Prime Life Limited

Stoneygate Ashlands

Inspection report

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Date of inspection visit:
07 June 2022
16 June 2022

Date of publication:
19 July 2022

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

Stoneygate Ashlands is a purpose-built residential care home for up to 37 older people, including people living with dementia. At the time of the inspection, the service was supporting 31 people.

People's experience of using this service and what we found
Staff deployment did not consistently meet people's individual care needs. This had impacted on the length of time people had to wait for assistance. People repeatedly told us this caused them frustration and distress.

The provider's systems and processes were not fully robust or effective in taking action to make improvements. There was no current action plan to drive forward improvements. Care documents were not accurately maintained. This raised concerns about management, leadership and oversight.

The service was not always person centred or inclusive. Social opportunities and activities including people enjoying interests, hobbies and pastimes were limited or not available. People did not feel listened to or valued. They had repeatedly raised concerns about the choice and quality of foods. Whilst the management team were addressing this, this had been ongoing for a long time with still no specific date for change.

A new manager and regional support manager had recently commenced. They showed a commitment in making improvements and developing the service and had started this work. As a result of this inspection, they took direct action in relation to documentation that needed improving to ensure people's safety. A review of care records was ongoing.

People received their prescribed medicines safely. Medicine were stored and managed in line with best practice guidance and staff had received training and their competency assessed.

Staff had received safeguarding training and were knowledgeable about their responsibilities to protect people from avoidable harm.

The environment was clean and hygienic and infection prevention and control best practice guidance was followed.

Lessons were learnt when things went wrong, and actions were taken to reduce further risks. The provider was compliant with their duty of candour requirements.

Resident meetings had recently been reintroduced to enable people to share their views and to receive information about the service.

The service had developed positive relationships with external health and social care professionals.

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

Rating at last inspection
The last rating for the service was good (published 19 February 2020).

Why we inspected
This focused inspection was prompted by a review of the information we held about this service.

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 have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report. Two breaches were identified in relation to good governance and staff deployment. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

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.

Stoneygate Ashlands

Detailed findings

Background to this 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.

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 an 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
Stoneygate Ashlands is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of the inspection, a new manager had been appointed and had submitted their registered manager application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed the information we had received about the service. 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. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who use the service and one relative to ask about their experience of the care provided. We also spoke with the manager, the operations support manager and six care staff. We looked at six care files along with a range of medication administration records. We looked at other records relating to the management of the service including staff recruitment and health and safety checks.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included training data, quality assurance records and policies.

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 good. 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.

Staffing and recruitment

- Staffing levels were not sufficient in meeting people's individual needs and safety. Staff deployment also put people at increased risk of harm. For example, staff breaks were not manged effectively resulting in staff having breaks at the same times and at busy times. This impacted on people's care needs being responded to in a timely manner.
- During the inspection, we were alerted to information about how staff provided support every afternoon to a separate registered service within the same grounds. This impacted on staff availability and compromised people's safety and welfare needs.
- People told us repeatedly how they had to wait for staff assistance and gave examples of excessive wait times. One person said, "Night-time is the worst and a couple of nights ago it was an hour I had to wait." Another person said, "If I want help, you get oh I'm doing so and so, I will come back to you, it could be an hour or two, if you are sitting in your own mess that's not good enough." We observed staff to be have limited time with people other than to provide care tasks. We did not observe excessive wait times.
- Staff raised concerns about staffing levels. They told us due to people's dependency needs staffing levels were insufficient. There were a high number of people cared for in bed, and it was not clear if this was people's choice or assessed need. There was also a high number of people who required two staff for assistance with moving and handling.
- The management team told us they had recently reviewed the call bell times. This review confirmed calls for assistance exceeded the response times the provider expected. The provider had recently revised their dependency tool, and the management team were in the process of assessing people's needs.

The provider failed to ensure there were sufficient numbers of staff to meet people's individual needs at all times. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the provider told us they had stopped the practice of staff leaving the building to provide support to another service.
- The provider had staff recruitment checks and procedures. Staff confirmed they had completed these and had received an induction and training. However, some staff recruitment files had missing interview, induction and health questionnaires documents. The manager told us they had requested the providers Human Resources team complete an audit of staff files.

Assessing risk, safety monitoring and management

- Risk associated with people's care needs were not always sufficiently assessed and planned for. For

example, catheter care plan guidance did not include the requirement of fluid input and output to be recorded. This is important due to people being at greater risk of infection. The manager was in the process of reviewing care plans and risk assessment and agreed to address these concerns.
● Guidance from a district nurse in relation to the care of a person's skin had been misinterpreted by care staff. This had a negative impact on the person and caused them distress. We discussed this with the manager who took immediate action. On the second day of our inspection this person told us they were happy with the outcome.
● We noted wardrobes were not fixed to walls for safety. The management team took action and arranged for the maintenance person to get wardrobes fixed. People were protected from risks associated with fire. People had personal emergency evacuation plans in place, staff completed fire drills and fire equipment was regularly checked and maintained. Safety checks were also completed on water temperatures and outlets.

