Ashill Lodge Care Limited

Ashill Lodge 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
Ashill Lodge care home is a residential care home providing personal and nursing care for up to 35 people. At the time of our inspection there were 29 people using the service, most had a diagnosis of dementia. The home had been extended in the last eighteen months to create an additional communal space and 10 bedrooms all with ensuite facilities. The home had a passenger lift and chair stair lift as well as generous outside space.

People's experience of using this service and what we found
We were given a mixed picture about this service from the evidence collated with most relatives sharing their positive experiences about their family members care, whilst a few relatives were not happy with the service. Through our observations we noted staff were kind and caring, however not always responsive to people's individual needs.

We found a number of risks associated with people's safety including unguarded stairs which people could access, hot teapots left unattended, the laundry room with chemicals left open and a stiff fire door which might impede people's exit in the event of an emergency. People were supported to socialise with each other, and breakfast was observed to be a lively affair. We found however, when staff were busy people were not supervised safely and there was a risk to them or other people. For example, one person was known to go into other people's rooms, we observed another person picked up a large television from the communal area.

Staffing levels were sufficient during the day, but numbers were significantly reduced at night. Night-time hours had not been reviewed in line with people's needs and routines. From reviewing records, we identified there was an increase in incidents and falls later in the day and early morning. A twilight shift had been introduced and the provider was introducing an early morning shift as a direct result of increased falls at that time of day.

Medicines management identified continued areas of concern for the second time and concerns were part of a previous breach of regulation 12. This meant we were not assured that robust arrangements were in place to ensure people always received their medicines as directed.

The provider took an active role in the home and knew people, relatives and staff well. They were responsive to feedback and acted immediately on the concerns we raised. They were supported by a deputy and acting manager but there was not a registered manager in post. They had been proactive in sending us regular action plans and were continuously trying to improve their service.

There was a good working relationship with primary health care services who supported the home and told us the home were responsive to people's needs and felt they identified emerging risks and addressed this quickly. A lot of people had equipment designed to promote their safety such as bed rails and sensor mats.

People were mostly supported to have maximum choice and control of their lives and staff mostly supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Documentation was in place which demonstrated people were involved in their care and consulted about what they wanted to do. One person was supported outside the home to maintain contact with family and continue to have an active life in the local community. Prior to our inspection we had received concerns about the restrictive visiting hours and the inflexibility of the visiting policy. This was discussed with the provider and the reasons for this understood but we would expect the provider to consider the person's wishes and circumstances of family members, for example when working full time.

Rating at last inspection and update
The last rating for this service was requires improvement (published 22 March 2019) and there was a breach of regulation 12: Safe care and treatment including medicines management. 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 was still in breach of regulation 12 for the third consecutive inspection.

Why we inspected
This was a focused inspection that considered safe and well led, we found both key questions required improvement. The overall rating for the service has remained requires improvement with breaches of the regulations, based on the findings of this inspection.

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.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment and the governance and oversight of the service at this inspection. We have also made a recommendation about staff records and ensuring that they demonstrate that staff competencies have been adequately assessed for the role they are doing.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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.

Ashill 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 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 three inspectors one of whom was a medicines inspector. An Expert by Experience made phone calls remotely. 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
Ashill Lodge 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. Ashill Lodge 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.

At the time of our inspection there was not a registered manager in post but the acting manager had submitted an application to complete the registration process.

Notice of inspection
This inspection was unannounced on the first day, on the second date, additional information was requested.

What we did before the inspection
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 reviewed all the information we hold about the service which included notifications which the provider are obliged to submit, this included safeguarding concerns. We reviewed the provider action plan, the local authority review and feedback from relatives and stakeholders. We used information gathered as part of monitoring activity that took place in April 2022 to help plan the inspection and inform our judgements.

