Stephen Oldale and Susan Leigh

Ashmeadows

Inspection report

Moorbottom
Cleckheaton
West Yorkshire
BD19 6AD

Tel: 01274861049
Website: www.emyvalecare.com/

Date of inspection visit:
30 June 2022

Date of publication:
05 January 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ashmeadows is a residential care home providing accommodation for up to 17 people, who require personal care, in one adapted building. There were shared communal areas on the ground floor, with bedrooms located on the ground, first and second floor. At the time of our inspection there were 9 people using the service.

People's experience of using this service and what we found
There were not enough staff deployed to meet people's needs safely. This meant people in the communal areas were left without staff support for long periods of time. Risks associated with infection prevention and control were not effectively managed. Staff were seen not wearing Personal Protective Equipment (PPE) appropriately. Risks to people's safety were not adequately assessed, monitored or managed. Medicines were not managed safely.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Staff were not provided with relevant training to ensure they had the right skills and knowledge to support people safely. Care records did not contain an accurate overview of people's care and support needs and were not person centred.

Shortfalls identified at the previous inspection had not been adequately addressed. Where there were systems and processes to monitor and improve the quality of the service, these were ineffective as they had not identified issues found at this inspection. There was no effective system for analysing, investigating and learning from incidents. People's confidential information was not always stored securely. Effective systems had not been established for gathering views from people and their relatives.

Staff were recruited safely. People and their relatives felt the service was safe. Staff were knowledgeable about people's dietary requirements and people spoke positively about the choices they were given with food and drink. People were appropriately referred to healthcare services, when their needs or personal circumstances changed. Staff told us they enjoyed their roles and spoke positively about the improvement in the culture of the service since the home manager had been appointed.

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 06 January 2022) and there were breaches of regulations. 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 we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to the management of medicines, staff training and managerial oversight of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

During this inspection, we also checked whether the provider had followed their action plan to confirm whether they now met legal requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to managing risks to people, medicine management, the management of infection control, consent, staffing and oversight of the home.

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
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?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Ashmeadows

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three inspectors, including a medicines inspector.

Service and service type
Ashmeadows is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ashmeadows is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service and three relatives about their experience of the care provided. We also spoke with six members of staff including the operations manager, the home manager, the cook and three care assistants.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at a variety of records relating to the management of the service, including policies and procedures. We met with partners and spoke with the provider about our enforcement action.

Inadequate

Is the service safe?

Our findings

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

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

Staffing and recruitment

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

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

• There were not enough staff deployed to meet people's needs safely. This meant people in the communal areas were left without staff support for long periods of time, including two people who required supervision to keep them safe.
• Four of the nine people living in the home needed assistance from two members of staff, which meant when they needed care, this resulted in a lack of staff in communal areas. During the morning, we observed extended periods where there were no staff members present to care for the six people in the lounge. Staffing levels reduced by one care assistant in the afternoon. On three occasions during this period, we had to summon staff from elsewhere in the building for two people, who were mobilising unsteadily in the communal lounge and seeking reassurance.
• We received feedback from people regarding staffing levels. One person told us staff appeared rushed and sometimes, during the day, there were not enough staff.

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

The provider responded immediately after the inspection. They confirmed they would increase staffing levels on the afternoon shift.

At our last inspection systems were not in place to ensure staff were recruited safely. This was a breach of regulation 19 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 regulation 19.

• Staff were recruited safely. Staff personnel records contained appropriate background checks, to ensure

new members of staff were suitable to work with vulnerable people.

Preventing and controlling infection

At our last inspection the provider had failed to implement effective systems to ensure government guidance around managing the ongoing pandemic was followed. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

• Risks associated with infection prevention and control were not effectively managed.
• Staff were not using PPE safely. Throughout this inspection, we observed several staff members in communal areas with masks worn below their nose or not worn at all.
• Infection risks for people were not assessed, reviewed or managed. For example, records for one person did not include an assessment of the risks associated with their catheter or provide guidance for staff on how to monitor the signs and symptoms of infection.
• The service appeared clean, although we found a used Lateral Flow Test had been left on the mantlepiece in one of the communal lounges.

The provider had failed to implement systems to ensure risks associated with infection prevention and control were effectively managed. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
• The service was following government guidance in relation to visiting and had a suitable system in place to support people to maintain important relationships with their relatives and friends.

