Ashrana Limited

Cleaveland Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Cleaveland Lodge is a residential care home providing personal and support for up to 54 people aged 65 and over in one adapted building. At the time of our inspection the service was supporting 51 people.

People's experience of using this service and what we found
We found continued shortfalls in the oversight and governance of the service. A chaotic culture of leadership scrutiny failed to identify significant shortfalls in the management of the service. These failings placed people using the service at risk of harm, and significant exposure to the risk of harm.

The registered manger resigned in March 2020 but continued to work as part of the management team on a part time basis. A new manager was appointed in April 2020 but had yet to register with the Commission. The provider's systems for identifying, capturing and managing risks to people's health, welfare and safety remain ineffective.

Risks to people's health, welfare and safety had not always been identified with action taken to reduce the risk of harm. Audits did not identify the shortfalls found as part of this inspection and there continued to be no effective quality and safety monitoring in place to drive improvements.

We were not assured the provider was doing all that was practical to ensure Covid-19 outbreaks would be prevented. The service was not consistently following the Government guidance, about how to operate safely during the Covid-19 pandemic, in areas such as the wearing of personal protective equipment (PPE), social distancing and ensure staff were provided with designated areas for putting on and taking off their PPE.

People's medicines were generally managed well, however not everyone prescribed as and when needed medicines, had a protocol in place to guide staff in monitoring their use. Previous inspections identified the need to implement a pain assessment tool for staff to identify and respond to people who lacked capacity to verbally express if in pain. Whilst a monitoring tool had been put in place staff had not been trained in its use and so it remained ineffective.

We recommended further work was needed to consider safeguarding risks and provide procedural guidance for staff where staff who were related or living in the same household worked on the same shift.

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

Rating at last inspection
The last rating for this service was requires improvement [published 7 February 2020].

At our last inspections in July 2019 and January 2020, we found shortfalls in the management of risk to people's safety. There was continued failure to robustly assess risks relating to the health safety and welfare

of people. We found continued breaches of regulation 12 [Safe Care and Treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 and Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
The inspection was prompted in part due to concerns received about unwitnessed falls and the provider's arrangements for falls management, care and support for people with a catheter and inadequate staffing levels. 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', 'Caring' and 'Well-Led' only.

You can read the report from our last comprehensive, inspection, by selecting the 'all reports' link for Cleaveland Lodge 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 have identified continued breaches in relation to safe care and treatment, recruitment, governance and failure to notify. Immediately after the inspection we wrote to the provider and requested they provide us with urgent information telling us what they were going to do regarding safe care, the management of risks, infection control and ineffective government arrangements.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and 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.

Special Measures
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 means 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 of 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.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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 caring?

Requires Improvement

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Cleaveland Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 completed by two inspectors. The inspectors were supported by and Expert by Experience who made telephone calls to relatives on the 29 September 2020. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Cleaveland House 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 had a manager in post, but they were not yet registered with the Care Quality Commission. This means 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.

What we did before 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.

During the inspection
Due to their complex needs, we were unable to speak with people using the service about their views and experiences. We therefore spent time observing the care and support they received. We spoke with one relative visiting the service and nine members of staff including the provider, management team and senior care workers.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with two members of staff on the 29 September 2020 and nine relatives.

We provided feedback of our inspection findings to the manager on 5 October 2020. We looked at information relating to people's care and support needs, including risk factors, staff training data, and the provider's quality assurance arrangements. We spoke with stakeholders including the local safeguarding authority and quality improvement team.