During the inspection
We carried out initial observations to include activities and the mealtime experience. We spoke with people, but most could not formally tell us about their experiences because they were living with dementia. We had a more in-depth discussion with 2 people using the service and 3 relatives on the day. We asked for feedback from a visiting health care professional and spoke with the registered provider. We spoke with 3 care staff, 1 who was a senior, the acting manager, the domestic, and the kitchen assistant. Our Expert by Experience spoke with an additional 6 family members and representatives.

We reviewed medicine administration and associated records for 17 people, observed medicines being given to people and we spoke with 2 members of staff about medicines. We reviewed 5 care plans and other records associated with the management of the service including staff recruitment records. Following the inspection we spoke with a member of the night staff. We continued to seek validation and ask for additional evidence from the provider.

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 requires improvement. At this inspection the rating 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.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
At this inspection not enough improvement had been made and the provider was still in breach of regulation 12: Safe care and treatment. Some concerns were identified in relation to people's safety.

●Risks associated with the environment on the day of our inspection were identified by inspectors and not the provider. For example, we noted a person who was frail and at risk of falls walking up and down the stairs when they were at an identified risks of falls and should according to their risk assessment be supervised. We also noted the fire exit door was stiff, the handrails had sharp bits underneath, the laundry room containing chemicals was left unlocked and hot teapots were left unsupervised at times. None of these concerns had been identified or actioned by the provider prior to our inspection.
●Where risks had been identified steps had been taken to reduce them. For example by introducing sensor mats and alarms to alert staff when people were moving around. Those at very high risk of falls were offered ground floor accommodation. However the stairs were open and therefore risks remained for those who tried to climb the stairs and this had not been considered as part of the risk assessment process.
●We found some contradictory information in care plans about the level of risk and review dates which did not assure us that staff knew what actions to take in line with the level of risk.
●People were encouraged to be active and join others in the communal areas. There were times across the day when all staff were busy and people were left unsupported which could increase the risks to their safety.

Using medicines safely
●At the last inspection concerns were identified about medicines in relation to insufficient numbers of staff trained to safely administer medicines at night. Assurances were received from the provider that this would be addressed. There were also concerns about guidance related to skin patches to ensure these were sufficiently rotated to reduce the risk of skin irritation.
●At our most recent inspection we found people received their medicines safely most of the time, however, there was still an issue about having sufficient numbers of staff trained to give medicines at night if required and continued concerns about the management of medicines
●Written information was available to help staff give people their medicines safely and appropriately. However, when people were prescribed medicines on a when required basis (PRN) there was insufficient

person-centred information available to help staff give people these medicines consistently and appropriately.
●Oral medicines were stored securely and at correct temperatures, however, some topical medicines such as creams and emollients were not being kept safely to ensure people could not access them and cause accidental harm. We noted that controlled drugs (medicines requiring additional security) were not being stored in a cabinet compliant with controlled drug legislation.
●During the inspection we acknowledged that there was a manager's audit of medicines and provision for reporting medicine management issues or errors. However, during discussion with the manager they were not able to assure us that staff were using the process to report medicine errors. The provider told us weekly and monthly medicine audit and monthly staff meetings were used to identify any errors and lessons learnt. Any delays in reporting could have serious consequences.

Preventing and controlling infection
●We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. A decision had been made and risk assessed that staff did not have to routinely wear masks unless infection was present in the home. This went against government recommendations at the time and placed people and visitors at increased risk of spreading infections.

The above evidence in relation to risks, safety of the premises, safe management of medicines and arrangements to reduce the spread of infection all support a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Regular checks on fire safety, water safety and electrical safety were seen from the records we reviewed. Staff received relevant training to manage risk such as first aid training and fire safety.
●Administrative errors in regards to recording the application and rotation of pain patches had been identified and rectified. This is important to reduce the risk of skin irritation if patches are not applied correctly.
●We identified some good practice around infection control. Staff encouraged people to wash their hands before meals to reduce the transmission of infection.
●Despite some domestic staff sickness, the home was clean and there were regular cleaning schedules followed by staff to ensure high standards of cleanliness were maintained across the home.
●Relatives spoken with all commented on the standards of cleanliness in the home and said spills were quickly addressed. One said, "Always clean and tidy with no smells and she [Relative] is well presented."

