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

We undertook an unannounced focused inspection of Heathercroft Care Home on 10 January 2018. This inspection was carried out following concerns which had been raised about a specific incident at the home. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led.

Heathercroft is a purpose built care home set in its own grounds in the Woolston area of Warrington. The registered provider is Ashberry Healthcare Limited.

The home provides nursing and personal care for up to 88 older people. There are currently three units within the home: Heathercroft unit for people with nursing and personal care needs; Ashcroft unit for people with nursing needs living with dementia and Ashberry unit for people living with dementia. On the day of our inspection there were 73 people living in the home.

The home does not have a registered manager. The manager in post who assisted with this inspection is applying to be registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection took place on 7 and 8 August 2017. At that inspection we identified six breaches of the relevant regulations in respect of the safe management of medicines, staffing, consent, person centred care, record keeping and governance. We also found that the provider was not always appropriately notifying CQC of incidents. At this inspection, we found that there were some improvements in the safe management of medicines; however the provider remained in breach of five regulations in the safe and well-led domains.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Risks to people were not managed safely and there was no clear guidance for staff on how to reduce the risks identified. There was no oversight or learning from incidents and accidents that happened in the home.

We found instances where safeguarding incidents had not been adequately recorded. Furthermore they had not been appropriately referred to the local safeguarding and related statutory notifications had not been sent to the Commission in a timely manner. There was little managerial oversight of these incidents so there was no learning on how things may be improved or prevented in the future.

There were insufficient staff to meet the needs of the people living in the home. Relatives, people living in the home and visiting professionals all commented on low staffing numbers within the home. Throughout our inspection, call bells were constantly ringing and we saw from records of previous days that these were not always answered promptly meaning that people were at potential risk and not receiving adequate standards of care. The provider had a heavy reliance on agency staff who at times did not attend for their shifts. The provider was actively recruiting for more staff and had addressed the issues with the agency around staff not attending.

We found that there had been some improvements in the management of medication such as medication was being stored and administered safely, but further improvement was required. Where medicines were given covertly, the correct procedures had not been followed, and there was no advice as to how these medications were to be taken and whether this was the most appropriate means of administering the medication.

We found that the provider had ineffective systems to monitor and improve the standard of care provided throughout the home. Whilst we saw that some improvements had been implemented on one of the units, there were serious shortfalls in another unit.

The registered provider did not have an effective quality assurance system in place. Where action plans were in place, it was not always clear to see what progress had been made against these plans. Insufficient progress had been made since the last inspection throughout the home as the systems that were in place had failed to identify the breaches that we found as part of this inspection.

We saw regular checks on the property were undertaken and the premises were safe without restricting people's ability to move about freely.

Recruitment of staff within the home was safe.

Following this inspection, we are taking further action against the provider for repeated and serious failures to meet the regulations. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks to people were not managed safely and there was no clear guidance for staff on how to reduce the risks identified. There was no managerial oversight or learning from incidents that happened in the home.

We found some safeguarding incidents had not been appropriately referred to the local safeguarding team.

There were insufficient staff to meet the needs of the people living in the home and the provider was using agency staff in order to cover staff vacancies. The provider was actively recruiting more staff.

We found that medications were administered and stored safely, however there was room for further improvement in relation to covert medication as the documentation was not in line with the Mental Capacity Act 2005.

Is the service well-led?

Inadequate

The service was not well led.

We found that the provider had ineffective systems to monitor and improve the standards of care provided throughout the home.

The registered provider did not have an effective quality assurance system in place. Where audits had been completed, these had not identified the shortfalls that we found as part of our inspection. Insufficient progress had been made since the last inspection and the provider remained in breach of a number of the same regulations.

We saw that staff and relatives' meetings were being held regularly within the home.

Heathercroft Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check 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.

This inspection took place on 10 January 2018 and was unannounced. The inspection was carried out by two adult social care inspectors.

