Aitch Care Homes (London) Limited

Ashford Lodge

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
Ashford Lodge is a residential care home providing personal care for up to nine people with a learning disability. At the time of the inspection there were seven people using the service. One person lived in an annex on the grounds of the service giving them their own space.

People's experience of using this service and what we found
People were not always treated in a way which was person- centred or took into account their wishes. Some people were restricted by staff and prevented from having a choice in their day to day activities. A few staff had raised some concerns with the registered manager, however, when these were they had not been acted upon or escalated outside the service

Professional help or guidance had not always been sought when people had unaccounted for lost weight. Fire checks and drills had not been completed in a timely fashion. Risk assessments had not been updated when people's needs changed. Relatives stated that communication was poor, and they were not always informed of changes in their loved ones needs.

There were not always enough staff to keep people safe and ensure they could go out or take part in activities they enjoyed. Staff did not have regular supervision and told us their views were not listened to. Incidents were not reviewed for learning and had not been shared with relevant professionals or notified to CQC.

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.

The service rarely applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons, people had restrictions placed on them for example the times they could watch television. People had limited access to food and were given food staff knew they did not like with no alternative available. Low staff levels restricted people's ability to go out or take part in activities they enjoyed.

The provider had put in place temporary managers from two of its other services to support the service, after the registered manager recently resigned, identify shortfalls and take action to improve the care people received. The manager had identified the shortfalls found at this inspection and a plan was in place to address them. When action was urgent such as seeking medical advice for people this had been done. The

managers were working to challenge poor practice and role model for staff.

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 06 July 2018).

Why we inspected
We received concerns about people being restricted and not having full choice in their lives, a closed culture and a lack of consistent support. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this report.

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

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

We have identified breaches in relation to safeguarding people from abuse and improper treatment and good governance. 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 coronavirus and other infection outbreaks effectively.

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

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Requires Improvement

Ashford Lodge

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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection team consisted of three inspectors. One inspector visited the service and two reviewed documentation and spoke to staff. This was to minimise the time spent at the service due to the current pandemic.

Service and service type
Ashford Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection to check the service's COVID 19 status.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four members of staff including the two temporary managers, and two support staff. We observed interactions between people and staff. We offered people the chance to speak to us, however, they declined.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment, staff supervision and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We contacted and spoke with two staff members.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.
This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- A culture had developed in the service which led staff to support people in a way which restricted people's choice and did not respect their wishes. Some staff supported people in a way which was for their benefit not those they supported. For example, during a spell of very hot weather, some people were refused by staff access to baths or showers they requested to cool them down. Staff also reported other staff members speaking to people in derogatory ways, telling them to 'shut up'.
- Staff told us, people had restrictions placed on them such as being unable to watch television at certain times of day and being given food they did not like to eat at meal times without another option. At other times people had very limited access to food, for one meal people had six mini sausage rolls and part of a tin of spaghetti for their main meal, which staff said was inadequate. Staff had reported the lack of available food, but action was not taken to resolve this.
- Staff had received training in safeguarding and told us they had raised some concerns about how people were supported and restrictive practices with the registered manager, but these had not been addressed. Despite their training staff did not raise concerns with any other agency, the provider or use the providers whistleblowing hotline. As a result, people continued to be treated unfairly.
- Temporary managers were overseeing the service in the absence of the registered manager, told us they had taken some action to address restrictive practices and ensure people had more choice in their lives. However, they stated they recognised that a change in culture would take some time.

People had not been protected from the risk of abuse. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people had been assessed, however risk assessments and guidance had not always been updated when people's needs changed, some had not been updated for two years. For example, one person's risk assessment stated they needed one to one support from staff when going out and did not detail new behaviours they may show. Their care plan stated they needed two to one support to go out and three to one support on certain types of public transport. Some staff knew the person needed two to one support however, newer staff were unsure.
- Staff had not completed regular fire checks, for up to four months. When checks were completed it was found some fire extinguishers needed replacement. There was a risk that fire systems would not have worked correctly in the event of a fire.

● Fire drills were due to be completed every three months with a night time drill annually. Only one drill had been completed in the last year and no night time drill since June 2018. There was a risk people and staff would be unsure what to do in the event of a fire. Staff were also unable to record how the changes in people's needs had impacted the support they would need to leave the service in an emergency.
● Staff did not always take action when people had experienced unaccounted for weight loss. One person lost 3 kilograms in one week in June 2020, staff did not seek any medical advice. They did not monitor the person's weight in August or September. The person continued to have issues with their health. However, when the current managers took over managing the service in September, they arranged for the person to see a GP.

