A Carnachan

Ashford Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Ashford Lodge Nursing Home is a care home with nursing providing the regulated activity accommodation for persons who require personal and nursing care to up to 20 people. The service primarily provides support to older adults including those living with dementia. At the time of our inspection there were 17 people using the service. The home is a large, converted residential property which has been extended.

People's experience of using this service and what we found
People were not supported safely at Ashford Lodge Nursing Home. People were at risk of harm due to widespread, poor infection control and prevention (IPC) practices. Risks associated with people's care and support were not always planned for, or mitigated, bedrails were not used safely, and the environment was not safe.

People were not consistently protected from abuse and improper treatment and there was a risk they may be supported by unsuitable staff. Although most people received their medicines as prescribed, records relating to medicines management were not always adequate to ensure safety.
Although there were enough staff available to meet people's needs, staff did not always have up to date training and their practice did not demonstrate they were competent to meet people's needs and ensure their safety.

People's needs were not always assessed when they moved into the home and national guidance was not always followed in the provision of care. People were not fully supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Some areas of the home did not meet people's needs or ensure their rights were respected. People had enough to eat and drink.

Ashford Lodge Nursing Home was not well led. The management team had not created a culture of high quality, person centred care. Systems to ensure the safety and quality of the service were not effective and the management team did not always take accountability for failings.

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 requires improvement, with one breach of regulation (report published 10 January 2020). The provider completed an action plan after the last inspection to show what they would do, and by when, to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about risk assessment and care planning, the management of people's nursing care needs, leadership and management. 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, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.
The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashford Lodge Nursing 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 have identified breaches in relation to safety, infection control, staff competency, consent and management and leadership.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not 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.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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
This inspection was carried out by an inspection manager, an 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
Ashford Lodge Nursing 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. Inspection activity started on 18 January 2022 and ended on 24 January

2022. We visited the location on 18 and 19 January 2022, we made calls to staff on 20 January 2022 and made calls to people's relatives on 24 January 2022.

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
As part of the inspection we spoke with the owner, registered manager, four members of care staff and a member of the housekeeping team. We also spoke with four people who used the service and the relatives of five people.

We reviewed a range of written records including nine people's care plans, staff recruitment and training records and information relating to the auditing and monitoring of service provision.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- People were at risk of harm due to widespread, poor IPC practices and a complete failure to implement effective measures in response to a COVID-19 outbreak.
- Staff did not use personal protective equipment (PPE) safely. PPE was not readily accessible throughout the home. We saw staff wearing fabric masks, including whilst supporting a person who had COVID-19. Staff did not change their masks after supporting a person with COVID-19, increasing the risk of infection spreading to others.
- There were insufficient measures in place to reduce the risk of infection spreading. For example, people with COVID-19 were not marked on the handover sheet. This was given to agency staff, who had never worked at the home, at the start of their shifts.
- There were no COVID-19 risk assessments or care plans for any of the people recently admitted to the home, or for those who had COVID-19 and there was no overall COVID-19 risk assessment for the home.
- Staff lacked knowledge of how to manage cleaning, laundry and waste safely during a COVID-19 outbreak. They had no awareness of procedures for the disposal of hazardous infectious waste. There was no enhanced cleaning of high frequency touch points within the home.
- The condition of the environment did not facilitate good infection and control procedures. Some areas of the home were in a poor state of repair and unnecessary items were stored in bathrooms. This inhibited effective cleaning practices and increased the risk of bacteria harbouring and infection spreading.

From 11 November 2021, registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

- The service did not have effective measures in place to make sure this requirement was being met. The registered manager had not sought evidence that agency staff had been fully vaccinated.

Assessing risk, safety monitoring and management

- People were not protected from the risk of harm due to a failure to assess and manage risks.
- Risks associated with people's care and support were not always planned for or mitigated. During our inspection we found that seven people had no care plans in place and the only risk assessments in place were bedrail risk assessments. Several of the people without care plans had complex nursing needs. There was no information available to staff about how to support these people safely.
- Bedrails were not used safely. During inspection, we found a person with their legs through the bedrails, they were saying they were trapped and could not get out. This posed a serious risk of injury. Although there was a bed rail risk assessment in place, there was no clear rationale for the use of bedrails and the fact that

the person was able to walk had not been considered as a risk. Failure to properly assess the use of bedrails exposed people to the risk of harm.

● Risks associated with the environment were not managed safely. A fire risk assessment completed in 2021, by a specialist fire risk assessor, had identified the need for multiple actions to be taken to reduce the risk of fire. The provider had not taken action to address many of the areas identified, this increased the risk of fire and consequent harm.