The inspection was prompted in part by notification of an serious incident following which a person using the service sustained an injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. CQC were aware that the police were also looking into this incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk and staffing. This inspection examined those risks.

Before the inspection, we checked information that we held about the service and the service provider. We looked at any notifications received and reviewed any other information held about the service prior to our visit. We invited the local authority to provide us with any information they had about Heathercroft Care Home. The local authority shared concerns that had been reported to them about the service. CQC had also received concerns raised by whistleblowers.

During the inspection, we used a number of different methods to help us understand the experiences of people living in the home.

We spoke with five people who lived at the home, three relatives and 12 members of staff including the manager, the director for care and quality, a nurse and ten members of care staff. We spoke to a hairdresser and two visiting health professionals.

Throughout the inspection, we observed how staff supported people with their care during the day.

We looked around the service as well as checking records. We looked at five care plans. We looked at other documents including policies and procedures; staffing rotas; risk assessments; complaints; staff files covering recruitment; maintenance records; health and safety checks; minutes of meetings and medication records.

Inadequate

Is the service safe?

Our findings

We asked the people living in the home whether they felt safe. We received mixed feedback from people, with some people feeling safe and others raising concerns about the length of time they had to wait for assistance. We asked one person if they felt safe. They told us "Oh god, aye. They come as quick as they possibly can. They are very good with me". Whereas another person told us, "There is not enough staff in my opinion. They are always busy, not enough staff".

Relatives visiting the home gave us mixed feedback on how safe they felt their family member was. Comments included, "Dad is safe here. No concerns about his care here, they look after him really well", whereas other relatives told us, "Probably not enough staff here. They seem to have things in place now, but there still does not seem to be enough staff" and "The staff are great, there is just not enough of them. Call bells are always going off. If two people are needed to help someone get dressed, there is no-one on the floor. Last week there was only one care assistant and lead on here".

At our last inspection in August 2017, we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that sufficient numbers of suitably qualified, competent and experienced staff were being deployed effectively. At this inspection, we found that the provider remained in the breach of this regulation.

We spoke to staff about whether they felt there were enough staff to keep people safe. We received mixed feedback. Comments included, "There are not enough staff. It's difficult to get people up in the mornings", "Sometimes there are enough staff, but if staff ring in sick, we're short", "Morale is very low due to staffing levels". Whereas other staff told us, "There are enough staff to respond to people" and "There seems to be enough staff to help people at the moment, but we are not full at the moment". Visiting professionals also raised concerns about the staffing numbers in particular on Ashberry's unit.

We observed during our inspection that call bells were ringing constantly throughout the day on Heathercroft and Ashberry's unit in particular. We asked for some random samples of call bell response times. We looked at two days as well as one person's call bell response times over the period of a week. We found on one day that there were seven instances where people waited over ten minutes for assistance. Another day showed that on twelve occasions people had waited over ten minutes for their call bell to be answered, the longest time being 23 minutes and 57 seconds. When we looked at the records for one person, we found for the period 3 to 9 January, they waited over 10 minutes on 18 occasions, the longest instance being 21 minutes. We spoke to staff in relation to the call bell response times and they told us that these were mainly sensor mats that were alerting staff when people at risk had moved within their room or entered another person's room. This is not an effective manner of managing the risk if there are insufficient staff to respond to these alerts. We asked the manager whether there was any oversight or analysis of call bell response times and we were told that was not done at this time.

We observed that there was only one member of staff deployed on the upper floor of Ashberry's Unit on the day of our inspection and that there were 11 people present on the unit on that day. We noted that on a

number of occasions, the staff member was in the kitchen area preparing drinks and the lounge area was unattended. There were also a number of people wandering along the corridors in the unit. We asked whether anyone was at risk of falls, or exhibited behaviour that challenged the service, and we were told that there were some people at risk on the unit, however if anything happened the staff member was to call downstairs for assistance. We spoke to the manager in relation to this and were told that one staff member had left the unit that day without notice and agency staff who had been booked had not arrived at the home. However, staff and relatives told us that this was not the only occasion that this had happened.

