W Scott

Ashleigh House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ashleigh House is a residential care home providing accommodation for persons who require nursing or personal care to up to up to 24 people. The service provides support to older people and people living with dementia, people with a learning disability, substance abuse, sensory impairment and mental health needs. At the time of our inspection there were 18 people using the service. Ashleigh House provides accommodation in a single house across 3 floors.

People's experience of using this service and what we found
The premises and environment were poorly maintained, placing people at risk of harm. Staff had received limited fire safety training on undertaking effective evacuation furthermore there was insufficient fire detection or staff to keep people safe in an emergency situation.

Fire Safety Inspectors from Nottinghamshire Fire and Rescue Service visited the premises on the day of our inspection and served a Prohibition Notice due to fire safety concerns. This meant the fire service was of the opinion the use of the premises involved a risk so serious to people that it should be restricted to ground and 'basement' (lower ground floor) area only.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Support
People were not supported to have maximum choice and control of their lives and staff did not 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.

Ineffective care planning led to people experiencing poor care and restrictive practices.

A failure to record and monitor incidents of a safeguarding nature meant there was no learning to avoid and reduce reoccurrence.

The service failed to provide a safe, well maintained environment; areas were unfit for purpose and significantly damaged, which posed significant risk to people.

Fire safety measures were completely ineffective posing a significant risk to life.

Medicines were not managed safely. The provider failed to appropriately store medicines leading to harm. Multiple medicines could not be accounted for meaning people were at risk of under or over administration of medicines.

Right Care
The service failed to protect people from poor care and abuse. Staff had failed to identify, record and report incidents. The provider had failed to monitor the quality of the service resulting in poor care and incidents of a safeguarding nature occurring.

The service did not have enough staff to meet the needs of people. Staff deployment meant people did not have suitably qualified and skilled staff to support them.

Risk management was poor. A lack of support plans and assessments in place meant people's needs were not identified assessed or managed effectively.

Right Culture
There were indicators of a closed culture. Staff had a lack of support or guidance on how to support people to lead inclusive and empowered lives.

People received poor quality care, due to staff not having the required skills and abilities to meet people's needs.

Staff did not always know the person due to a lack of training and support plans in place. This meant care was not personalised or tailored to their needs.

Staffing levels were consistently low, meaning people received inconsistent care from staff due to insufficient time to meet people's needs.

The culture of the home was negative, the manager told us the home was not safe and people needed to leave. Meaning there was no drive for improvement or quality within the service.

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 (published 08 May 2020). At this inspection we found the provider remained in breach of regulations 12 and 17, additionally breaches were found for 13 and 18.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to environmental and fire safety risks and infection control risks. A decision was made for us to inspect and examine those risks.

We found evidence during this inspection that people were at risk of harm from this concern. Please see the safe and well-led sections 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.

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 Ashleigh House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk management, safeguarding, staffing, leadership and governance at this inspection.

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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Ashleigh House

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 2 inspectors.

Service and service type
Ashleigh House 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. Ashleigh House 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 a registered manager registered with the commission, however they were no longer in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last 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 sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with 6 members of staff including the provider, manager, administrator, maintenance and carers. We looked at 2 people's care records in detail and records that related to how the service was managed including staffing, training, medicines and quality assurance. We also spoke with multiple visiting health professionals and 3 fire service professionals due to the immediate removal of all people from the service due to significant safety concerns.

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.

At our last inspection we found that there were issues regarding staffing and infection control. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found an increased risk in staffing and infection control, and further significant risk with fire safety, environmental safety, medicines, risk management and safeguarding. This means that the service remains in breach of Regulation 12 (Safe Care and Treatment).

Assessing risk, safety monitoring and management

- People's risks were not managed. We found historical information in care plans and risk assessments not relevant to people's current and ongoing needs. This meant people's risk were not assessed, monitored or managed effectively, leading to poor care and unwarranted restrictions for people.
- People were at risk of choking due to their adapted diet not being sufficiently assessed and risks were not mitigated. For example, 5 people required 'soft and moist' diet. We were told by the manager and staff this was not catered for. We observed during lunch unsuitable food was served to these people, placing them at significant risk of choking.
- The manager also informed us people who had specific dietary needs due to diabetes were not catered for. For example, low sugar diets were not followed, we were informed by the manager sugar is added to breakfast meals and excessive sugar was used for puddings served during the inspection. There had been no consideration for people's specific dietary needs, placing them at significant risk and health complications.
- We found risks to people were significantly increased due to a failure to assess environmental risks. For example, due to a failure to identify and assess fire safety risks, including inadequate fire detection and fire-fighting equipment that had not been regularly maintained, it led to a significant risk to life and the care home being an unsafe environment to live in.
- Further significant risk in environment were found. For example, multiple radiator covers were damaged, exposing the radiator, this put people at risk of burns. No wardrobes were fixed to the walls, and some were in poor state of repair. The building had 3 floors and we found many windows did not have window restrictors. The provider failed to identify and assess these risks, which put people at risk of harm.

