South West Care Homes Limited

Ashley House - Langport

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Ashley House- Langport is a residential care home providing personal care to up to 25 people. The service provides support to people aged 65 and over. At the time of our inspection there were 15 people using the service.

People's experience of using this service and what we found
People lived in a home where the providers system was not always effective to identify and address concerns and shortfalls in the service. During the inspection we identified issues relating to people's health and safety and fire safety. The provider had produced a service improvement plan which was completed prior to our inspection. However, some of the issues we identified were not detailed within this plan.

A number of audits took place to ensure the quality of the service was maintained. However, these were not always robust and had not always identified where improvements were needed. The lack of governance measures in place and poor management oversight meant people were at risk of receiving care which placed them at risk of harm.

People's rights were not protected because staff had not always acted in accordance with the Mental Capacity Act 2005 (MCA). The system in place for the oversight of the Deprivation of Liberty Safeguards (DoLS) needed improvement so applications to renew legal authority for any restrictions in place, were made in a timely way.

Not all staff had received training to equip them to support people, to understand their individual needs and mitigate associated risks.

We were not assured that all incidents which could constitute a safeguarding alert or concern were being identified or investigated by the registered manager. We made a recommendation that the provider researches current best practice guidance and liaises with the local authority to ensure they are identifying, investigating and referring safeguarding concerns appropriately.

Medicines were managed safely. The provider's staff recruitment procedures helped to protect people from harm. Practices relating to infection control were safe.

We observed kind, compassionate and caring interactions between people and staff. People looked comfortable and relaxed with staff who supported them. People and relatives spoke positively about the care provided.

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

Rating at last inspection

The last rating for this service was good (published 15 April 2020).

Why we inspected
The inspection was prompted in part by a specific incident, following which a person using the service died. This incident is subject to a police investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of safety. This inspection examined those risks. We have found evidence that the provider needs to make improvements. Please see the safe, effective 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.

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

We have identified breaches in relation to risk management, consent, staffing and the management of the service.

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, and require regular updates regarding this. 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Ashley House - Langport

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
Two inspectors completed the inspection

Service and service type
Ashley House - Langport 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. Ashley House - Langport 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 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 our inspection there was a registered manager in post. During the inspection the registered manager was not present. We were supported by the nominated individual (the person employed by the provider who is responsible for supervising the management of the service) and the provider's recently appointed director of business performance.

Notice of inspection

This inspection was announced. We gave a short period of notice of the inspection because we needed to be sure that the provider or registered manager would be available to support the inspection.

What we did before 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 met with all the people who lived at the home. We spoke with seven people and four visitors. Some people were unable to fully express their views to us as they were living with dementia, we therefore only had in-depth conversations with two people about their experience. We also spent time observing care in communal areas and interactions between people and staff.

We spoke with 11 members of staff. This included the nominated individual and director of business performance.

We looked at a selection of records relating to people's individual care and records relating to the running of the home. This included eight people's care and support records, three staff recruitment files, health and safety checks, a sample of medication administration records and minutes of meetings.

We made a referral to the local fire and rescue service in relation to fire safety.

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 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.

Assessing risk, safety monitoring and management

● At the last inspection in February 2020 we found people's safety was at risk. This was because the risks relating to people and the environment were not always being managed sufficiently to ensure people received safe care and treatment. At this inspection we found that people were still not consistently protected from risk. Not all risks were assessed, and the approach to risk management was inconsistent.

● Risks within the environment were not always identified and assessed. We found sash windows broken and held open with objects, which if removed could result in the sash window falling on someone. Cupboards containing hazardous objects were found unlocked although there was a sign on them stating they should be kept locked when not in use. Staff were living on site and were seen to be accessing the kitchen. Risks associated with how and where staff cook and eat, as well as risks to people living in the home were not assessed in relation to food hygiene and infection control.

● Risks were not always adequately risk assessed. This included risks associated with use of the stairs and stair lift to the first floor by individuals.

● Incident records detailed some people had a number of falls. Records of incidents, accidents and falls were recorded, although there was no system in place to look for trends, identify any learning, and reduce the risk of an incident happening again.

