Mrs Manny Wragg

Ashlands Care 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
Ashlands Care Home is a residential care home providing personal care to 20 people aged 65 and over at the time of the inspection. The service can support up to 30 people. The service is in an extended two storey detached building, converted and adapted to provide care both for people with dementia and older people.

People's experience of using this service and what we found
Risks to people in relation to their personal care were not always managed safely. PPE (personal protective equipment) was not always readily available throughout the building. Some areas of the home environment were not able to be effectively cleaned due to damage to surfaces. This put people at risk of preventable spread of infection.

The provider did not consistently assess, monitor and mitigate the risks in relations to the health, safety and welfare of people. Audits of the quality of care were not consistently effective at identifying or rectifying issues. The provider did not ensure that people were as fully involved as they could be in designing their care and support. People's care plans and associated documents did not demonstrate that people and their relatives had been consistently involved in developing and reviewing care.

The provider was aware of the requirement to notify CQC of certain incidents, but our records showed that these notifications were not always sent in as required. The provider had not provided CQC with an up to date statement of purpose.

People and their relatives felt the service was safe. Relatives spoke positively about the caring attitude of the staff team. Staff understood how to recognise and report concerns or abuse. There were enough staff to keep people safe. People received their prescribed medicines safely. We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Accidents and incidents were reviewed and monitored to identify trends and to prevent reoccurrences.

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 1 April 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
We received concerns in relation to medicines management, food and fluids monitoring, pressure area care and monitoring and how safeguarding was managed. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained the same. This is based on the findings at 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.

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

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

We have identified breaches in relation to regulations. Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the 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.

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.

Ashlands Care 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 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 carried out by one inspector and one expert by experience. 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
Ashlands Care Home 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 registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and the local clinical commissioning group about the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and

improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

During the inspection we spoke with one person who used the service and observed how care and support was given generally. We spoke with three care staff, the deputy manager and the registered manager. We looked at a range of records including five people's care records and how medicines were managed for eight people. We also looked at staff training, and the provider's quality auditing system. During the inspection visit we asked the provider to give us additional evidence about how the service was managed, which they sent to us.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

- Risks to people in relation to their personal care were not always managed safely.
- For example, one person's mobility plan said they always needed staff support in the garden. Staff confirmed the person needed support at all times when using the garden to ensure their safety. However, a related risk assessment did not specify this, and the person had left the premises on several occasions without staff being aware. This put the person at risk of harm, as staff did not have consistent information on supporting them to remain safe.
- The same person was at risk of not having enough to eat and drink. Staff told us the person was dependent on staff prompting the person to eat and drink regularly. The person's care plan did not reflect this. There was a risk staff would not consistently know they needed to remind the person to eat and drink, putting the person at risk of dehydration and malnutrition.
- Another person was at risk of dehydration and was on a special diet for diet-controlled diabetes. The care plan for nutrition and hydration did not instruct staff to take action if the person's fluid intake fell below what they required. This put the person at risk of becoming dehydrated and staff not seeking medical advice in a timely way. There was no information to guide staff on what specific foods the person needed to maintain health in relation to their diabetes. This put them at risk of harm from poorly managed blood sugar levels.
- A third person's care plan for maintaining skin integrity did not tell staff how to ensure skin round the person's catheter site should be monitored. The same plan also failed to document what pressure relieving equipment the person was using. This put the person at risk of skin breakdown.
- One person did not have an up to date care plan to inform all staff about their communication needs. Staff told us the person's verbal communication had deteriorated, and they now needed to offer choices in a specific way to help the person make decisions. Staff also told us about the person's non-verbal communication and what it meant. However, this was not documented in care plans for all staff to support and understand the person consistently. There was a risk the person's needs and wishes would not be recognised.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- People and their relatives felt the service was safe. Staff understood how to recognise and report concerns or abuse. Staff received training in safeguarding and felt confident to raise concerns.
- The registered manager and deputy manager reported any allegations or abuse to the local authority

safeguarding team. The provider had policies on safeguarding people from the risk of abuse and whistleblowing, and staff knew how to follow these.

Staffing and recruitment
● There were enough staff to keep people safe. People told us there were enough staff to support them when they needed this. Staff felt there were enough of them to provide care in a timely way.
● The registered manager reviewed staffing levels regularly, and, when necessary, increased staff numbers to ensure people's needs were met. Our observations during the inspection showed us that people were supported by enough staff. This included when people needed support to eat, needed reassurance, or wanted to participate in activities.
● Staff told us the provider undertook pre-employment checks to help ensure prospective staff were suitable to care for people. Additional evidence from the provider confirmed this. The provider ensured staff were of good character and were fit to carry out their work.

