Nationwide Healthcare Limited

Ashwood Lodge Care Home

Inspection report

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25 January 2023

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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

About the service
Ashwood Lodge Care Home is a residential care home that provides accommodation and personal care for up to 25 people. Some of the people were living with dementia. At the time of our inspection there were 18 people using the service.

People's experience of using this service and what we found
The provider had taken the decision to close the home. The communication of the intended closure of the home was badly managed. People and staff told us they did not know what was happening and had been given very little information.

The home was not well maintained, which meant it was difficult to sustain infection prevention and control (IPC) measures. Adequate plans to keep people safe in the event of a fire were not in place. The Fire Service had recently inspected the home and found a number of safety issues which resulted in an enforcement notice being issued. The provider had implemented an agreed action plan to reduce the risks.

The management of people's weight loss was not effective. Food required to support people with a fortified diet was not readily available. Malnutritional universal screening tool (MUST) were not used to assess people's needs in relation to diet and maintaining a healthy weight.

Medicine management was unsafe. Contingency plans had not been put in place for the re-ordering of medicines. Protocols for PRN 'when required' medicines were not always in place or lacked detail.

Permanent staff were recruited safely. The home did not have safe procedures for the use of agency staff. Protocols for checking the identity of agency staff and the completion of an induction was not in place.

The provider did not have robust quality assurance processes. Systems were in place to investigate safeguarding matters. Staff had completed safeguarding training.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was good (published 16 September 2019).

Why we inspected
We received concerns in relation to people's care and support. 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 good to inadequate 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.

Due to the shortfalls found during the inspection the provider was requested to produce an action plan detailing what action and by when that they would address the issues identified.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, the assessment and mitigation of risk and the management of the home.

Please see the action we have told the provider to take at the end of this report.

Follow up
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 will mean 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 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.

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 well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

Ashwood Lodge 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
2 inspectors carried out this inspection.

Service and service type
Ashwood Lodge Care 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. Ashwood Lodge Care Home is a care home without 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.

The registered manager had recently left the home. The provider had employed the services of a management consultancy firm to support in the running of the service and the closure.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 18 January 2023 and ended on 27 January 2023. We visited the home on 18 and 25 January 2023.

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 professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people about their experience of the care provided. We spoke with 12 members of staff including the interim manager, the managing director of the consultancy firm, 3 seniors, a cook, 5 care staff and the nominated individual.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at the care records of 4 people, a sample of medicines records and other records related to the management of the home.

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 changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Risks to people were not always identified and mitigated. Risks associated with certain health conditions had not been managed to ensure people remained safe.
• The home did not ensure assessment tools were used effectively. Malnutritional universal screening tool (MUST) were not used to assess people's needs in relation to diet and maintaining a healthy weight.
• Guidance from external health care professionals was not always followed. Information to support people to remain safe with their dietary needs had not been passed to kitchen staff. Food to supplement people's diet was not always available.

We sought assurances from the provider in relation to people's weight management and to ensure foods used to fortify people's meals were purchased.

• Effective plans to keep people safe in the event of a fire were not in place. The Fire Service had recently inspected the home and found a number of safety issues which resulted in an enforcement notice being issued. Due to the decision to close the home by the provider, an agreed action plan was put in place to reduce the risks.
• Evacuation guidance held inaccurate information which if staff had followed would have placed people at risk of harm.

The provider failed to ensure care and treatment was provided in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Medicine management was unsafe. Contingency plans had not been put in place for the re-ordering of medicines. The registered manager was responsible for ordering medicines, they had left the home and no systems had been put in place for future ordering.
• Protocols for PRN 'when required' medicines were not always in place. Information to support staff in recognising when people might need their medicine lacked detail.
• Medicine administration records (MARs) contained inconsistencies which had not been recognised and managed. Changes recorded on MARs did not always have a supporting record from the prescribing healthcare professional.
• Gaps in recording of Topical Medicines Application Records (TMARs). The application of topical medicines was not always recorded. Therefore, we could not be assured creams were being applied as prescribed.

We found no evidence people had been harmed however, systems and processes were either not in place or

not robust enough to demonstrate safe medicines management. The failure to ensure safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• Infection prevention and control (IPC) was not always safely managed. The local NHS IPC nurse had conducted an inspection and had raised concerns. The home was currently working with that team to address the issues identified.
• Areas of the home were tired in appearance. An action plan was in place however due to the decision to close the home by the provider elements of the plan had not been completed.
• Equipment was worn. In a bathroom, paint was flaking off a hoist base exposing rust, which meant it was difficult to clean and apply IPC measures effectively.

Staffing and recruitment
• The home did not have safe procedures for the use of agency staff. Protocols for checking the identity of agency staff and the completion of an induction was not in place. The provider produced new documentation to be completed when agency staff were deployed.
• Staff had been recruited safely. The home conducted pre employment checks including obtaining references from previous employers and Disclosure and Barring Service checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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).

• The home was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse
• Systems were in place to investigate safeguarding concerns. Staff had completed safeguarding training. Safeguarding concerns were investigated and reported to the appropriate authorities.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

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

- The home lacked leadership. Leadership arrangements in the absence of the registered manager were inadequate. The provider had employed the services of a management consultancy for two days per week and the nominated individual was responsible for the rest of the time. The nominated individual lacked knowledge about the running of the service and was not able to produce a number of documents we requested. Contingency plans for the ordering of medicines had not been put in place.
- Systems for the ordering of food and the requesting of agency staffing were not robust. The provider failed to recognise these failures. We had to seek assurances from the provider that enough food was ordered, and appropriate staff were deployed, ensuring people were safe.
- The provider did not ensure it had oversight of the home. Following interventions by the Fire Service, NHS IPC nurse and Local Authority the provider was asked to produce a number of action plans, outlining how the home was to improve and be safe. The provider had failed to recognise these failures.

The provider did not have effective systems in place to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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 did not demonstrate an open and honest culture. The closure of the home was communicated in an inappropriate and unorganised manner. People living at the home were told of the closure two days after staff and relatives. No consideration was given to how the information was given to people and if they might wish for a friend or relative to be present for support.
- People and relatives were given very little information about the closure. People were distressed and concerned about how they would be moved to new homes.
- People and relatives were not provided with any written information until the Local Authority issued a letter outlining the support on offer for people. Staff repeatedly told us they did not know what was happening with their jobs.

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

• Staff ensured people received person centred care. Staff supported each other and offered a continuity of care for people.
• The provider understood their legal requirement to notify the CQC of certain accidents, incidents and events. The home had submitted the required statutory notifications to CQC.

Working in partnership with others
• The provider worked with external healthcare professionals; however, information was not always included in care plans.

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 The provider failed to ensure care and treatment was provided in a safe way. Medicines were not managed safely. Regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor and improve the quality and safety of the service. Regulation 17