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. At the time of the inspection, one person had a DoLS authorisation without conditions. The manager had submitted seven recent DoLS applications.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were protected from the risk of abuse. Staff had received safeguarding training and had access to the provider's safeguarding policy and procedure.
● People told us they felt safe living at the service. A person said, "I feel safe, I have no reason not to be." A relative said, "In general, there is always someone around if you look for them if needed."
● The provider ensured safeguarding incidents were reported to the local authority safeguarding team when required. The management team worked in partnership with external professionals to investigate incidents.
● Systems and processes were in place to investigate and learn from incidents. An example of this was actions taken to improve hospital discharge admissions.

Using medicines safely
● People received their prescribed medicines safely. The provider had medicines systems and processes that followed best practice guidance in the ordering, receipt, storage, and administration.
● Staff had guidance about people's medicines, including how these should be administered. We observed people receiving their medicines and this was completed safely and respectfully. Pain relief was seen to be offered to people who had this prescribed to be taken when required.
● Staff had received relevant training and had competency assessments completed and had access to the providers medicines policy.

Preventing and controlling 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 using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● 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
● People were supported to maintain contact with their family, friends, and advocate. The provider had safe visiting procedures in place.

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 good. 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.

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

- The provider's systems and processes that monitored quality and safety were not fully effective. The provider's last internal compliance visit report was dated February 2021. Where shortfalls were identified, no action was recorded to confirm what had been done to make improvements.
- A medicines remote audit was completed in March and April 2022. These audits identified shortfalls and actions for improvement. However, there was no evidence the actions identified had been completed. This put people at increased risk of harm.
- During day one of the inspection, we found people's dietary information in the kitchen was not fully up to date to reflect people's needs.
- The staff handover document was not correct with people's name recorded who were no longer at the service and some people recorded in wrong bedroom numbers. A priority needs document that provided staff with additional information about people's care needs was also found to not be up to date. This lack of accurate records put people at risk of receiving unsafe and inconsistent care.

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

- People did not consistently receive care and support that was person centred, inclusive or empowering.
- People repeatedly told us they felt frustrated with having to wait for staff to assist them. The management team told us they were aware of these concerns but did not have a timescale for improvements. We were therefore not sufficiently assured the provider was acting of feedback from people in a timely manner.
- People told us they had no opportunities to pursue interests and hobbies and were offered limited social activities and opportunities. People's care plans records included details of routines, interests and hobbies but the provider had failed to provide people with meaningful activities and stimulation. Staff deployment did not facilitate activities, during the inspection we did not observe activities being offered to people.
- A repeated concern raised by people was about the quality and choice of meals that were cooked off site and delivered daily. People told us they had shared their concerns with staff and the management team frequently but did not feel valued or listened to. We were aware this practice was delivered in the provider's other services and we had raised it previously with the provider. The management team told us they were in the process of implementing improvements. This further demonstrates a lack of action in a timely manner to feedback raised by people.

The provider had failed to have robust and effective systems and processes to monitor and improve the

quality of the service. Records were not always accurate or up to date. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We asked the management team if there was an action plan or improvement plan and were told there was not one in place. Whilst an action plan was not shared during the inspection, the provider forwarded a copy of their action plan post inspection.
● A new manager had been appointed and had submitted their application to register with CQC. They had started to make improvements at the service and showed commitment in making the required improvements. On the second inspection day we found improvements had been made to care documents.
● The provider had met their registration regulatory requirements and had notified the care quality commission, of events they were legally required to do.

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; Continuous learning and improving care
● The provider had systems and processes implemented to respond to events that went wrong. From our monitoring of the service, we were aware the provider understood their responsibilities under the duty of candour. This included being open and honest and taking responsibility when things went wrong.
● Internal investigations and lessons learnt actions were completed when things went wrong to reduce further reoccurrence and risks. An example of this was the procedure of how new admissions from hospital were managed to ensure this was safe.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People did not feel involved or engaged with. The service had experienced several changes in the management within the last 12 months. Most people we spoke with did not know who the current manager was and expressed some concerns about this. A relative told us, "We don't know the manager, there's been no chat's, introductions."
● Resident meetings had recently been re-introduced. The new management team were aware these had been impacted on by the COVID-19 pandemic. However, showed a commitment to making these positive opportunities for people moving forward.
● The management team told us of their quality assurance process. Surveys were sent to people and relatives inviting them to share their experience about the service. The last survey was sent in February 2022, but the management team advised none were returned. However, they told us they intended to resend them again shortly and would review and analyse feedback for any action's improvements.

Working in partnership with others
● Feedback from external health and social care professionals were positive. One professional said, "Good experience, always someone at the front desk - COVID rules all followed. Always a staff member available and supportive. No complaints, staff are alert and make timely and appropriate referrals."
● The manager was new in post and was found to have a positive approach to multi agency working to support people to achieve positive outcomes.

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 17 HSCA RA Regulations 2014 Good governance A failure to have effective systems and processes to improve quality and safety and to maintain accurate records put people at increased risk of harm. Regulation 17 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing A failure to deploy staff to meet people's care and support needs put people at increased risk of harm. Regulation 18 (1) (2)