● Falls were not always managed in line with the provider's own policy, to fully ensure safety of people's care. For example, one person had recently fallen within the home. The providers falls prevention policy states, 'If the person is complaining of any pain, or there is an injury or blood which causes concern, then the paramedics should be called'. Although the person was in pain, there was a delay of 13 hours in seeking medical advice.

● During the inspection shortfalls were identified in relation to fire safety which placed people at risk. The providers fire risk assessment had been completed by the registered manager and did not identify all risks. For example, we were concerned that there was no evacuation device to assist people down the stairs in the event of a fire. We discussed this with the higher management team and on the second day of the inspection we were informed that they had ordered an appropriate evacuation device.

● Fire checks and drills were carried out and there was regular testing of fire and electrical equipment. Fire safety checks did not include checking the external fire escape stairs, where we found rubble, which could make it unsafe for people to use in the event of an evacuation. We saw steps leading from the conservatory to the fire assembly point with yellow paint to highlight, which was worn and would not be easily visible. This was an issue we identified at our inspection in February 2020, and the provider took action at that time. The provider's service improvement plan had identified this prior to this inspection; however it had not been prioritised to ensure a person who recently moved into the home could access the garden safely. The provider's 'fire emergency plan' last reviewed on June 2021, recorded that 'maintenance person will inspect

regularly…to ensure that external fire escapes are kept free from obstruction'. Records did not record that these checks had been undertaken. We discussed this with the director of business performance who advised that they would be cleared.
● Not all staff had received relevant training to ensure the safety of people. The training matrix, and records viewed, showed that three staff had not completed their fire safety, two people had not completed their first aid refresher training, one staff member had not completed their moving and handling refresher training and four people had not received falls awareness training despite their being a high level of falls within the service.

The provider had failed to assess, monitor and manage risks to service users' health and safety and provide safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The training matrix viewed showed that people received first aid and moving and handling people competency checks.
● Prior to the inspection, the provider's management team had recognised that the fire risk assessment currently in place was not sufficient and had arranged for an external company to complete a new assessment.
●There were individual personal emergency evacuation plans (PEEP's) which took account of people's abilities, the assistance they required, room location and equipment needed. These were held in a secure fire box next to the fire alarm panel. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely.
● After the inspection, we contacted the local fire and rescue service and informed them about our concerns in relation to fire safety.

Systems and processes to safeguard people from the risk of abuse
● The provider did not have effective systems and processes in place to safeguard people from the risk of abuse.
● Two staff had not been provided with safeguarding training, but were already working with people. Staff spoken with understood their responsibility to report abuse and neglect and felt confident to do this.
● We were not assured that all incidents which could constitute a safeguarding alert or concern were being identified by the registered manager. This was because the system to review and monitor incidents was not effective. We saw records where people had fallen, received an injury and the paramedics called. Although they had been reported to the registered manager, no further investigation had taken place. This lack of investigation meant people were at risk of recurring falls and injury.

We recommend the provider researches current best practice guidance and liaises with the local authority to ensure they are identifying, investigating and referring safeguarding concerns appropriately.

Learning lessons when things go wrong
● Due to a recent incident, the provider's nominated individual and director of business performance were at the service supporting staff and had taken immediate action to mitigate the risk to others.

Staffing and recruitment
● Staff had been recruited safely. All required pre-employment checks had been carried out including criminal record checks and obtaining references from previous employers.
● The provider's management team used recognised dependency tools to assess the staffing levels required to meet people's needs. These tools had identified there was sufficient staff. However, since the incident

they had reviewed the shift patterns so there were more staff available to support people at busy times. At the time of the inspection this was still in the process of being changed, so we were unable to see how effective this might be.
● One person told us that, "Sometimes they are short of staff, but they are all very kind, I have a bell and they come when I ring it."

