A Carnachan

Ashford Lodge 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
Ashford Lodge Nursing Hone residential care home providing nursing and personal care to up to 20 people. The service provides support to people living with dementia, older and younger adults. At the time of our inspection there were 8 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

The provider had failed to ensure staff completed training to know how to interact with people who have a learning disability. This became a legal requirement in July 2022.

Since the last inspection a new management team had taken over, although some improvements were in place further improvements were required to ensure people always received safe care. Medicines were not always safely managed. Risks to people's safety were not always effectively assessed or mitigated. Staff were not always safely recruited.

New policies and governance processes were in place but were not always effective at recognising risks to people's safety.

People were protected from the risks of infection. There were enough staff on duty to meet people's needs in a timely manner. 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. People's outcomes of their care had improved since the last inspection.

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 inadequate (published 24 August 2022). At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended the provider review their deployment of staff to ensure people received care in a timely manner. At this inspection we found improvements had been made.

Why we inspected

We received concerns in relation to the safety of the care people received. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. 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 inadequate to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
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 safety, governance and staff recruitment at this inspection.

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 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.

Ashford Lodge 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.

Inspection team
This inspection was carried out by 2 inspectors.

Service and service type
Ashford Lodge 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. Ashford Lodge 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 not a registered manager in post. There was a new management team who were employed on a consultancy basis and were preparing to apply to register with CQC as a new provider under a new legal entity.

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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We reviewed care plans and records of care for all 8 people. We reviewed multiple medicine administration records, governance records and 3 staff recruitment records. We spoke with 2 people. We spoke with 6 staff, including care staff, a nurse and the management team.

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 inadequate. At this inspection the rating has changed to requires improvement. 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.

At our last inspection the provider had failed to implement systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Using medicines safely

- Medicines were not always safely managed.
- People had not always received their medicines as prescribed. One person had been prescribed a medicine cream 18 days before the inspection, we found this was not in stock in the building so had not been applied.
- Another person was prescribed a medicine twice a day but had only taken this medicine once between 31 October and 17 November 2022. There was no recorded reason for this omission.
- Where people may have needed to take their medicines without their knowledge, known as 'covert medicines', the provider had failed to follow best practice guidelines by not seeking pharmacist instructions on how to safely support people to take these. This means there was a risk that staff could mix people's medicines with food that affected how the medicines worked.

Assessing risk, safety monitoring and management

- Risks to people's safety were not always safely managed or monitored.
- One person required staff support to move to prevent them developing sore skin, known as 'repositioning'. The records of this person's repositioning did not demonstrate they were regularly repositioned. Some records showed the person was not supported with repositioning for days at a time. However, this person had not developed sore skin so was considered to be an issue with recording rather than the care provided.
- One person had healthcare professional advice about how to ensure they were comfortable and safe in a chair. We saw this advice had not been followed. However, the person did not appear to be uncomfortable during the inspection.
- Where people had wounds to their skin, the provider had not ensured best practice guidelines were followed to document the wounds. This meant staff were not able to effectively assess if the wounds were healing or deteriorating.
- One person had contradictory entries in their care plan advising staff to use different levels of support for

moving and handling. For example, one record stated they required a hoist, another stated they could walk with support. This meant that staff may not have known the best way to support this person.

Learning lessons when things go wrong
● Where people had accidents there was not always an investigation or record of how to prevent the same thing happening again.
● One person had sustained 4 skin tears in 7 weeks. The provider had failed to investigate how these happened or put in place any measures to prevent the same thing happening again.

The provider had failed to implement enough improvement in medicine management, risk management and accident investigation. This placed people at risk of harm. This was a continued breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection we found people who required medicines 'as and when required' [PRN], there was not always guidance in place to inform staff how and when people should take these medicines. Improvements had been made and these were now in place.
● At the last inspection we found many areas of the home were unsafe, there were cluttered rooms, frayed and loose carpets causing a trip hazard and exposed wires in holes in the wall. At this inspection we found the environment had been made safe.
● At the last inspection we found some people had lost weight. At this inspection we found there were improvements. All of the people living there had either gained or maintained their weight.

After the inspection the provider confirmed they had completed moving and handling reviews on all people to ensure there was clear guidance in place. They also assured us they would ensure medicine management and wound recording was improved. They had purchased a camera to ensure wounds could be photographed.

Staffing and recruitment
● Staff were not always safely recruited.
● One staff member had been working independently in the home without pre-employment checks such as criminal records checks, previous employer references or an interview.

The provider had failed to always operate safe recruitment. This was a breach of regulation 19 (Fit and Proper Person's Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we recommended the provider review their deployment of staff to ensure people received their care in a timely manner. The provider had made improvements.

● There were enough staff on duty, deployed safely to meet people's needs in a timely manner.
● Other staff had been safely recruited.

Preventing and controlling infection
● At the last inspection we found infection prevention and control was not always safely managed. At this inspection we found improvements had been implemented.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● 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.

Visiting in care homes
● The provider had ensured people could spend time with visitors and there were no restrictions on this. Safety measures were in place, visitors were provided with PPE and had access to COVID-19 testing.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse.
● The provider did make referrals to safeguarding professionals and their contact details were available to staff.
● Staff completed training in safeguarding to recognise signs of potential abuse.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● The new management team were in the process of reviewing MCA and DoLS records and preparing updated applications.

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 inadequate. 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.

At our last inspection the provider had failed to ensure effective governance and leadership. This was a continued breach of regulation 17 (good governance) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Systems for identifying and capturing risks to people's safety were not always effective.
- Since the last inspection there had been a change of management. There was no registered manager in post, but a company had signed a management agreement with the provider and were preparing to apply to register with CQC .
- The audit system implemented since the last inspection did not always identify where care was unsafe. For example, the medicines audit had not identified the issues reported above.
- The accident and incident audit did not identify themes and trends so was not used to drive forward improvements in care. Records for people being repositioned to prevent sore skin were not reviewed.
- At the last inspection we found that staff did not complete training in caring for people with learning disability. This became a legal requirement in July 2022. At this inspection we found this was still the case. There was a person with a learning disability living at the home.

The provider had failed to ensure systems were used effectively to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- People's outcomes from their care had improved since the last inspection. There were more person-centred activities that kept people engaged and happy.
- The environment had been de-cluttered, and areas of the home had been opened up for people to enjoy.
- The management team had further plans for improvements including a new care planning system. These were in progress but not yet used in practice as staff were completing training in using the new systems.

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 provider was working in line with the duty of candour. Where people had accidents these were

discussed with people and their relatives.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People, relatives and staff were involved in the ongoing improvements.
- When the new management team had come into the home they held meetings with people and their relatives and listened to their concerns. When changes were implemented people, staff and relatives were asked to give feedback about how well they were working.
- The new management team worked openly with external professionals, commissioners and CQC. They shared weekly updates on the progress of improvements and sought feedback.

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	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to always operate safe recruitment.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to implement enough improvement in medicine management, risk management and accident investigation. This placed people at risk of harm.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems were used effectively to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

warning notice