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 inspections in July 2019 and January 2020, we found shortfalls in the management of risk to people's safety. The provider had failed to robustly assess risks relating to the health safety and welfare of people. This was a continued breach of regulation 12 [Safe Care and Treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 and Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

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

- At this inspection we found systems for assessing and managing the risks to people's safety had deteriorated.
- Not everyone had a care plan in place. Where care records had been produced and risks to people's welfare and safety had been identified, there was a lack of risk management plans with actions for staff to protect people from harm.
- Risk assessments did not reference for example, measures to prevent or minimise the risk of falls occurring, catheter care to prevent infection and prevention of pressure ulcers. There were no moving and handling plans which would describe the equipment in place and how to use it. For example, the use of hoists, a description of the correct sling size to avoid injury as well the care of people who had catheters.
- We identified people with a diagnoses of diabetes. We found a lack of information which would identify what type of diabetes they had and any management plan in place to ensure people's health and wellbeing needs would be met. There was no information which would describe people's medical histories.
- Inspectors asked the manager if there was anyone with a pressure ulcer. The manager told us there was only one person with a grade three wound. This person's care plan made no mention of the pressure ulcer or provide guidance for staff to protect people's skin integrity. We were told by the local authority, that community nurses had identified concerns in the rising number of people acquiring pressure ulcers. They also told us they were visiting the service to treat four people as opposed to the one person the manager had informed us of.
- Staff told us they did not have access to nor had they read any care and risk management plans. This meant staff were not involved in the planning and review of care and did not have access to the written guidance they needed to understand people's needs and actions they should take to avoid the risk of harm.
- Staff told us they did not record the care and support they provided. They said the policy of the provider was that they verbally reported the care and support they provided to senior care staff who then recorded on their behalf in daily logs. This meant there was a risk that vital information would be missed as the senior care on each shift would need to record for all 51 people. In response to our findings the manager told us, this policy was in place because a high number of staff employed lacked the ability to write in English as it was not their first language.

● Risk assessments when in place were brief in detail, contained conflicting information and did not clearly determine the level of risk. They did not reference for example, measures to prevent or minimise the risk of falls occurring and prevent pressure ulcers. There were no moving and handling plans which would describe the equipment in place and how to use it. For example, the use of hoists, a description of the correct sling size to avoid injury as well as catheter and continence care aids.
● We were provided with the manager's fall and incident analysis. However, this failed to identify trends with action described as to steps to reduce the risk to people from falls, skin tears, chest and urine infections and Covid-19 outbreak experienced in the early stages of the pandemic.
● Following incidents where people sustained injuries from falls, we were not assured the provider had taken action to fully explore all safeguarding concerns in order to implement required learning.

The provider continued not to robustly assess risks relating to the health safety and welfare of people. This was a continued breach of regulation 12 [Safe Care and Treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 and Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Preventing and controlling infection
● A review of the infection control and prevention measures found significant shortfalls in steps taken to protect people from acquiring Covid-19.
● We were not assured that the provider was using PPE effectively and safely. We observed staff not following NHS and Government guidance in the wearing of PPE. Staff wore masks around their necks whilst not observing socially distancing measures. Designated changing areas to enable staff to change and dispose of their PPE safely had not been provided with signage in place to guide staff as stated in the providers own policy.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. For example, hygiene guidance had not been implemented to guide staff in protecting people from the risk of cross contamination when emptying commodes and the disposing of urine and faeces. We found a lack of hand sanitiser throughout the service, including bathrooms and staff toilets. Bars of soap were found in bathrooms for general use, which posed a risk of cross contamination. Bathrooms contained commodes with significant amount of rust on them which posed a risk of harbouring bacteria.
● Consideration had not been given to layout of the premises to ensure social distancing. For example, in the layout of seating as people crowded in dining rooms, lounges and corridors.
● We were not assured that the provider's infection prevention and control policy was robust and steps to protect people in place as described. The provider's policy stated an infection control lead person would have oversight of the service. The manager told us no one had been appointed to this role. The manager also told us there were no infection control audits carried out which would have identified the shortfalls we found at this inspection.
● There were no care plans or risk assessments in place which would guide staff as to any infection control measures in place for people and staff most vulnerable from acquiring Covid-19.
● We were assured that the provider was accessing testing for people using the service and staff.

Effective arrangements were not in place to mitigate risks for people using the service. The continued lack of oversight and risk management systems in place demonstrated a continued breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Staffing and recruitment
● Staffing rotas reviewed for the last month did not reflect the numbers of staff on duty. We found incorrect information as to who was responsible for the day to day management of the service. For example, the rota

recorded the management team each worked 13 hours per day over seven days each week. However, the manager told us the management team did not have specified working hours. They said, "I come in some days but not others. We don't have set working days or hours. When we [the management team] are not here a senior care staff will cover."

