Ashberry Healthcare Limited

Heathercroft Care Home

Inspection report

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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
Heathercroft Care Home is a 'care home.' The service is registered to provide nursing and personal care for up to 88 older people. The service is purpose built. There are two units within the service. Heathercroft unit is for people with nursing and personal care needs and the Ashberry unit is for people living with dementia. On the day of our inspection there were 69 people living in the service.

People's experience of using this service and what we found
People were happy to live at Heathercroft but one person felt they waited a long time for support and two people didn't think there was much to do at the service. Most relatives were positive but had some feedback about having to depend on staff to use their own mobile phone data to contact them. They felt the service should help provide better access to the internet to help them speak with their relatives and they felt the communications could be improved. Two relatives had concerns about their family members care which we have referred to the provide to investigate formally within their complaints procedures.

Care plans within the nursing unit were not consistent and did not contain the most up to date information about people's health care needs and requirements. Care records lacked person centred detail and some did not reflect and take into account peoples actual needs and preferences.

Risk assessments were not always accurately completed or managed to minimise risks to people within the nursing unit. Daily care records were not maintained. People's care, support and treatment had not always been carried out or monitored. Care records did not evidence appropriate care provided which exposed people to a risk of harm. During the inspection we identified people who were at significant risk of harm and we made safeguarding referrals to the council.

We found concerns around how continence care, personal care, pressure care and wound care was provided. A visiting professional raised their concerns about one person and felt the care was inappropriate and not meeting their needs.

Recruitment practices showed incomplete checks and lacked actions to demonstrate support for a new member of staff. There was a high number of staff off sick during the inspection which meant a higher number of agency staff were brought in to provide care. There was a lack of appropriate management and supervision of the agency staff who relied on long standing staff members to direct them to provide care to people within the nursing unit.

The physical environment was clean and tidy. But some areas within bedrooms identified clear risks with torn and worn floor coverings that created trip hazards.

Recent visits by the local authority and the infection control team had identified some inconsistent use of personal protective equipment (PPE) amongst staff. Most staff wore masks during the inspection but some

staff walked around the building with the mask under their nose which was not the correct way to wear PPE and could pose potential risks to people. Hand washing audits had not been regularly carried out and highlighted potential risks amongst the staff team with management of infection control.

Quality assurance and auditing processes had been reviewed by the provider to help generate improvements to the service. However on-going concerns regarding clinical leadership, poorly maintained records, specifically in the nursing unit continued to be an issue highlighted by both the local authority and within the inspection. Governance systems within the nursing unit did not mitigate risk to the health and welfare of people living at the service.

We noted some personal records accessible and unlocked throughout the inspection to the nursing office. This was a continued concern noted at the previous inspection. It showed a potential breach of confidentiality.

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 May 2019) and there were two breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, we found not enough improvement had been made and the provider was still in breach of regulation. We also identified new breaches of regulations, meaning that the service had further deteriorated.

Why we inspected
We undertook this focused inspection due to concerns in relation to recent safeguarding's and to check the provider had followed their action plan and to confirm they now met legal requirements. 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 deteriorated to Inadequate. The service is therefore in 'Special measures'. 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 Heathercroft Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service 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) and Regulation 17 (Good governance) at this inspection. We have also identified new breaches of Regulation 18 (Staffing.)

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.

As the service is now 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

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.

Heathercroft Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
This inspection took place on 31 July 2020 and was unannounced. The team consisted of one inspector and a specialist nurse advisor. A second inspector was available to carry out telephone interviews with staff after the inspection and an Expert by Experience carried out telephone interviews with relatives the following week. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case, people living with dementia. Inspection activity ended on 12 August 2020. This is the date finalised for review of documents requested from the service.

Service and service type
Heathercroft 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 means that the provider is 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 but we provided one hours' notice due to the risks posed by Covid-19..

What we did before the inspection
Before the inspection, we reviewed information we had received about the service. This included details about safeguarding events and all statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury. We sought feedback about the service from the local authority and other professionals involved 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 the manager, two nurses, six staff and four people living at the service. We looked at records in relation to people who used the service including their care plans and medication audits. We looked at records relating to recruitment, staff rotas, complaints, training and systems for monitoring the quality of the service provided. Details are in the Key Questions below.

After the inspection
Due to the risks of Covid-19, we sought feedback from people's family's members by phone and spoke with 11 relatives. We did not speak with any staff following the inspection despite offering this availability over two days. We requested further documents from the service to seek clarification from the manager to validate evidence found.