Using medicines safely
● People received their medicines safely from staff who had received medicines training and had their competency assessed.
● Medicines were safely managed. Processes were in place for the ordering and supply of medicines and medicines administration records (MAR) indicated people received their medicines at the right time.
●There were suitable arrangements for storing and disposal of medicines, including medicines requiring extra security and refrigerated medicines.
●Staff administering medicines wore a red tabard reminding people not to disturb them, to minimize the risk of making a medicine error. Staff were observed taking time supporting people with their medicines.
● Some people were prescribed medicines on an 'as and when required' basis, for example for pain management. The service had protocols which provided staff with information about when these medicines should be given.
●People's MARs had an up to date photograph of the person so staff could ensure they were administering medicines to the right person.
●Regular medicine audits were completed by the team leaders. Where errors or concerns were identified, action was taken.
● People received their prescribed creams in accordance with their needs. Care staff supported people to apply prescribed creams and lotions and records were kept of when these had been applied. This enabled their effectiveness to be monitored.

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 supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● 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 have visitors as per their preferences without limitation through a booking service.

Requires Improvement

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 requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- We found gaps in supervision arrangements. This had been identified by the provider and a new framework was in the process of being implemented at the time of the inspection.
- The provider had an induction process in place. For staff within their induction period, not all courses were yet completed. For example, one person had not yet completed safeguarding training, and two had not yet completed Deprivation of Liberty Safeguard and Mental Capacity Act training but were already working with people.
- The provider had a policy that staff would complete the Care Certificate as part of their induction. The director of business performance confirmed this was not being completed by staff.
- The provider failed to ensure staff received training relevant to their roles. We found staff had not always undertaken the provider's mandatory or refresher training and at the time of the inspection a small number of staff were working without the necessary training. The training matrix, and records viewed showed that three staff had not completed their fire safety, two staff had not completed their first aid refresher training, and one staff member had not completed their moving and handling refresher training.
- Staff were not always supported to access training that was specific to peoples' support and health care needs. For example, not all staff had received training in caring for people living with dementia or in falls management. This meant they may not have the skills and knowledge to support people appropriately.
- Staff were not supported to keep up to date with best practice. Staff did not receive regular one to one supervision with their line manager to provide them with an opportunity to receive feedback and discuss any concerns. Some staff had not been provided with one to one supervision in 2022. A staff member told us, "I haven't had a one to one supervision for a while, they class team meetings as supervision."

Staff did not receive effective and sufficient supervision and training to enable them to carry out their roles. This was a breach of Regulation 18 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Further work was needed to ensure people's rights under the MCA were protected.
● Although we were not concerned that people's rights were being restricted unnecessarily, not all restrictions were assessed under the Mental Capacity Act and the approach was inconsistent. For example, when people appeared to lack capacity to consent to monitoring of their movement, such as sensor mats, their capacity had not always been formally assessed and there was no evidence of how the decision had been made in their best interests.
● There was no effective system to monitor DoLS applications, authorisations, conditions or expiry dates. This presented a risk that people could be unlawfully deprived of their liberty. The DoLs applied for did not detail all restrictions and for one person, whose DoLs expired on 30 November 2021, there was no evidence that it had been reapplied for.
● Some staff had not completed training in MCA and DoLS.

Systems to ensure people received care in line with the MCA and DoLs were inconsistent. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People's drink intake was being recorded, although no target was set to ensure staff were aware of the amount people were required to drink to maintain good health. However, we observed people were continually offered drinks throughout the day and snacks were also available for people.
● We observed mealtimes were close together. Lunch was served at midday, with tea at 16:00 hours. Although staff told us people had the opportunity to have a snack in the evening, people did not have another main meal until the following day. We discussed this with the providers higher management team who told us that they would be making changes to mealtimes.
● People and their relatives commented positively on the food provided at the service. Comments included, "They go out of their way to find food she likes. [Chef] comes around every day to decide what she wants to eat", and "I can't fault it, somethings I send things back if I don't like it and they always bring me something else". One person told us, "They don't give me enough". This persons family told us that this has been raised with the home and portions had been increased.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We were not assured that people always receive healthcare support in a timely manner as detailed in the safe section of this report.
● People's care records showed how the service worked in partnership with other professionals.

Adapting service, design, decoration to meet people's needs
● The main communal area did not provide a stimulating environment due to lack of decoration and pictures.