Visiting in care homes
●A recent concern was raised about inflexible visiting hours. The provider has since reviewed and updated the visitor's policy but maintains visiting is in line with people's needs and wishes.
●Visiting arrangements were kept under review in line with COVID 19 restrictions. A relative told us lockdowns only occurred when necessary.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

●We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met. The service established people's consent for all aspects of their care and support. Where they were unable to give consent, they consulted with family and other professionals as appropriate to determine what was in the persons best interest.
●We were made aware of concerns from one family for a person no longer at the service who had concerns about the visiting policy and did not feel this met theirs or their family member's needs. The policy did not take into account the persons best interest but adopted a more blanket approach.
●Routines were flexible, and night staff told us most people were in bed early in line with their preferences, but we observed staff not offering choices in a meaningful way. Staff did not use appropriate communication in line with people's needs to help people express themselves and make choices.

Staffing and recruitment
●Recruitment records showed how safe recruitment decisions had been made. Staff were interviewed and documentation was in place to check their suitability. A recruitment checklist had been implemented to help ensure recruitment processes had been adequately followed and all the necessary documents collated. Some documentation such as interview notes had not been dated or signed.
●Disclosure and Barring Service (DBS) checks were in place, to ensure staff were suitable to work with vulnerable people. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Whilst records reflected information in relation to staff relevant to their employment status. There was some conflicting information found in relation to one staff member. There was no evidence to suggest this had been explored further.
●Staff new to care, completed the care certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
●Staff then received observations and supervisions as part of a regular review. Initial induction records could be improved to show the level of support new staff received.

We recommend the provider ensures staff records demonstrate how they have assessed staff's needs and competencies to deliver care in line with people's needs before working unsupervised.

●Staffing levels were generous during the day but we noted people were not always supervised across the day and attributed this to the deployment of staff across different areas of the home. We also had concerns about the low staffing levels at night particularly given people's level of need and how staff would respond in an emergency. We however had concerns that should there be an incident or anyone required additional support how 2 members of staff could effectively assist.
●The provider confirmed up to 22 people currently needed some assistance with personal care and 4 needed assistance with moving and handling transfers. We raised our concerns with the provider that if 2 night staff were required to support one person there would be no other staff monitoring other people for their safety.
●The provider told us staff were responsive to people's needs and the provider used both a formal dependency tool and observations across the day and night to ascertain if people's needs could continue to be met safely. They provided us with their night audits which were completed regularly. They had recently increased staffing in the evening to support people retiring to bed and said they were increasing support earlier in the morning to help with people's morning routines.
●Relatives spoken with were assured that staffing levels were appropriate, and staff were described as responsive and supportive and took time to inform relatives of falls or changes to the person's needs.

Relatives said they thought staffing levels were maintained across the weekends as appropriate and activities took place for those wishing to participate.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong

- The provider worked collaboratively with the local authority safeguarding team and reported concerns as and when appropriate. Staff had received training to enable them to identify safeguarding concerns and know what actions to take. Speaking with staff and reviewing staff and training records confirmed this.
- A number of safeguarding concerns were being reviewed at the time of our inspection by the local authority; one we were informed had not been substantiated. Concerns were raised with us by people's relatives during the inspection and we gave feedback about this to the provider. They responded by raising a safeguarding concern without delay.
- The provider had systems in place to review incidents, falls and safeguarding concerns and they acted accordingly. We found however risks identified on the day of the inspection had not been identified by the provider. Adjustments to the service provision had been made to take into account incidents and how to reduce a reoccurrence.

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 requires improvement, at this inspection the rating 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.