We observed in the downstairs lounge of Ashberry's Unit that this was also left unattended for periods. We spoke to staff who told us that someone should be in here at all times as there were people who were at risk of falls and also people who may display behaviour that challenges. We noted in the afternoon of our inspection that the lounge was left unattended for at least seven minutes. During this time, one of the inspectors observed an incident between two people where one had taken the other's walking frame by mistake. One person was very confused and became very unsteady on their feet whilst trying to mobilise without a walking frame whilst the other service user tried to take their walking frame from the other person. The inspector intervened in the incident to help both people regain the correct walking frame. When staff returned, both service users were safely seated.

We looked at previous staffing rotas and spoke to the manager about the dependency tool that they used to calculate the staffing. The home is very large and spread out however the manager advised that the dependency tool did not take account of the environment. When we looked at staffing rotas, it was not clear to see how many staff had been present on each shift as many of the shifts did not have permanent staff. The manager was able to show us emails confirming that agency staff had been requested; however there was no clear records of which agency staff had attended and which unit they had worked on. This made it impossible to see how many staff had worked on each shift for the previous month. The manager advised that they had now implemented a signing in sheet for agency staff, but acknowledged that this was not always consistently filled out.

The above issues constitute a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We met with the provider shortly after our inspection and we were informed that the staffing numbers had been increased in the home following our inspection. These improvements need to be sustained.

At our last inspection in August 2017, we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that medicines were managed safely and where risks to people's health and well-being had been identified, these had not been appropriately managed to reduce the risks to people. At this inspection, the provider continued to be in breach of this regulation.

When we reviewed people's care records we found that risks were not appropriately identified and managed. For example, one person had had three falls in October but their falls risk assessment had not been updated and the care plan evaluation recorded no falls for that month. This person had also experienced weight loss and the care plan indicated that additional food and fluid charts needed to be completed. We saw that the charts on the day of our inspection had not been completed and we also found that they had not been completed on 4, 5, 8, 9 January 2018. The care plan evaluation noted that a referral to the dietician had been requested by a family member; however we could not find evidence that this referral had been completed. The risk assessment in place for eating and drinking recorded this person as being at low risk of malnutrition and when reviewed each month was just signed, there was no evaluation of

the person's current situation and what other action could be taken to mitigate the risk. Another person had lost 10kgs between September and December 2017. The care plan was contradictory mentioning in one place that the person ate independently, in another that they required assistance. We saw bed rails in place for one person, however the bed rails risk assessment was completed in 2016 and stated that bed rails were not required. The sleep care plan had been written in May 2017 and did not mention bed rails but instead mentioned that the person gets ups in the night. We spoke to a member of staff who stated that bed rails had been put in place along with a sensor mat as the person sometimes tried to climb over the bed rails. The risk assessments and care plans did not mention this risk and alternative solutions had not been considered given this risk.

We found in general that where high risks were initially identified in risk assessments, there were not clear actions of what action staff should take to mitigate these risks; however the conclusions of the risk assessments would often then rate the risk as low. They were not adequately reviewed to take account of any incidents or changes in the person's health.

We looked at the accident and incident records in the home. We could see that staff completed an incident form when anything happened in the home; however it was not always clear to see from these forms what action had been taken following the incident. We saw that one person had four falls in October 2017, and two in November 2017. We checked this person's care plan and we found that the section on mobility was completed in October 2015; it had been evaluated but had not been updated since this date. The falls risk management plan was signed each month, but there was no evaluation or analysis. This meant that the provider was not taking all reasonable steps to minimise risks to this person in relation to falls. We asked the manager whether there was any analysis of the accidents and incidents that may identify any trends and patterns in how and when people fell so that preventative action may be taken. We were informed that there was no analysis of these accidents and incidents at present. There was also no opportunity for staff to reflect upon these incidents.