Learning lessons when things go wrong

● Lessons were not always learned following incidents such as falls.

● Records showed one person sustained a fall in late 2021. Despite this, they had no falls risk assessment or care plan and it was unclear what measures were in place to reduce the risk of future falls.

● During our inspection we saw one person was found in a situation that placed them at risk of serious injury. On the second day of inspection, we saw that no action had been taken to reduce the risk of this occurring again.

● Failure to improve care based on adverse incidents exposed people to the risk of harm.

Using medicines safely

● There was a risk people may not be supported to take their medicines safely.

● Although most people received their medicines as prescribed, records relating to medicines management were not always adequate to ensure safety.

● Seven people who had recently been admitted to the home did not have sufficient records to ensure medicines were administered safely. There were no photographs of people on medicines records and there was no information about how these people preferred to take their medicines. This increased the risk of error and meant people may not receive support that met their needs.

● One person was prescribed 'as required' medicines to help manage agitation. They had been given this medicine 13 times in the previous four weeks. There was no information about why the medicine had been given, or what had been tried to avoid the use of medicine. This meant we could not be assured that the medicine had been used as a last resort as intended.

Systems were not in place 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 breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to the COVID-19 outbreak the provider had been facilitating visits from people's relatives. People's families told us they were happy with visiting arrangements. However, given the concerns we found about IPC we were not assured visitors were protected from the risk of infection.

Systems and processes to safeguard people from the risk of abuse

● People were not consistently protected from abuse and improper treatment.

● Staff had not identified or acted upon an incident that placed a person at serious risk of harm. Records from 2021 showed a person had climbed over their bedrails and fallen to the floor. This incident had not been investigated by the home and no referral had been made to the local authority safeguarding adults' team.

● The registered manager and owner told us there had not been safeguarding issues. Failure to identify an action upon safeguarding incidents exposed people to the risk of harm.

● During our inspection we were concerned that seven people who did not have any care plans in place were at risk of having their needs neglected. We made referrals to the local authority safeguarding adults' team. This remained under investigation at the time of our inspection.

● Feedback from people was mixed. Whilst two people told us they had 'no complaints.' Another two people said staff did not always talk to them, or support them in a respectful, gentle manner.

Staffing and recruitment

● There was a risk people may be supported by unsuitable staff. We were not assured safe recruitment practices were always followed.

● The provider had not always sought adequate information about the conduct of staff in previous care posts. In addition, the provider could not demonstrate that Disclosure and Barring Service (DBS) checks had been completed prior to staff starting work at the service. DBS checks provide information about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● At the time of our inspection there were enough staff to keep people safe. The provider used a tool to work out staffing numbers based on people's needs.

● Agency staff were deployed to cover vacancies in the staff team, and short notice absence, and recruitment was underway.

● Feedback about staffing levels was, overall, positive. Most people told us that staff were available when needed; however, one person said they were sometimes left waiting.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People did not always receive safe and effective care as staff did not have adequate training or supervision.
- Many staff did not have up to date training in key areas. For example, 12 members of staff had not had any IPC training since the start of the pandemic. Eight staff had not had any safeguarding adults training since 2018. We found significant issues with both IPC and safeguarding during inspection. This lack of training had a negative impact upon staff competency.
- Staff did not have training in vital areas to enable them to fully support people's mental and physical wellbeing. For example, one person had a condition which effected their impulse control, staff had not had training in this condition. Staff lacked competency and understanding in this area, for instance, we found staff had used derogatory language to describe the person in records, such as 'deviant.'
- Staff did not have regular, formal supervision of their practice. Supervision meetings only took place once a year. None of the staff we spoke with could recall when their last supervision was. This meant there were limited formal opportunities to monitor staff performance and provide support.

The provider had not ensured staff were competent. This was a breach of regulation 18(2), (Staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People's rights under the MCA had not always been respected.
- Several people were subject to restrictions on their freedom of movement, for example two people had a

baby gate preventing them from leaving their bedrooms. Their capacity to consent to this arrangement had not been assessed, there was no evidence that this was the least restrictive option, or in their best interests.
● One person had another person moved in to share their bedroom for a short period. Their capacity to consent to this had not been assessed, there was no evidence that this was in their best interests.

People's rights under the MCA were not upheld. This was a breach of regulation 11, (Need for consent), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Applications had been made for DoLS for some people. These were awaiting authorisation.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always assessed when they moved into the home and national guidance was not always followed in the provision of care.
● Seven people had been admitted to the home in a four-week period. No assessments had been completed by the home, prior to them moving in. This posed a risk the service may not be able to meet the needs of these people.
● Nationally recognised tools to assess risk and plan care had not been used consistently. Although people who had lived at the home for some time had their needs assessed, this approach had not been applied to the seven new people.