Staffing and recruitment
● Rotas did not always plan for enough staff to support people and keep them safe. There were seven people at the service and three staff on a shift during the day and two staff at night. Two people at the service were assessed to require one to one support all the time and two people required two to one support when going out. As a result, people did not always receive the correct support hours or could not go out when they chose or as often as they would like. If a person with two to one support left the service, this left one member of staff to provide both the remaining one to one support and support for the other five people. This meant people could be at risk from the challenging behaviour of others, were unable to be supported with daily tasks or could not go out.
● The managers who were temporarily supporting the service told us, staffing levels should be based on people's assessed needs and contracted hours and there were not enough staff available to meet peoples contracted hours. Staffing levels had not been increased to take into account people's changing needs. For example, some people at the service were getting older and had increased health needs which required more staff support.
● Staff were recruited using safe recruitment practices. Staff supervisions were infrequent with some staff not having had a supervision whilst working at the service. A plan was in place to ensure all staff had regular supervision meetings moving forward.
● The temporary managers told us they had raised concerns about staffing levels with the provider and had used some agency staff to ensure people were safe.

There were not always enough staff to keep people safe and meet people's needs. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The registered manager had not always taken action to review incidents for learning or to update people's needs in their care plans or risk assessments. For example, one person had had an increase in behaviours which could challenge. These had not been reviewed for learning and advice had not been sought from other professionals. The temporary managers had contacted the providers positive behaviour support team for support immediately prior to the inspection.
● After reported incidents where people did not have enough food action was not taken to ensure this did not happen again. Information was not shared with the provider or their senior management team.

Using medicines safely
● People were supported to have their medicines by staff who were trained and assessed as competent. Records relating to medicines were accurate and complete.
● When people had medicines to take 'as and when required' (PRN), a PRN protocol was in place to guide staff when the medicine should be offered, the dose and how often people could have the medicine. When people's PRN medicine was prescribed for anxiety or agitation this was given as a last resort in line with their

care plan.

Preventing and controlling infection

● We were assured that the provider was using PPE effectively and safely. All staff had completed training about COVID 19. Staff had access to enough PPE and used this appropriately.

● We were assured that the provider was admitting people safely to the service. When people left the service for family holidays, they were supported to access testing for COVID, before they left and returned to minimise transmission to their peers.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Infection control audits were completed, and actions had been taken to address any shortfalls.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 culture of the service was not person centred. People had their choices limited and their preferences ignored, in relation to both their day to day activities and what they ate.
- There was a closed culture at the service meaning concerns were not raised with other agencies or senior management. Although a few staff challenged and raised concerns to the registered manager, the registered manager did not address these concerns or challenge how staff supported people. Staff continued to support people in a way which was not inclusive, empowering or person centred.
- The temporary managers planned to speak to people's families about the issues which had been found at the service and how they planned to address them. They were aware of their responsibility under the duty of candour. Duty of candour is the responsibility to be open and transparent when things have gone wrong and to inform people what changes you will make as a result.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff told us and recent staff interviews showed that they had raised concerns about restrictive practices and staff working in a non-person centred way and made suggestions which had been ignored by the registered manager. Staff stated they were made to feel uncomfortable for raising issues and so stopped doing so. Some staff stated this had impacted their mental health.
- Family members were contacted by the temporary managers and stated they had received very limited communication from staff about their loved ones. Some stated that they had not been given information about their loved one's health or appointments they had attended. Relatives stated staff could be unapproachable and they were often not informed of changes at the service. A plan was in place to address the concerns raised.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At the time of the inspection the service was being managed by two temporary managers from the providers other services. The registered manager was in their notice period and was not working at the service.
- The provider had a regional manager who visited the service on a monthly basis. They had not fully

identified the issues with how people were being treated at the service or recognised the shortfalls found at this inspection for example in relation to fire safety.
● The registered manager had not informed the provider of sanctions placed on the service by the local authority. They had not been open and transparent about concerns raised about people's care, which did not give the provider the opportunity to give support or address the issues.
Systems had not been effective in assessing, monitoring and improving 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.

● The registered manager had not always shared information with the local safeguarding team or submitted notifications to CQC when required. There were seven occasions found by the temporary managers where the correct action had not been taken following incidents. The temporary managers had submitted a number of notifications to CQC retrospectively.
Notifications had not been submitted in line with requirements. This is a breach regulation 18 of Care Quality Commission (Registration) Regulations 2009.

Working in partnership with others
● The registered manager had not always engaged with other agencies or professionals to ensure people got the support they needed. For example, not seeking medical advice for people or advice on positive behaviour support from the providers dedicated team, this had now been put in place.
● A visiting health professional told us, "Historically it has been difficult to get engagement from this home - calls were not returned. Paper work has not been completed, for example COVID passports given to the registered manager and had not completed or returned. Now it's completely different. Support we have put into place has not been supported previously by the manager. Since the [temporary managers] have been here it has improved."