Using medicines safely

- Medicines were not managed safely.
- We were informed by the manager a significant incident had occurred due to the mismanagement of medicines, due to the incorrect storage of medicines a person gained access and "ate them like smarties" resulting in hospitalisation for this person.
- Staff were not appropriately trained to administer medicines. We reviewed the training records with the manager who informed us, staff who are not trained frequently administer medicines. A person required rescue medicines due to seizures, the service did not have any staff trained to administer this. The manager

informed us they would be called and lives 40 minutes away, this meant rescue medicines could not always be given in a timely way.
● Multiple gaps in recording were identified on the medicines records and tablets were unaccounted for. One person had a discrepancy of 28 tablets, it is unclear due to poor recording if these had been administered or missing. Another person had a total of 124 tablets unaccounted for. The provider failed to manage medicines effectively, this placed people at significant risk.

Preventing and controlling infection
● Several areas of the environment were very unclean which posed a risk of infection and compromised the effectiveness of cleaning.
● We found urine soaked and stained mattresses in peoples' bedrooms. Unclean communal toilets with urine and faeces stains.
● Several people's bedrooms had not been cleaned for some time. For example, a person's bedroom had a strong odour of urine, dead bugs were in the room, and the bathroom area was covered in faeces.
● The laundry area in the basement, was unclean and did not promote good cleaning standards. Sinks were stained, and a damp area had damaged and compromised the washing area.
●Equipment in the kitchenette was unclean and unfit for purpose. This dining room was frequently used by most people, and in an area which mainly accommodates people with dementia who are unable to ensure their own safety. This posed a significant risk of harm due to poor environmental safety and impacted on effectiveness of cleaning.
● We reviewed cleaning schedules and identified these were last completed 23 March 2023, a staff member confirmed they had no housekeeper and were unable to maintain the cleaning or complete the cleaning some days due to being short staffed. This put people at increased risk of infection due to a failure to ensure the cleanliness of the home.

Learning lessons when things go wrong
● There was no evidence of learning from incidents. As detailed above and information from the manager incidents included absconding, environmental safety and mismanagement of medicines. Only two incidents were logged on the provider safeguarding log.
● The provider failed to respond appropriately to any concerns raised and during the inspection we found significant risks in all the aforementioned areas. This demonstrated that the provider did not always learn lessons when things go wrong.
● The provider failed to ensure staff reported and recorded incidents appropriately, we found no evidence incidents were reviewed or monitored to prevent reoccurrence. Systems were either not in place, needed embedding or robust enough to address the concerns identified during the inspection. Due to systematic failures the provider failed to ensure the safety of people meaning they were at risk of harm.

The provider systematically failed to assess and manage a wide range of risks placed people at risk of avoidable harm and was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
Due to the severity of the risks and the unsafe environment within the care home and the significant risk to people, visiting was not reviewed, and we are unable to make comments on the visiting arrangements at the care home.

Systems and processes to safeguard people from the risk of abuse
● People were not kept safe from avoidable harm. During our inspection we found the provider had failed

to properly assess and mitigate a wide range of potential risks to people's safety and welfare. This included individual risk assessment, medicines management, infection prevention and control, environmental safety and nutritional risks.

● Records showed not all staff had received safeguarding training. Staff did not always know how to recognise and report abuse. We were informed about incidents of a safeguarding nature by the manager, these were not reported to the relevant professional bodies, meaning these could not be investigated fully. When we spoke to staff they consistently told us the service was not safe and could not meet the needs of people.

● The provider had private flats within the care home which were occupied by members of the public. Full access to all areas of the care home could be gained by the members of public. The provider failed to ensure people were safeguarded by completing appropriate checks of these people to ensure they were suitable to be around vulnerable people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

● We found the service was not working within the principles of the MCA.

● There are indicators of a closed culture at the service where punitive measures were used to manage people's behaviour.