● We were not assured sufficient staff were available to meet people's needs. During our visit we observed additional staff to those specified on the rota arriving for work. Staff told us this was at the request of the manager upon arrival of inspectors. This increased the numbers of staff available in addition to those we had been told by the manager were needed.

● At our last inspection we recommended the provider put in a place a needs-based system of assessment to determine, and regularly review the numbers and skills of staff needed to meet the changing needs of people. The local authority had also identified this as a shortfall and had provided examples of tools to enable the provider to implement this system. The manager told us, "We decided not to take this forward and put one in place as we have been told by other homes manager's they are not worth the paper they are written on."

We found no evidence that people had been harmed however, the manager was unable to evidence how dependency levels were considered in determining staffing levels. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were not assured the provider operated a robust, open and transparent system to ensure staff employed were of good character, had the skills and experience they needed to meet people's needs and keep them safe. A review of the three most recently employed staff showed us references had not always been obtained from the previous employer in accordance with the provider's policy.

● We found gaps in employment history had not been explored. In the recruitment of two staff, references claimed to be from the most recent employer, we found paragraphs of duplicate wording which had been copied and pasted from one reference to another. This meant we were not assured a transparent recruitment process had been followed.

This demonstrated a breach of Regulation 19 [Fit and proper persons employed] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Using medicines safely

● A review of Medicine Administration Records (MAR) found people's routine medicines in tablet form tallied with the stock for all but one person. This confirmed people were receiving their medicines as prescribed by their GP.

● People's medicines were generally managed well, however not everyone prescribed as and when needed medicines, had a protocol in place to guide staff in monitoring their use. The manager told us this would be rectified immediately.

● Previous inspections identified the need to implement a pain assessment tool for staff to identify and respond to people who lacked capacity to verbally express if they were in pain. We found only blank forms attached to MAR records. When staff were asked to describe how they would use this tool to assess people's needs for pain relief, they and the manager said they did not understand how to use it. In response to our feedback the manager told us they had organised for external training to be provided to staff in the use of this pain assessment tool.

Systems and processes to safeguard people from the risk of abuse

● Staff told us that they had undertaken on-line training in safeguarding and described what action they should take in response to any concerns.
● We noted from a review of staffing rotas a number of staff who were related and or living in the same household who worked on the same shifts. It was evident from our feedback to the manager there had been a lack of consideration as to any potential conflict of interest and safeguarding risks.

We recommend further work was needed to consider safeguarding risks and provide procedural guidance for where staff were related or living in the same household and who worked on the same shift.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● There were widespread serious shortfalls in the service provided to people which meant that their immediate needs, safety and wellbeing did not benefit from a caring culture. Further work was needed to imbed a culture of caring throughout the service. Staff were not provided with enough information about people's life history, health care conditions and preferences in how they wished their care and treatment to be provided.
● People's life histories had not been assessed with information and guidance provided. Where people were unable to verbally express their needs there was a lack of guidance which would instruct staff to look for body language that would indicate pain or to interpret facial expressions. This meant people were at risk of not having their needs met and their rights to making their own choices respected.

Ensuring people are well treated and supported; respecting equality and diversity;
● There was a lack of planning and guidance in how to support people in a personalised way.
Care plans for the high number of people who had little or no verbal communication, contained little or no information to guide staff in meeting their social and emotional needs.
● Where people expressed distressed behaviours there was a lack of management plans to guide staff in supporting people in a dignified, respectful manner. People were often referred to as 'aggressive' and 'argumentative'.
● We noted one person's care plan stated, '[Person] practices a religion' but did not state what and, how to support this person to express their spirituality as they may wish to do so.