Assessing risk, safety monitoring and management
• Risks to people's safety were not adequately assessed, monitored or managed.
• People's care records did not always contain risk assessments or relevant information for staff to support people safely. For example, we saw one person was supported using a moving and handling belt. However, their care records referred to the use of a different piece of equipment, yet the risks associated with using either piece of equipment had not been assessed. This meant staff did not have enough information to support this person safely.
• Risks associated with pressure care were not being managed. For example, one person's care records stated they needed to be repositioned every two hours. However, this person's repositioning records were not completed on a consistent basis. We also observed this person sat in the communal lounge for more than four hours without being repositioned. This placed this person at risk of further pressure damage.
• Systems were not in place to ensure staff understood risks in the home. For example, daily handovers did not always take place to ensure any concerns were shared with staff. Handover records were not completed on a consistent basis and on the day of this inspection a handover did not take place.

Systems were either not in place or robust enough to demonstrate risks to people's safety were effectively managed. This placed people at risk of harm. This was a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we shared our findings with the local authority and asked the provider to tell us what they would immediately do to address the risks.

Using medicines safely
• Medicines were not always managed safely, which placed people at risk of harm.
• It was not clear whether people received their medicines as prescribed. For example, records for one person showed they had gone two separate periods of 10 days without their pain relief patch being applied. This meant this person might have experienced an increase in their pain during this time.
• We found time specific medicines were not always given safely. For example, records for one person showed staff did not take account of the four hour gap between doses of paracetamol. This meant this person was at risk of being overdosed.
• Medicines were not always stored securely. All staff were able to access medicines that were to be disposed of, as they were stored on the floor of an unsecured room. We also found thickener was stored on top of the medication trolley and accessible to people.
•Staff were not always given guidance on how to safely administer people's medicines. For example, people's care records did not always contain guidance as to when a person may need their 'as required' medicines.

People had been placed at risk of harm from unsafe administration and management of medicines. This was a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• Systems to safeguard people from the risk of abuse were not always effective.
• The provider did not have a suitable safeguarding policy in place, as it was out of date and had not been reviewed since the legislation changed in 2015.
• Not all staff members had received safeguarding training. However, staff we spoke with could identify different types of abuse and were aware of their responsibility to report concerns to management immediately.
• People and their relatives told us they felt the service was safe.

Learning lessons when things go wrong
• Systems and processes were not in place to learn lessons when things go wrong.
• Accidents and incidents were not managed appropriately, as they were not analysed for themes or trends. The home manager told us they intended to start doing this in the future.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• Systems and processes were not in place to ensure people consented to their care. This meant people were unlawfully restricted.
• One person's care record showed their needs were, at times, being met against their wishes. However, this person's capacity had not been assessed and a best interest meeting had not been held to discuss the least restrictive options and whether or not the support provided was in the person's best interests.
• It was not clear whether people had capacity to consent to their care and support. For example, there were no records of capacity assessments, or best interest meetings taking place with the person's representative, in people's care plans.

Care and treatment of service users was not always provided with the consent of the relevant person. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after this inspection and confirmed they had applied for a DoLS for the person referred to above.

Staff support: induction, training, skills and experience

• Staff were not adequately trained. Staff told us they had completed online training, but not recently. The training matrix showed most subject areas had not been completed by staff this year. For example, five staff members had only completed one training module out of a possible 16 modules.
• Staff did not receive ongoing support through regular supervisions and appraisals. For example, the supervision matrix showed staff had not received a supervision meeting for five months. We found no evidence of annual appraisals taking place.

The provider failed to ensure staff received appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us the home manager, who had recently been appointed, had started carrying out monthly supervisions, which they found useful.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before they started receiving a service. However, care records did not contain an accurate overview of people's care and support needs.
• The home manager was able to tell us about people's needs, but this information was not always recorded in people's care records. This meant staff did not always have guidance to meet people's needs safely.
• Care records were not person centred. They contained minimal information about people's life history or their preferences, and there was no evidence of reviews of people's care taking place.

Supporting people to eat and drink enough to maintain a balanced diet
• One person was identified as at significant risk of weight loss. However, they were not being weighed in line with advice from health professionals and their care records did not include any details regarding their dietary needs.
• People were not always appropriately supported at mealtimes. For example, one person's risk assessment stated they required plastic cutlery, to reduce risk of injury to others. However, on the day of this inspection we saw this person using metal cutlery without oversight from staff. We also observed one person with food debris round their mouth for some time after they had finished their meal.
• Staff were knowledgeable about people's dietary requirements and people spoke positively about the choices they were given with food and drink. One person told us, "We've got a good cook now, they make some good meals. The cook asks if you've had enough." A second person was drinking a black tea, which they told us is how they preferred their hot drink.