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

At our last inspection we found that medicines were not always managed and administered safely. This meant that people were at risk of not receiving their medicines as prescribed, and in line with best practice guidance.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection although we found some improvements with medications we found other areas of concern around the management of safety within the service. Not enough improvement had been made to manage risks for people living at the service, This was a breach of regulation 12.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong, Systems and processes to safeguard people from the risk of abuse.

•We noted evidence of poor care within the nursing unit around pressure care, maintaining fluids and diet and managing peoples continence, weight loss and wound care which put people at risk of deteriorating in health.
•One care plan referred to four hourly pressure care needed to be provided to the person. There was no reason given in the care plan how staff had assessed a need for this care to be provided four hourly or whether it was effective for their health. Care charts were poorly maintained and it was impossible to show whether this person had received appropriate pressure care. This is of concern due to a recent safeguarding that substantiated inappropriate pressure care. This safeguarding outcome had also been acknowledged by the provider as needing action and improvements to be made at the service.
•The provider was transparent in sharing a root cause analysis report following a recent safeguarding investigation. This helped them identify concerns around poor practice, lack of competencies of their staff team within the nursing unit, especially regarding the management of pressure care and managing necessary record keeping.
•There have been continued concerns identified by the local authority during recent visits regarding the lack of appropriate documentation to evidence appropriate care.
•It was recognised that the service was still in the process of redecoration and refurbishment. However, we noted some bedrooms with rips to their flooring which presented increased risks to trips and falls and had no signs/advice in place to reduce risks to these areas.

We found evidence that people were at risk of harm within the nursing unit. This was a breach of Regulation

12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
•We noted various concerns that highlighted on-going risks in the current management of infection control to keep people safe.
•We observed one staff member providing personal care with a ripped glove. Most staff were observed wearing face masks but some had them under their nose which is not consistent with current infection control guidance to keep people safe.
•A newly recruited member of staff had been made the infection control lead for the service. They were provided with an updated file with just four staff hand hygiene audits carried out since March 2020. There was no plan in place to improve the management of infection control and complete audits with the whole staff team.
•The local authority had found inconsistent use of personal protective equipment (PPE) amongst the staff team during their recent visits although some issues had been rectified during subsequent visits.

Inappropriate management of infection control puts people at risk of infection. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
•There were areas of concern around the lack of effective clinical leadership and management in prioritising people's needs. This impacted on people's basic care needs.
•Due to unexpected sickness the service was working on lower staffing levels than normal while they awaited agency staff to arrive throughout the day. This led to a chaotic atmosphere and senior staff identifying later in the day that 13 people on the nursing unit had still not received personal care.
•We met four agency staff who arrived at the service throughout the day. One staff member had never been to the service before and was unfamiliar with the layout of the service and people's needs. They received no support or supervision to help orientate them around the building to provide support.
•One person told us they had to wait at times for the staff to receive support. We saw one person in their room who did not have a call bell in reach to be able to contact the staff if needed. This concern of people not having easy access to their call bell was identified at the previous inspection and by the local authority during their recent visit to the service.
•Staff had not always completed the relevant training they needed to meet people's needs, including continence care. We asked for the services training records during the inspection and following the visit. However, the provider has not submitted this information to evidence appropriate training provided to staff to meet their competencies and training needs.
•One staff file for a new staff member lacked evidence to show safe recruitment and the management decisions made for recruitment. Their file had limited information to demonstrate their training needs were being supported and developed.

We found evidence that staffing was not being appropriately managed to safely meet the needs of the people at the service. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
•One new member of staff told us they were learning to administer and manage the medication system They had no training or induction records to show how their training needs for necessary topics such as medications would be met.
•Medication audits were carried out by senior staff on their own units. Whilst we identified no concerns there

was no evidence of any manager/provider oversight regarding the auditing of medications.
•Medicines were stored safely and waste medicines were stored in line with best practice guidance.

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 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; Planning and promoting person-centred, high-quality care and support

At our last inspection we found systems to monitor the service were either not in place or fully embedded to demonstrate safety and quality was effectively managed. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our previous inspections in January 2018 and April 2018, We found that the provider was repeatedly in breach of Regulation 17.

At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 17.