● We were informed by the manager a person who accessed the community was patted down on their return and items they had purchased removed by staff. We were also informed a person, "Was tagged like a dog" with a tracker due to them frequently absconding.

● We requested care plans and mental capacity assessments for the use of restrictive interventions, however these were not made available to us, this meant people were at risk of restrictive practices without appropriate care plans and authorisations. This indicated a culture of control where staff had power over service users.

Systems were either not in place or not robust enough to demonstrate people were safeguarded and deprived of their liberty with the lawful authority. This placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We found systems in place which evidenced inadequate staffing had been deployed.

● The providers dependency tool calculated 3.5 staff were required at all times, however, the provider only allocated 2 staff per shift day and night. All staff we spoke to consistently told us they worked at low staffing levels directly impacting on the delivery of care.

● The provider had been directed by external professional they required 4 staff on shift 24hrs per day to ensure peoples safety. The provider failed to comply with this, placing people at significant risk.

● The service did not have enough suitably trained and competent staff. We reviewed arrangements for deploying staff and found staff supporting did not always have the required skills to meet the needs of

people, despite this the provider allocated these staff to support, placing people at risk of poor care.

● Records showed the provider had failed to safely recruit staff. We reviewed recruitment and background checks, which were not always completed. The provider had failed on some occasions to demonstrate Disclosure and Barring Checks had been completed. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

The provider failed to deploy sufficient staff. Staff lacked competency and support in order to meet peoples' needs and assess and mitigate known risks to people. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Inadequate. The rating for this key question has remained 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 there were a lack of improvement in systems and processes to manage and monitor the home and poor provider oversight. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found a significant deterioration in the management and oversight from the provider to monitor the quality and safety of service provision, which meant that they remain in breach of Regulation 17 (Good Governance)

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

- We found indicators of a closed culture within the service, due to a lack of managerial and provider oversight. The service had seen changes in management resulting in an unstable environment, with no clear guidance and delegation of responsibility.
- The changes in management had meant infrequent provider and manager oversight within the service, consequently we found a decline in care standards delivered to people.
- The provider had failed to ensure people's needs could be meet. Admissions had been accepted, when it was clear the service did not have the adequate staffing or skills to support people. This meant people were at risk and had their care impacted, due to inadequate support.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- The provider failed to sustain adequate management at the service. Multiple changes to the management created additional risk and reduced their ability to identify, achieve and sustain improvement.
- The provider had also failed to monitor the performance of the management team at the location. This was evidenced by the failings we found at the inspection not having been identified prior to our visit. This failure of organisational oversight and governance created additional risks to the safety and effectiveness of service provision.
- The manager acknowledged the severity of the concerns, they told us, "They [Provider] are risking people's lives here. Nothing would make me happier than to move these people out so I know they will be safe."
- We discussed the areas of concerns within care delivery, governance and leadership with the provider. The provider failed to demonstrate any understanding regarding the severity of the concerns, only telling us, "We are in a bad place" and stating the significant environmental and fire risks, "Would all be sorted by tonight". This gave us no assurances the provider was able to make the required improvement in leadership and care delivery in the service.

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

● Governance processes were ineffective. A lack of oversight at the service and provider level meant the quality and safety of the service had declined. We found no effective monitoring in place, which resulted in poor care.

● Organisational governance and quality monitoring systems had failed in assessing, monitoring and mitigating potential risks to people's safety. This was evidenced by not identifying environmental and fire safety risks and risk management. We found no systems in place to monitor the safety and effectiveness of service provision. The failure to have these in place significantly restricted the ability to identify risks and address shortfalls, exposing people to the risk of avoidable harm and poor-quality care.

● Audit documents we reviewed for medicines and health and safety were also ineffective. The provider failed to recognise the risk identified on inspection. Consequently, we found significant concerns in these areas as detailed in the report, which posed risk to people.

● Collaborative working had not been effective within the management structure of the provider and manager, we observed conflicting conversations taking place, this led to lack of information shared and conflicting information regarding the safety and quality of the service provision. This lack of collaborative working posed a significant risk to people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider needed to improve professional relationships with outside agencies to improve people's care. Due to a lack of leadership, closed culture and minimal reporting, we could not be assured people received the referrals to relevant healthcare professionals as and when needed.

● People were not always supported in the least restrictive way. As detailed in the safe section of this report, people were subjected to restrictive practices due to ineffective systems in place to identify and support least restrictive options.

Systems were either not in place or robust enough to assess and monitor the quality of the service. This placed people at significant risk of harm. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.