Respecting and promoting people's privacy, dignity and independence
● Care was not always person centred and, while we observed some caring interactions, we also observed a staff team focused on the completion of tasks. Feedback from the management team suggested this may be due to care staff limited command of the English language hindering conversation.
● People and their relatives were not involved in the planning of their care. One relative told us, "I have power of attorney, but I've not been involved in any discussions as to any care plan. I am not kept informed as to what is going on."
● Relatives told us they had not been kept informed and updated as to the wellbeing of their loved one. Some relatives said they had not been informed as to any policy on visits to the service during the pandemic. Comments from relatives included, "Even if the manager could schedule a call once a week with or without [person's relative] I would know how they are getting on. That would make for better communication and help ease the pain of not being able to visit much easier to cope with." Another told us,

"We have found them [staff] very accommodating in the past. They have a good garden. It could be used as a place to access visits rather than sitting in the car park."

● We noted the provider's policy on visits to the service during the pandemic stated, 'Family members are kept fully informed of the changing situation. The manager will provide information that meets the communication preferences of people and staff and will make the use of literature in a format that meets people's needs.' We were not provided with evidence that action had been taken to provide information in a format which met the high number of people with complex communication needs living at the service.

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 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.

At our last inspections in July 2019 and January 2020, we found the providers quality assurance arrangements were not consistently applied or were ineffective. Governance systems had not been used effectively to identify, capture and mitigate risks to the health, safety and welfare of people using the service. These failed to identify significant concerns relating to the standard of care, monitoring of people at risk of falls, catheter care, pressure ulcer prevention, diabetes management and infection prevention control in a pandemic.

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

- We were not provided with reassurance that lessons have been learnt from previous investigations and findings from previous inspections. We found continued shortfalls in the oversight and governance of the service and a chaotic culture of leadership, which did not ensure the delivery of quality and safe care.
- The previous registered manager had de-registered in March 2020 but continued to work in the service on a part time basis. This is a family run service and management of the service had transferred from one family member to another.
- The current manager had not yet registered with the Commission. There was a continued failure to implement systems to ensure effective quality and safety monitoring of the service. The manager demonstrated a lack of understanding of fundamental standards and the principles of good quality assurance and planning for improvement.
- There was a continued failure to implement systems to ensure analysis of falls, pressure ulcers and outbreak of infections and to analyse themes and trends with action plans to reduce the risk of harm.
- Where people told us incidents and accidents had occurred, these had not always been recorded with actions taken to mitigate further risk of harm. Monitoring systems had not ensured concerns about people's care and exposure to the risk of harm were responded to. Failure to have effective systems to respond to feedback prevented prompt, effective action and improvements being made as to how the service was run and the quality of care people received.
- Following our feedback, the provider took the decision to re-instate the previous registered manager

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

- We found 13 incidents of falls in August and September 2020 where people had fallen and sustained

injuries. One incident resulted in one person sustain and injury with admission to hospital. The manager had failed to notify CQC of these incidents as required by law.

This demonstrated a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

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

● Relatives including those with lasting power of attorney for health and welfare told us there was often a lack of communication to inform them of falls and changes to people's wellbeing. One relative told us, "There is no communication you have to phone them to find out how [named relative] is doing. We are not able to visit with this Covid thing, and so better communication would be useful. [Relative] says they are happy but are not stimulated enough. We are trying to find another home." Another told us, "[Relative] has had a couple of falls at the home, at least two falls, which I didn't find out about until we phoned."

Continuous learning and improving care

● The overall management of the service did not ensure it was consistently well-managed with effective oversight and governance.

● There has been repeated breaches of regulations and the provider has failed to learn and put effective measures in place to monitor the quality and safety of the service.

● As described in the 'Safe' section of this report, there was evidence to demonstrate a continued failure by the management team to ensure people using the service were safeguarded against the risk of harm.

Working in partnership with others

● The provider was aware that changes needed to be made at the service and had previously received support from other organisations such as the local authority quality team and the prosper project which is a scheme to reduce hospital admissions. However, we found advice and tools to support improvement had not been implemented to ensure improvement to the quality and safety of the service.

● Since our inspection we have contacted commissioners and additional support has been offered to the service to help drive the improvements needed. This has been well received by the new manager. For example, infection prevention and control training support has been arranged via the clinical commission group and the local authority quality team are providing support with improving care planning and risk management.