Ashmore Nursing Home Limited

Ashmore Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Ashmore Nursing Home is a care home providing personal and nursing care for up to 42 older people in one adapted building. At the time of our inspection there were 27 people living in the service.

People's experience of using this service and what we found
We found shortfalls in the management of risks to people's safety and welfare including, oversight of environmental risks, catheter care, wound care and medicines management. Audits in place had failed to identify the shortfalls we found at this inspection. These concerns had not been identified or resolved through any governance process.

Not everyone had a care and risk management plan in place. This meant staff had not been provided with formal guidance as to the care support needed and identify any risk to people's health, welfare and safety.

People were at risk of being supported by unsuitable staff as safe recruitment procedures were not always followed.

We have made a recommendation for guidance to be reviewed to ensure staff wear the correct Personal Protective Equipment (PPE) at all times.

We observed positive relationships between people and staff. There was mostly positive feedback from people and their relatives about staff approachability and good communication. Further work was needed to ensure people isolated in their rooms had sufficient staff to meet their social and emotional needs and planned activities to protect them from the risk of social isolation.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 good (published 19 March 2020).

Why we inspected
We received concerns in relation to staffing, a lack of training, and people left isolated in their rooms leading to a lack of social stimulation. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe 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.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the list relevant key question sections of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to medicines management, risk management and staffing.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Ashmore Nursing 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 (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
The inspection was carried out by two Inspectors and an Expert by Experience who made telephone calls to relatives.

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
Ashmore Nursing Home 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. Ashmore Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 29 September 2022 and ended on 12 October 2022 when we gave feedback.

What we did before the inspection
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 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
During the inspection we spoke with four people who used the service, 14 staff, including the registered manager. We also spoke to 14 family members of people receiving support.

We reviewed ten care records, medicines administration records (MAR) and four staff records. We also reviewed other records, including policies and procedures, and records relating to the quality and safety monitoring of the service.

Requires Improvement

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. The rating for this key question has remained. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Improvements were needed in the quality of risk management plans to ensure clear guidance was provided for staff in how to meet people's needs and reduce risks to people's safety.
- There was a high number of people cared for in bed, but it was not always evident in care plans as to the reasons for this. One member of staff told us, "Some people are left in bed for staff convenience. There are a lack of activities and people are often left isolated in their rooms for a long time."
- People spent significant periods in sedentary positions without mobilising and there were gaps in repositioning records of up to nine hours. The failure to follow risk assessments and ensure that people were assisted to reposition at regular intervals placed people at increased risk of skin breakdown.
- People identified at risk of acquiring a pressure wound had appropriate pressure-relieving equipment in place. However, we found a number of bed rails in a poor state of repair.
- People with a catheter in situ did not always have timely support with catheter changes in line with their plan of care. This meant action had not always been taken to protect people from the risk of blockages, infection and ensure their comfort. There was no management oversight of this.
- People were at risk of inadequate fluid intake. People were observed not to always to have access to a drink. Monitoring records showed for some people intake was low and oversight of this ineffective. There were no clear fluid targets to provide staff with the information they needed to meet people's needs.
- Risks to people's safety associated with access to stairs, risks of scalding from hot water and unstable wardrobes not secured to the wall had not been identified. We found water outlets including baths and shower temperatures exceeding 50c. In response to our findings the provider took action to install thermostatic water valves which would ensure temperatures did not exceed 43c and a weekly system of monitoring. They also secured wardrobes to walls.
- Two people recently admitted to the service did not have a care plan in place. This meant staff had not been provided with formal guidance as to the care support needed and identify any risk to people's health, welfare and safety.
- We found areas of the building including the outside grounds left unsecure. We observed people walking around the building who had easy access to outside spaces and stairs. These risks to people's safety had not been considered.

Using medicines safely

- We were not assured people had received their medicines as prescribed. Where medicines administration records (MAR) in place for prescribed creams and lotions, we found multiple gaps in staff signatures to evidence these medicines had been administered.

● Our stock check of oral medicines identified not all medicines signed for had been administered.
● Where medicines required storage in a fridge, we found significant gaps in daily monitoring of temperatures as required
● There was no system in place as is good practice to record the room temperature where medicines were stored. This meant the provider could not be assured medicines maintained their integrity and had not been impacted by extreme temperature changes. For example, in the case of recent heatwaves experienced.
● We found on two occasions throughout our visit the medicines room was left unlocked with medicines on display. This room was located directly opposite people's rooms and so was easily accessible.
● Nursing staff told us there was no one receiving medicines administered covertly to people who lacked capacity to consent, i.e. within food or drink. However, daily records showed that for some people medicines had been administered covertly in food and drink without authorisations obtained.
● For people who were unable to talk to staff about their pain, assessment tools were not in use. These would support staff in identifying verbal and non-verbal indicators that a person was showing signs of discomfort, so they could give them their painkillers.

In relation to the above shortfalls we found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the management of risk was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Following our feedback the provider told us they have taken immediate actions to ensure improved systems for ensuring health and safety checks in line with HSE guidance on the management of risks within a care setting.