- We identified some immediate risks which had not been identified by the provider, in relation to people's needs and their inability to identify risks for themselves due to their frailty and dementia. This did not assure us of the continued safety of people using the service.
- Prior to the inspection we were made aware of a number of concerns from relatives and a health care professional. Although not all the concerns were substantiated there were some common themes including poor communication, whether timely care was always provided, risks associated with reduced staffing and general care issues.
- At the time of our inspection there was not a registered manager in post but the acting manager had submitted an application. There had been a number of changes of registered manager since the last inspection, which did not assure us that people using the service and staff had continuity.
- Care records were generally good, but some contained contradictory information and information about reducing risk was sometimes contradictory and not followed. For example, people not being supported to safely use the stairs.
- There were times when the care observed was not person- centred. Activities were provided at times of the day when people were up and dressed, but we did not see spontaneous activity or staff sitting with people to encourage them to eat and drink. During our observations we noted peoples choices were not always promoted in a way that demonstrated that staff used different communication methods appropriate to people's needs
- At the last inspection we identified a breach of regulation 12: safe care and treatment and medicines management. Although improvements were identified at this inspection, the provider was still in breach with some repeated concerns.
- We found oversight and governance was not sufficiently robust and did not ensure people received the regulated activity in a safe and person-centred way. Audits were in place but did not sufficiently focus on people's experiences and their safety within the environment. We had concerns about record keeping, safe working practices and staffing.

The above evidence supports a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●Most feedback from relatives was positive, but a number of concerns were identified. During our observations one person was sitting at a table by themselves in the dining room because of previous incidents with other people. Interaction with them was limited with the exception of another person telling them off. There were times when staff were not visible and there were 16 people in the dining room which meant potential incidents may not be identified and reduced in a timely way, and did not assure us that everyone was receiving care as appropriate.
●We also noted that staff did not fully promote people's choices at mealtimes by showing them the different options or using a picture menu. There were no condiments on the table and some people were able to ask for them. No plate guards were observed, and sauces were already added to meal, tomato sauce to burgers. Staff may have asked people, but this approach does did not promote people's independence.
●Champions had been identified for: Dementia, Health and Safety, Infection Control, diabetes, fire, technology, safeguarding, medication, continence and diversity. A champion is someone who has enhanced knowledge and or oversight of a key area of practice so they can lead and support other staff. Staff new to care did complete a 'Skills for Care' induction which is a nationally recognised qualification.
●Most relatives confirmed that staff were both caring and responsive.
●One relative told us that the service responded to any feedback and they supported their family member to join in, be sociable and concerns about their skin were responded to immediately. One relative told us, "Care is brilliant, so friendly, Mum [Relative] idolises the staff, they always make us welcome, lovely to me, a really nice team."

Continuous learning and improving care
●The provider had a number of audits they completed both across the day and night to look at risks and staffing. However these did not identify the concerns we did or lead to improvements necessary to the care and safety of people using the service. The use of agency staff and the loss of skilled staff had impacted on the service, but there was ongoing staff recruitment and use of agency staff was reducing.

Working in partnership with others
●The provider was completing additional training to become a dementia champion which would help them provide more holistic care based on people's needs.
●The health care professional spoken with expressed their satisfaction and said there was good partnership working and the service was proactive.

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: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●The provider worked in partnership with others and had regularly shared their action plan with the local authority and CQC.
●The provider submitted notifications and other records such as safeguarding alerts as appropriate and worked collaboratively with other agencies.
●The provider liaised with families and staff to try and resolve issues where identified.
●As part of their quality assurance the provider formally sought the views from staff, and relatives to establish their views and how it could be improved. We did not see however a summary of how feedback was included as part of the providers overarching action and improvement plan.
●The provider documented people's views and wishes as part of the care planning process to help ensure people received care in line with their needs. There was limited consultation with people using the service who might find it difficult to express their views.

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 associated with people's care and the environment had not been properly identified and risks effectively reduced. This exposed people to possible avoidable harm.

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 17 HSCA RA Regulations 2014 Good governance Governance and oversight did not always identify risks to peoples safety or ensure all staff could deliver the regulated activity in line with people's needs.

The enforcement action we took:

We served a warning notice on the provider in response to regulation 17