Adapting service, design, decoration to meet people's needs; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• At the time of our inspection, some people in the home were living with dementia. However, there were limited dementia friendly features in the home to support these people and enhance their living experience.
• The home worked in partnership with other professionals involved in people's care, such as; speech and language therapists, district nurses and GPs. However, the service did not always follow advice from professionals. For example, we found advice for one person regarding their weight and two people regarding their pressure care management was not being followed.
• People were appropriately referred to healthcare services, when their needs or personal circumstances changed. Staff told us the home manager was responsive and made the necessary referrals for people.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems and processes were established and operated effectively to assess, monitor and improve the safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The provider had not taken enough action to resolve the shortfalls identified at the previous inspection. At this inspection they remained in breach of the regulations relating to safe care and treatment, staffing and good governance. We also identified a further breach of regulation relating to consent.
• At the time of this inspection, the home was still without a registered manager. A home manager had recently been appointed, but the provider had failed to provide adequate or appropriate support to ensure they understood their role and responsibilities, in order to provider safe care to people living at the home.
• The provider had failed to establish their own systems for assessing and improving the quality of the service. We were provided with only one provider audit, which had been completed just prior to this inspection, yet it failed to identify the concerns we found.
• Quality assurance processes were in place, but they were not effective. We found evidence of some audits taking place, however these were not robust. For example, audits of care plans had taken place just prior to this inspection but failed to identify any of the issues we found.
• The provider had a series of policies in place, but some were out of date and there was no evidence they had been reviewed in a timely manner. One staff member, who was responsible for administering medication, told us they were unsure what the medication policy was used for or where it was kept.
• There was no effective system for analysing, investigating and learning from incidents. This failure meant opportunities may have been missed to identify ways of preventing future incidents, and exposed people to the risk of harm.
• Systems were not in place to ensure people's confidential personal information was kept securely. For example, we found information relating to two service user's health had been left on top of the medication trolley in the communal lounge. We also found staff were using their own personal devices to access people's care records on the day of this inspection, as there were not enough devices available from the provider.

People were at risk of harm as governance systems and processes had not been fully established and operated effectively. The provider failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after this inspection to confirm devices were available in the service for staff to use.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.
• The provider had failed to establish effective systems for gathering views from people and their relatives. People who used the service were not asked to provide feedback about their experience living at the home. For example, we found meetings had not been held with people or their relatives since the start of the pandemic. Satisfaction surveys had recently been left out for relatives, staff and visitors to complete, but people living in the home had not been included in this process. This meant opportunities to improve people's living experience in the home had been missed.

The provider failed to seek and act on feedback from relevant people, for the purposes of continually evaluating and improving the service. This was a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home manager responded after the inspection to confirm meetings with people and their relatives would resume and one would be held soon.

• The management team had undergone further changes since the last inspection. However, staff told us they enjoyed their jobs and the culture in the home had improved since the home manager had been employed. Comments from staff included, "We've had so many managers since I started. Some of them have not been helpful at all and then just gone. [Name of home manager] is more stable", "It's a really lovely home and the atmosphere is really nice", "It's a lovely little home and I enjoy working here" and "It is a positive environment and staff seem happy."

Working in partnership with others; 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 service worked in partnership with relevant health and social care professionals but did not always act on or follow advice. Improvements had been identified by other agencies and the provider was working towards addressing these matters.
• The provider was aware of their responsibilities under the duty of candour requirement.

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the relevant person. Regulation 11 (1)

The enforcement action we took:

We served a Notice of Proposal to vary a condition of the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate risks. Medicines were not being managed safely. Infection prevention control measures were not implemented effectively. Regulation 12 (1), (2) (b) (g) and (h)

The enforcement action we took:

We served a Notice of Proposal to vary a condition of the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were effective systems and processes in place to assess, monitor and improve the quality and safety of the service or to assess, monitor and mitigate risks to service users. The provider had failed to maintain an accurate, complete and contemporaneous record in respect

	of each service user. The provider had failed to seek and act on feedback from relevant persons. Regulation 17 (1), (2) (a) (b) (c) and (e).

The enforcement action we took:

We served a Notice of Proposal to vary a condition of the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough suitably qualified, competent, skilled and experienced persons deployed to meet people's needs safely. Staff did not receive appropriate support, training, supervision and appraisal to enable them to carry out the duties they are employed to perform. Regulation 18 (1) and (2) (a)

The enforcement action we took:

We served a Notice of Proposal to vary a condition of the provider's registration