● Where people were living with dementia, the environment did support them to orientate themselves within the service. For example, there was adequate signage for people to access toilets independently.
● External contractors undertook regular servicing and testing of moving and handling equipment and stairlift maintenance.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were assessed prior to moving into the service. This assessment process ensured a comprehensive care plan that detailed guidance for staff on how to meet people's needs was completed on admission.
● Each person had a care plan which gave staff information about how best to support people.
● Staff told us that prior to the pandemic, people attended and enjoyed community activities but due to the restrictions associated with the pandemic, people were not currently accessing the community. We discussed this with the higher management team and on the second day of the inspection one person was supported out into the community.

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

- The provider had not ensured there was consistent leadership when the registered manager was not available, and did not have clear oversight of the management team at Ashley House. During the inspection, the higher management team informed us of the management structure in place although this structure was not reflected in staffs understanding.
- The provider had a range of systems in place to monitor the service. These had not been used effectively to monitor and improve the quality and safety of care in the service. There was a range of service and provider level audits to monitor the health, safety and welfare of people who used the service. However, a number of the issues found at the inspection had only recently been identified by the provider following a significant incident.
- A service improvement plan was in place which identified some of the issues. However, some of the issues we identified were not detailed within the plan.
- Due to unexpected changes in management, the last full provider audit of quality and safety was in May 2021. We were informed that since then, provider level visits had taken place and during our inspection we viewed audits that had been completed and submitted to the provider by the service. The provider told us some of these were affected by inaccurate information being submitted by the service, with checks not being completed to ensure they were accurate. A new audit regime was in the process of being implemented.
- There was a call bell system in place which alerted staff if people required support, or if a person who was at high risk of falls had moved and required prompt responses from staff to minimise the risk of falling. At the time of the inspection call bell times were not being monitored to see if there was any correlation between the length of time staff respond and people falling. Although no concerns were raised during our inspection regarding call bell response times, they were not being monitored and looked at during falls analysis to establish if there was any link.
- The system in place to audit the service had not identified some known risks had not been assessed. This included risks in relation to fire and broken windows which placed the safety of people at risk.
- Internal governance systems to monitor Deprivation of Liberty Safeguards (DoLS) were not in place.
- Accidents and incidents were clearly documented by staff, although there was no clear management oversight or learning from them.
- The provider had no effective system for seeking feedback about the quality of the service from staff, people who used the service or their relatives and other stakeholders. Although residents meetings were

taking place, the last residents and professionals survey took place in 2020 and a visitor survey took place in 2021.
● The registered manager did not always act on feedback received. An action from the visitor's survey completed in 2021 in relation to the environment had not been actioned. The provider had not identified this action had not been taken. This meant the provider failed to ensure people's feedback was listened to and acted on.

Systems and processes were not operated effectively to assess, 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.

● Systems and processes were in place to monitor staff training.

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's nominated individual and director of business performance were open and honest throughout the inspection. They had recognised things were wrong, and were already taking action to ensure systems were more robust. This included a new provider audit system which would be completed monthly, and a training needs analysis would be completed for all staff. Following the recent significant incident, they also took immediate action to learn from this and reduce the risk to others.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was not a positive culture at the home. Staff told us they did not feel listened to, or supported by the registered manager. Staff told us the registered manager was not always approachable. One staff stated that if they raised concerns they felt, "Nothing will get done or it will take a long time".
● Staff told us they were a good team and felt supported by each other. They told us that they had felt supported by the providers higher management team and senior staff following the recent incident.
● We observed kind, compassionate and caring interactions between people and staff. People looked comfortable and relaxed with staff who supported them with tasks. People and relatives spoke positively about the care provided. One person told us that they felt listened to. Other comments from people spoken with included, "It's very nice here", "I can't fault it" and "They really look after me well".

Working in partnership with others
● People's care records showed how the service worked in partnership with other professionals.

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 11 HSCA RA Regulations 2014 Need for consent Systems to ensure people received care in line with the MCA and DoLs were inconsistent. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 failed to assess, monitor and manage risks to service users' health and safety and provide safe care and treatment. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to assess, 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.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff did not receive effective and sufficient supervision and training to enable them to carry out their roles.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014