We looked at medication and how this was managed. We could see there had been some improvements since our last inspection, however there was scope for further improvement. We saw both the medicines trolley and the treatment rooms were securely locked and daily temperature checks were made. We observed medicines being dispensed and saw that practices for administering medicines were safe. We checked medicine administration records, which showed people were getting their medicines when they needed them and at the times they were prescribed. We saw records were kept of all medicines received into the home and if necessary their disposal. Controlled drugs were stored securely and in the records that we looked at, these were being administered and accounted for correctly. However we found that one person's medication was being crushed and given covertly. The documentation was not clear whether this was to be given in food or drink. There were no records of a mental capacity assessment or best interest decision recorded to look at whether this was the most appropriate means of administering the medication. Furthermore, it is not appropriate for some medication to be crushed and a pharmacist should always be consulted and there was no paperwork to indicate that a pharmacist had been consulted in this instance.

All of the above issues constitute a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We met with the provider following our inspection to discuss our concerns and we were given additional information in relation to the people we identified as being at risk which gave us satisfactory reassurance that the provider was taking action to address the issues identified. These improvements need to be maintained.

We saw that the provider had a safeguarding policy in place. This was designed to ensure that any safeguarding concerns that arose were dealt with openly and people were protected from possible harm. The manager told us that they were aware of the relevant process to follow and the requirement to report any concerns to the local authority and to the Care Quality Commission (CQC).

The staff members we spoke with told us that they understood the process to follow if a safeguarding incident occurred and they were aware of their responsibilities for caring for vulnerable adults. Staff were aware of the need to report safeguarding incidents both within and outside of their organisation. We saw that the provider had a whistleblowing policy in place. Staff were familiar with the term whistleblowing and each said they would report any concerns regarding poor practice they had to senior staff.

However, we found a number of safeguarding concerns that had not been reported to the local authority or CQC. We saw in two people's care files that a number of body maps had been completed as unexplained bruising or injuries were noted by care staff when completing personal care, but there were no details as to what action had been taken following this. There were no indications that any investigation had been completed to ascertain the cause of these injuries and there was no evidence that these had been escalated or reported to the local safeguarding team.

We saw records in someone's care plan that two safeguarding referrals had been completed in December 2017, however when we checked the safeguarding folder, there was no paperwork to explain what the incidents were or what action had been taken. We found, in one person's care plan, a record that they had been restrained by a staff member, however there was no indication in the care plans that restraint was required and there was no risk assessment in place in relation to this. We asked the manager if the provider had a restraint policy and were told that they did not. We asked for this to be referred through to the safeguarding team. We have received confirmation following our inspection that this has been done and the staff member has been suspended pending an investigation.

We spoke to the manager about the safeguarding referrals and they told us that prior to December, they were unable to account for what safeguarding referrals had been completed. They had now implemented a tracker in order to keep a record of what referrals had been sent and what the outcomes were in order to begin to analyse and take learning from these incidents. The manager stated that staff had been reminded of policies and procedures in recent staff meetings. The manager had also arranged a meeting with the safeguarding team to look at what safeguarding referrals were outstanding in the home to try and improve these systems.

These issues constitute a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We met with the provider following our inspection to discuss our concerns and were given satisfactory reassurances that the provider was taking action to address the issues identified. These improvements need to be sustained.

We looked at the files for three members of staff to check that effective recruitment procedures had been completed. We found that appropriate checks had been made to ensure that they were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Each file held suitable proof of identity, the application form with full employment history, a medical check and references.

Staff members were kept up to date with any changes in people's care during the handovers that took place at every staff change.

We checked some of the equipment and safety records for bath hoists, bed rails and other safety equipment and saw that they had been subject to recent safety checks. We conducted a tour of the home and our observations were of a clean, fresh smelling environment which was safe without restricting people's ability to move around freely.

We could see that a number of maintenance checks were being carried out weekly and monthly. These included the fire alarm system, emergency lighting and water temperatures. We saw appropriate safety certificates were in place for gas, electrical installation and legionella prevention.