•Governance systems had been reviewed over the last 16 months by the provider to help them assess and monitor the quality of the service. However, the revised changes had not generated enough improvements to the nursing unit which left people at risk of inappropriate management of their care needs. The provider had agreed with the local authority to put in place a voluntary embargo to admissions until they could be assured that standards had improved.
•People within the nursing unit were at risk at times of not receiving appropriate care and treatment. People's care needs were not documented appropriately, and care records were inconsistent and did not contain the most up to date information.
•The provider advised they were to recruit a new clinical lead to help develop the clinical teams and improve the standards within the staff team. However, this was something they had informed us of at the last inspection.
•The service had ineffective clinical oversight in the management of people's care needs specifically within the nursing unit. Both a visiting professional and the inspection team saw evidence of inappropriate care being provided to people during the visit. Staff were only able to confirm that people on the nursing unit had been provided with assistance by 4pm. The unit was chaotic and agency staff that arrived at short notice to cover staff absences were offered no support to help them safely manage people and meet their needs.
•Following the last inspection the provider continued to support the service in improving management and records by employing additional managers and supplying additional resources. However, the service has had seven managers following the last inspection which has affected the stability of the service and hindered the ability to improve and embed good practice.
•It's of concern that in 16 months the provider has not been able to stabilise a management team for this

service and been unable to provide sufficient clinical leadership of their nursing unit to evidence appropriate care.
•Although Improvements were being made to the décor and furnishings within the service, we noted some health and safety risks that presented as trip hazards.
•Management of infection control showed poor oversight in evidencing that staff were competent in understanding risks and safely using PPE equipment.

We found evidence that people were at risk of harm within the nursing unit as systems and leadership were not robust enough to demonstrate safe, effective management of their needs. This was a continuing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care- Working in partnership with others
•Training records for one new staff member were limited and there was no plan or evidence their training needs were being met or supported to meet the needs of people at the service. We had requested training records from the manager, but we have not received any evidence to show that staff training needs are being met.
•A visiting professional shared concerns about the poor standards of care she observed of one person they were assessing. They felt they had to intervene to provide basic care as they could not find any staff members to assist. They felt the basic care needs for continence care had not been met and staff told her they needed training for continence care. Following the inspection, we raised concerns about two people we felt needed further review for their care needs ad submitted safeguarding referrals to the local authority.
•The manager had only been in position for two weeks and had not received a handover from the previous manager. They advised they had not carried out daily walk about to meet people as they were still new to post. Some people commented that they still did not know the new manager.
•Periodic monitoring of the standard of care provided to residents funded via the local authority was also undertaken by the local authority's contracts and commissioning Team. This is an external monitoring process to ensure the service meets its contractual obligations. They had recently inspected the service and identified issues around improvements needed with record keeping, no access to call bells for some people and inconsistent use of PPE.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
•Feedback was sought from people, their relatives and staff. Most people were happy with their care, one person felt they waited a period of time to assist them and was not sure if they had a choice of baths or showers. Relatives were generally happy but felt the provider needed to improve access to communicate with their family members as they had to rely on staff using their own mobile data.
•Following the inspection two relatives raised comments about their family member's care regarding their personal care. We referred their comments to the provider to review via their complaint's procedures.

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
•Systems and processes did not operate effectively to prevent inappropriate care.
•Over the last few months CQC had received some updates from the provider regarding outcomes to their own audits, internal inspections and investigations to concerns and complaints. The provider was engaging and transparent in sharing outcomes and actions they were taking to improve the service.
•Prior to the inspection CQC had received anonymous complaints and Warrington local authority had received recent complaints. The provider was investigating concerns raised. We have not received outcomes or information as yet regarding the provider's recent investigations.

•We were still awaiting outstanding updates to documents requested relating to a person who sustained an unwitnessed fall and fracture to ascertain whether they were safely supported. We requested from the manager, details of staff to offer them the opportunity to speak with the inspection team following the inspection. However, we received no details from the manager to assist with these telephone interviews.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This was a repeated breach of regulation 12.We found evidence of poor care within the nursing unit which put people at risk of deteriorating in health.

The enforcement action we took:

We will serve an a nop to impose a condition to restrict nursing care being provided.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance This was a repeated breach of regulation due to significant shortfalls in service leadership and systems to monitor the service were not fully embedded to demonstrate safety and quality being effectively managed. Concerns raise about the nursing unit left people at risk of inappropriate management of their care needs

The enforcement action we took:

We will serve an a nop to impose a condition to restrict nursing care being provided.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were areas of concern around the lack of effective clinical leadership and management in prioritising people's needs. This impacted on people's basic care needs. Staff had not always completed the relevant training they needed to meet people's needs, including continence care. Records lacked evidence to show safe recruitment and the management decisions made for recruitment of suitable staff.

The enforcement action we took:

We will serve an a nop to impose a condition to restrict nursing care being provided.