Using medicines safely
● People received their prescribed medicines safely. Staff received training about managing medicines safely and had their competency assessed. Staff told us, and evidence showed that overall, medicines were documented, administered and disposed of in accordance with current guidance and legislation.
● People received their 'as and when' (PRN) medication when they needed it. There was guidance in place for people's PRN medicine which told staff when this medication was needed.
● Each person's medicines records had key information about allergies and how people liked to be given their medicines. The system for managing medicines ensured people were given the right dose at the right time.

Preventing and controlling infection
● PPE (personal protective equipment) was not always readily available throughout the building, particularly where one person was being cared for in isolation following a move into the home. We were assured that the provider was using PPE effectively and safely.
● Some areas of the home environment were not able to be effectively cleaned due to damage to surfaces. For example, the upstairs bathroom flooring was not sealed. This put people at risk of preventable spread of infection.
● We were assured that the provider was preventing visitors from catching and spreading infections. We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service. We were assured that the provider was accessing testing for people using the service and staff. We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● 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.

We have also signposted the provider to resources to develop their approach to ensuring good stocks of readily available PPE for staff.

Learning lessons when things go wrong
● Accidents and incidents were reviewed and monitored to identify trends and to prevent reoccurrences. We saw documentation to support this and saw where action had been taken to minimise the risk of future accidents. Learning from incidents was shared with staff to improve care.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

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

- Audits of the quality of care were not consistently effective at identifying or rectifying issues. For example, two people's plan audits identified a number of areas where work needed to be undertaken but did not identify who was responsible for addressing the outstanding actions in a timely way. Care plans that had insufficient information for staff to follow, or inconsistent information were not identified in audits. There was a risk that poor quality care or inaccurate recording would not be identified quickly and put people at risk of harm from an inconsistent approach to their personal care.
- The provider did not consistently assess, monitor and mitigate the risks in some areas in relation to the health, safety and welfare of people. For example, people at risk of dehydration did not have robust care plans for staff to follow. This put people at risk from dehydration through inconsistent support from staff.
- The provider's action plan, last updated in July 2021, was not effective at ensuring people's care plans and risk assessments reflected their changing needs. For example, one person's ability to recognise the need to eat and drink had deteriorated. They were dependent on staff to prompt and monitor their food and fluids and to check their weight monthly. The action plan said people's weights needed to be monitored more closely. However, the person had not been weighed since May 2021, and their care plan had not been updated to reflect their increased risk of dehydration and malnutrition. This put the person at risk of undetected weight loss and illness associated with lack of good nutrition and dehydration.
- The provider's action plan did not incorporate feedback from people, relatives or staff. It was not clear how the provider would demonstrate that everyone's feedback about the quality of care was important in driving improvements.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was aware of the requirement to notify CQC of certain incidents, but our records showed that these notifications were not always sent in as required. For example, notifications in relation to abuse or allegations of abuse were not submitted. This meant the provider was not informing us about events that occurred in the service which assist us to monitor the quality of care.
- The provider had not provided CQC with an up to date statement of purpose. A statement of purpose describes what the provider does do, where they do it and who they do it for. Providers must notify CQC of any changes to their statement of purpose and ensure it is kept under review and notify CQC when there are

any changes. We asked the registered manager to ensure the provider updated their statement of purpose and notified CQC of this, but the provider has not done this.

● The provider was displaying their ratings from the previous inspection as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a registered manager in post. They and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

● The provider had carried out some audits which were effective in identifying areas where care needed to improve. For example, using feedback from a recent clinical commissioning group visit, audits identified areas in cleaning and infection control which required improvement. We saw action had been taken to improve cleaning standards. The provider had also taken action to improve medicines management following the clinical commissioning group visit.

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 provider did not ensure that people were as fully involved as they could be in designing their care and support. People's care plans and associated documents did not demonstrate that people and their relatives had been consistently involved in developing and reviewing care.

● Relatives said they were aware of people's care plans, but said they were not involved in designing or reviewing care. One relative said, "I haven't had a survey or questionnaire, nothing formal like reviews - it's only in conversations when I phone that they may ask if I'm happy with how things are going." Relatives also acknowledged the coronavirus restrictions on visiting care homes meant they did not have as much opportunity to be involved in their family members' care since March 2020.

● Relatives spoke positively about the caring attitude of the staff team. One relative said, "The staff are very caring. The regular staff know them and because of the quality of care they get their mental health has improved since they have been there."

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 management and staff team understood their roles and were open and honest during our inspection.

● The management team were aware of the duty of candour, which sets out how providers should explain and apologise when things have gone wrong with people's care.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people in relation to their personal care were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not consistently assess, monitor and mitigate the risks in relations to the health, safety and welfare of people. The provider's action plan, last updated in July 2021, was not effective at ensuring people's care plans and risk assessments reflected their changing needs. Audits of the quality of care were not consistently effective at identifying or rectifying issues.