The home conducted regular fire drills and staff had regular training on fire safety. We found that the people living in the home had an individual Personal Emergency Evacuation Plan (PEEPS) in place. PEEPS are good practice and would be used to assist emergency personnel evacuate people from the home in the event of an emergency such as a fire.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. The current manager had been in post since November 2017 and was in the process of registering with CQC. They were supported by a director of care and quality as well as a deputy manager.

We spoke to people and their relatives about how the home was run. People we spoke with were generally positive but we did receive comments about staffing levels as discussed in the safe domain of the report. Comments included, "I've not had to raise any concerns but could raise them with the manager", "I've not had to raise a complaint, but when anything is raised, it's been dealt with" and "I raised concerns last summer and they were dealt with. I'm going to speak to the manager today [about an issue]".

Staff morale was low and they told us that they had experienced an unsettled period with a number of staff and management changes. However, they told us that they found the new manager supportive. Comments included, "[Name] has not been here long, but helps out loads", and "[name] has been great".

At our last inspection in August 2017, we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had ineffective systems and processes in place to ensure compliance with the regulations. At this inspection, we found that there were systems and processes in place. However these systems had not been effective at monitoring and improving the service and insufficient progress has been made since the last inspection as we found continued breaches in four regulations and an additional breach. Therefore the provider remained in breach of this regulation.

The new manager had recently introduced a system to track safeguarding incidents but we found incidents within care plans that had not been recorded on this register. The manager acknowledged that they planned to complete analysis of accidents and incidents but they had not been able to do this since being in post. Following our inspection, we were provided with evidence showing that this analysis had been carried out for November and December 2017. We saw evidence that one person had repeatedly fallen and no analysis was carried out to look at whether preventative action could be taken. Audits were being carried out on care plans each month and we could see where actions had been identified that these were being followed up. However we found inaccuracies and inconsistencies in the care plans that we viewed. We saw that where people needed additional monitoring charts where they were identified as being at high risk that these charts were not always being completed contemporaneously and in some cases charts had not been completed for some days. We identified these issues at our last inspection and insufficient progress had been made throughout the home. We saw that medication audits were now being completed and issues raised were actioned and followed up.

The provider had an audit planner to help the manager know when different audits were to be completed, although since the manager was new in post, not all these had been completed. We asked to view the action plan that the provider was working to and we saw that whilst actions had been identified, it had not been populated with any updates on progress.

Whilst we saw some improvement, the systems and processes in place were not effective as we found continued breaches in regulation during our inspection and there had been insufficient progress since our last inspection in August 2017.

The above issues constitute a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in August 2017 we found that the registered provider had failed to submit some statutory notifications to the Commission in accordance with Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. It is an offence not to submit required statutory notifications and the Commission will report on further action in respect of this when it is completed.

Following our inspection, we met with the provider and they provided additional information about their quality assurance systems. The provider also had a quality assurance framework report that should be completed each month as well as a provider visit report that was completed monthly by the director of care and quality. Since the manager was new these had not been completed, in order that the manager had sufficient time to settle in. Weekly management reports were sent to the director of quality and care that documented staffing issues and complaints into the home as well as training, any hospital admissions as well as accidents in the home. We were shown templates of the manager's daily walkaround. These systems need to be fully embedded throughout the service in order to be effective.

We saw on the day of our inspection that relatives' meetings had been held to speak with relatives about the previous inspection as well as the recent media interest in the home following a specific incident. We saw that these meetings were taking place on a regular basis and relatives confirmed that they had chance to discuss their concerns with the manager.

We saw that staff meetings had been held and issues such as documentation, staff sickness, complaints, confidentiality, the action plan, recruitment and staffing had been discussed.

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 Risks to people were not managed safely and there was no clear guidance for staff on how to reduce the risks identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents had not always been appropriately referred to the safeguarding authority or investigated.

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 The provider's quality assurance systems were not effective as they had not identified the breaches that were found as part of this inspection.

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 were insufficient staff to meet the needs of the people in the service.