Staffing and recruitment
● We observed staff were visible and responding to call bells in a timely manner. However, some people told us, staff were not always able to spend quality time with them and were rushed at times.
● Time was not considered within staffing allocations to ensure there were enough staff on each shift to support people to have a bath or shower, as and when they required one.
● Comments from relatives included, "They are short staffed sometimes. (Person's relative) is waiting a long time for staff to help. Some days (person's relative)] does not get help with a wash, it can happen quite a lot, staff say they will come back, but don't. We came in last week and (person's relative) had not had a wash and it was 1pm. We left at 4pm but still no one came to provide this support." And, "There is sometimes not enough staff. When I visit (Person's relative) is often still waiting for a wash. Not sure they ever get a bath; the young carers are doing other people and get distracted. They are always busy."
● Further work was needed to ensure people isolated in their rooms had sufficient staff to meet their social and emotional needs including planned activities to protect them from the risk of social isolation. Comments from people included, "I feel so lonely, I wish they (staff) would come and sit with me and talk. They come and go but don't spend time with you." And, "You spend a long time here on your own. I can't get out of bed and I get very lonely at times."
● Improvement to recruitment practices was needed to ensure people are protected from the employment of unsuitable staff.
● Not all references required had been obtained prior to staff starting work, including those from the most recent employer.
● Staff started work prior to Disclosure and Barring Service (DBS) safety checks had been obtained. (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People looked comfortable and had a good rapport with staff supporting them.
● Staff had received training in safeguarding and had an awareness and understanding of abuse and their responsibilities to protect people. They were able to explain what they would do if they had concerns and who to report to.

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.

● People's consent to their care and treatment had been sought but not always in line with best practice when administering medicines covertly. Records lacked detail to show how consent was sought.

Preventing and controlling infection
● Infection prevention and control practices were not consistently applied. Throughout our inspection we observed staff did not consistently wear face masks or had their face mask sitting under their mouth and nose. This increased the risk of infection transmission and did not follow recommended guidance. We recommend guidance is reviewed to ensure staff wear the correct Personal Protective Equipment (PPE) at all times.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Whilst the home was visibly clean, we observed a high number of flies in people's rooms where we found uncovered plates of food. There were also some areas of malodour. Equipment such as wheelchairs, hoists and the underside of commodes were in found in need of cleaning.
● A recent visit to the service from environmental health inspectors resulted in a rating of four out of five stars due to a number of recommendations. Whilst some action to rectify shortfalls had been actioned, further work was needed to ensure food stored in fridges was dated after opening and a sink splashback installed to prevent the risk of cross infection.
● We were not assured that the provider was preventing visitors from catching and spreading infections.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes

● The registered manager was following current government guidance in relation to visiting at the time of the inspection. People and their relatives told us there were no restrictions on visiting.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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; Continuous learning and improving care

- Risks to people as referred to within the safe section of this report had not always been fully assessed and recorded.
- We found shortfalls in the management of risks to people's safety and welfare including, oversight of environmental risks, catheter care, wound care and medicines management. Audits in place had failed to identify the shortfalls we found at this inspection. These concerns had not been identified or resolved through any governance process.

The governance systems in place were not robust enough to independently identify shortfalls and address them. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Staff morale was mixed. Some staff spoke of supportive hands on management support, whilst others said there was a lack of planned supervision and training.
- Staff did not have a personalised development plan which reflected professional development or specialisms linked to their role or the needs of people they cared for.
- Whilst we acknowledge there are various forms of supervision such as group and assessment of competency and knowledge. Care staff did not receive regular staff group meetings, annual appraisal as well as protected and recorded supervision time to have a planned two-way discussion about care practice issues, learning gaps and development needs. The on-going monitoring and assessment of staff helps ensure the effective support of people using the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The majority of feedback about the care and treatment from people and relatives was positive. However, we were not always assured that a positive, person-centred, inclusive approach to care was being achieved. There was greater emphasis placed on meeting people's medical needs. Care records were task focussed.
- There was a system in place for the management of complaints.

Working in partnership with others

● A recent safeguarding investigation had identified further work was needed to improve record keeping. The registered manager told us they welcomed support from the local authority with offers to provide record keeping workshops for staff which they hoped would commence soon.

● In response to our feedback the registered manager told us, "We acknowledge we have let things slip. The COVID-19 pandemic has not helped This inspection is what we needed to get us to refocus. We had already identified a need to improve our record keeping and were planning to put in place an electronic care planning system which we are sure will improve things."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure risks to people were appropriately and accurately assessed and risks to safety and welfare mitigated to ensure care was provided in a safe way. Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were failures to assess, monitor and mitigate risks relating to people's health, safety and welfare. There were failures to maintain accurate, complete and contemporaneous records in respect of each person. 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient staff to meet people's needs. Safe recruitment practices had not always been followed. Staff did not receive supervision, appraisal and support as required. Regulation 18(1)(2)(a)