Adapting service, design, decoration to meet people's needs
● Some areas of the home did not meet people's needs or ensure their rights were respected.
● Several of the bedrooms were double occupancy rooms. We saw that some of these rooms were not big enough to ensure people's right to privacy was respected.
● Communal areas, including the entrance foyer, activity room and bathrooms, were used as storage. These areas were cluttered with equipment and other unnecessary items. This made them unhomely and hard to access.
● Although several people living at the home had dementia, there was no dementia friendly signage around the home to help people find their way around.

The provider had failed to assess people's needs and plan their care and the environment did not always facilitate person centre care. This was a breach of regulation 9, (Person centred care), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● There was a risk people may not receive effective support in relation to their health. None of the seven people who had recently moved into the home had any care plans relating to their health conditions. This posed a risk staff may not know how to support them.
● People did not always have support from expert health professionals, the provider told us this was due to difficulties with the local GP practice.

Supporting people to eat and drink enough to maintain a balanced diet
● People had enough to eat and drink and most people told us they enjoyed the food.
● People who had lived at the home for some time had care plans in place detailing their needs and preferences in relation to food and drink. In contrast, there was no written information, about eating and drinking, for the seven people who had recently been admitted to the home. This posed a risk they may not get the correct support.

● Systems were in place to monitor people's weights, and action had been taken where people had lost significant amounts of weight.

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 requires improvement. 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.

At our last inspection in November 2019, we found a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure adequate governance systems were in place. At this inspection we found improvements had not been made and the provider remained in breach of this regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The management team had not created a culture of high quality, person centred care. Records of care and support were written in a judgemental manner. The handover sheet referred to people using derogatory language, such as, 'unkempt' 'attention seeking', 'kleptomaniac', 'psychotic' and 'vacant.' Use of traditional, outdated language in care records did not promote a positive culture.
- The management team had not ensured that new admissions to the home were managed safely. Seven people had been admitted to the home over a period of 24 days. None of these people had adequate care plans or risk assessments in place at the time of our inspection. The registered manager told us that they usually completed the initial risk assessments, however these had not been done. This was not in line with the provider's policy. The fast pace of new admissions and failure to ensure care plans and risk assessments were implemented in a timely manner placed people at risk of harm.
- Systems to ensure the safety and quality of the service were not effective. There were insufficient audits and governance systems in place. For example, there was no overall IPC audit and serious issues we found in this area were not identified prior to inspection.
- The provider had a total reliance upon the registered manager to ensure the safe and effective running of the home. The provider did not compete any audits of the performance of the registered manager. Consequently, issues with the performance of the registered manager, such as the failure to implement basic assessments of people's needs and risks had not been identified by the provider.
- The management team had failed to keep accurate and up to date records. Recruitment records were incomplete. The registered manager told us DBS checks had been undertaken at point of recruitment but the failure to keep complete records meant they could not evidence safe recruitment practices had been followed.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was no evidence of continuous learning and improvement. The management team had not kept up

to date with Government guidance on the management of COVID-19 outbreaks in care homes. Consequently, during our inspection we found poor PPE and IPC practices which increased the risk of infection. The IPC policy had not been updated to reflect COVID-19 guidance.
● There had been no regular staff meetings and staff supervisions were annual so there were very limited opportunities to share information with staff and improve care.

The failure to ensure effective governance and leadership was an ongoing breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the findings of our inspection, the majority of feedback from people's relatives was positive. However, feedback from people who used the service was mixed. Whilst some people were happy with the support provided, others expressed concerns about the quality of the service they received.

Working in partnership with others
● The provider was dismissive of advice from some expert professionals. For example, an external fire risk assessor had identified multiple high-risk areas that required action. The provider had not acted upon these issues and told us that the risk assessor was a 'jobsworth' and was just 'looking for issues.'
● The provider did not take accountability for failings in the home and frequently looked to apportion blame to others. This did not facilitate positive working relationships with external professionals.

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 team had failed to identify serious incidents. Consequently, they had not investigated these to identify any wrongdoing which meant they had not been in a position to be open and honest with people and apologise if necessary.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people were provided with person centred care that met their needs.

The enforcement action we took:

We cancelled the registration of the manager and 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 had not ensured people were provided with safe care and treatments, Risks associated with care, equipment and the environment had not been mitigated.

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not implemented effective systems to ensure the safety and quality of the care provided.

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff had sufficient training or support to ensure their competency.

The enforcement action we took:

We cancelled the registration of the manager and provider.