "They [domiciliary care service] should be called Ashley don't care. We don't have the same staff and they don't come at the same time."
• People told us there were occasions whereby they experienced missed calls. One person who had poor mobility and a sensory impairment told us when they experienced a missed call, they had had to get themselves washed and dressed; including providing their own breakfast. They told us, "It's the little things I can't do." Additionally, the same person confirmed there had been a recent incident when a member of staff arrived so late for their morning call that it was merged with their lunchtime visit.
• 11 out of 17 members of staff spoken with reported too many calls were often scheduled for either the morning, lunchtime, teatime or evening periods and this meant calls were either missed, were late or did not last for the allotted time people had been assessed to receive, resulting in the care provided being rushed. Comments included, "We are so short staffed, that's why everyone is getting late and missed calls. The morning calls can be at 12.00 midday, you are really pushed. They [office] tend to give us excess amounts of clients, if you did the whole time you would be well over time and into the lunch calls" and, "On a weekend we can have 10 to 11 people, we try our best to fit everyone in. We do try to stay the allocated time, but we do not get travel time, so it is impossible to get to people when they want. There is definitely missed calls, sometimes we cannot get to people and they cancel as it is too late. Clients have been left without calls or their medication."
• The timesheets for one person demonstrated 36 occasions over a 47 day period whereby staff did not stay for the required time they should. On these occasions the duration of the calls was recorded to last between three and 17 minutes instead of 30 minutes. This was despite the person's care plan stating they required support with their personal care needs [including being washed, dressed and undressed in the morning and the evening], having their continence needs met, including their continence products being changed and their skin integrity being monitored to ensure this was not compromised.

We found no evidence that people had been harmed however, improvements were required to ensure people received a consistent and reliable service. This demonstrated a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last inspection in November 2020, the provider had failed to ensure newly appointed staff were robustly recruited in line with regulatory requirements. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of this element of the regulation.

• The service's recruitment practices demonstrated staff employed had the proper checks to ensure they

were suitable to work with vulnerable people. However, minor improvements were required to ensure these arrangements were robust. For example, references received for two members of staff were not from their most recent employer. Information recorded within another member of staff's personnel file suggested the human resources manager offered to compose a reference for a prospective employee.

Learning lessons when things go wrong
• When things go wrong, lessons were not always learned to support improvement, and this was evident from our findings at this inspection. This meant the service did not achieve learning, reflective practice and improvement.
• Shortfalls identified at our previous inspection in November 2020, had not been addressed. Breaches of regulation relating to risk management, quality assurance and missed and late calls remained outstanding. However, improvements were noted relating to some aspects of medicines management and recruitment practices.

Systems and processes to safeguard people from the risk of abuse
• Staff had a good understanding of what to do to make sure people were protected from harm or abuse. Staff confirmed they would escalate concerns to the management team, office and external agencies, such as the Local Authority or Care Quality Commission.
• Where safeguarding concerns were raised, and an internal investigation undertaken, not all investigations completed by the registered manager were robust and improvements were required.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection in November 2020, quality assurance arrangements at the service were not effective and required improvement. This was a continued breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Because of this a Warning Notice was issued in December 2020 and this required the provider to achieve compliance by 10 April 2021. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; 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 leadership and overall management of the domiciliary care office did not ensure the service was consistently well-managed and demonstrated not all people using the service received positive outcomes. People told us their care could be rushed and meant staff did not have the time to chat with them. One person told us, "They [staff] should have a chat. This would be great; I don't see anybody because they are rushing in and rushing out." Another person told us because the care provided was rushed, they found it difficult to have a rapport with staff.

• Not all people using the service or those acting on their behalf were happy with the domiciliary care service. Four out of eight people spoken with were positive about the service. Comments included, "Oh yes, oh yes" when asked if they were happy with the care provided and, "Definitely yes, my carer is definitely a professional. Less favourable comments included, "No, [I am not happy with the service received] because it is so erratic. I would not recommend them but there doesn't seem to be anything else, so I'm stuck with them" and, "Well, I have to put up with it, what other service can I have." When asked if they would recommend the service, the person told us, "Not really, no."

• The quality assurance and governance arrangements in place were not reliable or effective in identifying shortfalls in the service. The lack of effective oversight and governance of the service has resulted in continued breaches of regulatory requirements, particularly in relation to managing missed and late calls and ensuring staff receive appropriate training to meet the needs of people using the service. There was a lack of understanding of the risks and issues as detailed throughout this report and the potential impact this had on people using the service.

• Although the provider had audits in place to monitor the quality of the service provided, these were not as effective as they should be. For example, these had failed to accurately identify and assess medication

errors, the number of missed and late calls and compliments and complaints.
• The provider had failed to notify the Care Quality Commission without delay of incidents as specified under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4). Records viewed demonstrated seven safeguarding adult concern forms had been raised with the Local Authority, but a statutory notification was not submitted to the Care Quality Commission as required for all concerns highlighted.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Although the registered manager was clear about their role and demonstrated a willingness and eagerness to achieve compliance with regulatory requirements, they demonstrated a lack of understanding about effective governance procedures and how this linked with high quality performance and person-centred care.
• Out of ten people spoken with, only three knew who the registered manager was. Where others did not, comments included, "I have no idea", "I haven't got a clue" and, "No, I don't know."
• Not all staff felt supported and valued by the organisation or the registered manager. Where positive comments were recorded, these included, "The registered manager is quite good to talk with and is approachable" and, "I feel supported one million percent by the registered manager and management." Less favourable comments included, "Ashley Care is not a good company to work for, I would not recommend them to anyone or let a relative use this company" and, "Personally, the support is not great, it's not good."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People told us communication with the domiciliary care agency office was variable. Where positive comments were recorded these included, "If there is ever any trouble, I get numerous calls from Ashley Care" and, "Yes, they [office staff] are normally very good." Where comments were less favourable, comments included, "They [office staff] staff say 'so and so' is coming, it's as if they are trying to get rid of you as quick as they can" and, "I don't know the people in the office."
• Staffs comments relating to communication were inconsistent. Most staff reported office staff were often rude, abrupt and only nice when they wanted care calls covered. One member of staff told us they had raised concerns about this through the service's confidential staff survey but stated, "Nothing gets done." Another member of staff told us, "Communication is very lacking."
• People and their relatives were given the opportunity to provide feedback about the quality of the service through a satisfaction questionnaire. This was sent out in January 2021 with responses due by 1 March 2021. A report detailing the results confirmed a response rate of 43% and reported the overall comments received were good and often excellent. This did not concur with or reflect our findings from this inspection.
• Staff questionnaires were sent out in March 2021 with responses due by the end of April 2021. The proportion of responses returned and received were low [14%] and demonstrated a lack of staff engagement with the organisation. Additionally, the comments made by staff during this inspection highlighted the provider had not listened to or acted upon their feedback to make the required improvements.

We found no evidence that people had been harmed however, effective systems to monitor and improve the quality of the service, were either not in place or robust enough. This demonstrated a continued breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Working in partnership with others

• The service was able to demonstrate they were working in partnership with others, such as the Local Authority and other healthcare professionals.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks for people were routinely recorded or provided sufficient detail as to how these were to be mitigated for their safety and wellbeing.

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
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Arrangements to monitor the quality of the service for people using the service were not effective and significant improvements were required.

The enforcement action we took:

Impose Condition

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Improvements were required to ensure people received a consistent and reliable service that meet their needs.

The enforcement action we took:

Impose Condition