Sanctuary Care Limited

Ashgreen House Residential and Nursing 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
Ashgreen House Residential and Nursing Home is a care home providing personal and nursing care to older adults. The home accommodates up to 52 people across four floors and in five units, each of which has separately adapted facilities. One of the units specialises in providing care and support to people living with dementia. At the time of this inspection, 39 people were using the service.

People's experience of using this service and what we found
People were not always protected from the risk of avoidable harm. Risk management plans were not always in place or did not provide staff with the information they needed to ensure people received safe care and support. There was not always enough staff, deployed across all units, to ensure people's needs were safely met. Where accidents and incidents had occurred, lessons were not always learnt to prevent reoccurrence.

We have made a recommendation about the management of medicines.

Care and support was not always planned and delivered to meet people's diverse needs. Records were not always, accurate, complete and consistent.

There were systems and processes in place to assess and monitor the quality of the service, however these systems did not identify the shortfalls we found. The culture at the service was not always positive and staff morale was low.

The provider had sought people and their relative's views to improve on the quality of the service; however appropriate forums were not always in place to gather staff views and act on them.

People were protected from the risk of abuse. People and their relatives were complimentary about the service; particularly in relation to how the provider had managed in response to the COVID-19 pandemic.

We were assured by the provider's infection prevention and control measures and staff followed government guidance, to prevent and minimise the spread of infection.

The service worked in partnership with health and social care professionals to provide joined up care.

Rating at last inspection
The last rating for this service was good (published 9 June 2018).

Why we inspected
We received concerns in relation to staffing, medicines management, organisational culture and infection prevention and control. 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 full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashgreen House Residential and Nursing Home on our website at www.cqc.org.uk.

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

We have identified breaches in relation to risk management, staffing, lessons learnt from accidents and incidents and good governance at this inspection.

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?

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.

Ashgreen House Residential and Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 first day of the inspection was carried out by two inspectors. The second day of the inspection was carried out by one inspector. An Expert by Experience made telephone calls to people and their relatives. 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
Ashgreen House Residential and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

There was no registered manager in post. The manager had applied to CQC to become the registered manager of the home. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service since our last inspection. This included information received from the provider, as required by law, to report certain types of incidents and events. We sought feedback from the local authority who commissioned care from the provider. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people using the service and twelve relatives by telephone, about their experience of the care provided. We spoke with thirteen members of staff including the area manager, the home manager, a nurse, nine care workers and a domestic staff.

We reviewed a range of records. This included fourteen people's care and risk management records and medicine records. We looked at four staff files in relation to recruitment and a variety of records relating to the management of the service, including policies and procedures.

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.

Assessing risk, safety monitoring and management

● Staff were not always provided with the information they needed to protect people from avoidable harm. For example, where people had been assessed as being at high risk of choking, malnutrition and dehydration, there was a lack of guidance for staff about what action they needed take to mitigate these risks.

● Information in people's care records were contradictory. For example, one person had been assessed as being at high risk of malnutrition. However, additional information in their care plan stated they were not at risk of malnutrition.

● Where healthcare professionals, such as the speech and language therapists (SALT), were involved in people's care and treatment, their recommendations had not always been included in people's care records.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these issues with the provider who told us action was being taken to review record keeping and the quality of information included in people's care records.

● Despite these issues with record keeping, staff who had worked at the service for a long time, knew people well and what level of support to provide.

● Risk to people had been identified and assessed in areas including medicines, moving and handling, falls, mobility, skin conditions, eating and drinking and COVID-19.

Learning lessons when things go wrong

● Accidents and incidents were not always investigated or learnt from, to prevent reoccurrence. The provider had carried out an audit of falls for the previous year. However, this only included where and when a fall had occurred and did not seek to identify any underlying causes. For example, one person had fallen twice and on one occasion, they had sustained injuries following a fall in the shower. There was no evidence of any analysis of the incident or of any action taken to prevent reoccurrence.

● One person had left the home without staff knowing and were supported to return to the service by a member of the public. There was no investigation into how this incident had occurred, or action taken to manage any identified risks, or lessons learned to prevent this from happening again.

There was a lack of robust systems and processes in place to improve the safety and quality of the service.

This was a further breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised this issue with the provider who informed us they were taking action to analyse accident and incident records and to share any lessons learnt with staff.

● The provider had policies and procedures for reporting and recording accidents and incidents. Staff told us they would follow the provider's protocols in reporting accidents and incidents.

Staffing and recruitment
● Staffing levels was not always appropriate across all units in the home. One person told us, "I was there for four days without showering, the staff are always so busy… they are short of staff here."
● Staff told us the staffing levels were not always enough to deliver safe care and support on some units. Staff gave us examples of not being able to meet people's needs or attend to them promptly. They said they were unable to finish their tasks for the day and could not always take a break during 12-hour shifts. A member of staff told us, "I felt angry for not being supported."
● On one unit, there were five people receiving support from one staff member. On occasion, these people were left without support, when the staff member had to collect the medicines and/or food. The absence of staff, even for short periods of time, placed people at risk.
● People were at risk of social isolation due to the lack of availability and limited skill mix amongst staff. There was one activity coordinator in post, who also has caring responsibilities. There was minimal meaningful activity for people to engage in, especially for people who preferred to stay in their rooms.

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

We raised these issues with the provider who told us they would review staffing levels, to ensure people's individual needs were adequately met.

●Managers told us staffing levels were planned using a dependency tool based on people's needs. Staffing rotas were consistent and reflective of the number of staff on shift.
● The provider had an appropriate recruitment policy and procedures in place to ensured pre-employment checks were satisfactorily completed for all staff before they began working at the home. These checks included two references, right to work in the United Kingdom and a criminal records check. Nurses were also supported to maintain their registration with the Nursing and Midwifery Council.

Using medicines safely
● Protocols for 'as required' medicines (PRN) were inconsistent and did not follow best practise. For example, where a variable dose had been prescribed, it was not clear which dose to give.
● Nurses working at the service were reviewing PRN protocols. This should be carried out by the GP only.
● Covert medicines were not routinely reviewed or updated following pharmacist recommendations.

We recommend the provider review their policies and procedures in relation to the safe management of medicines and update their practise accordingly.

● There were systems in place to acquire, store, administer, dispose of and monitor medicines; including controlled drugs.
● Staff responsible for supporting people with their medicines had completed medicines training and their

competencies assessed to ensure they had the knowledge and skills to safely support people.
● Each person had a medicines administration record (MAR) which included their photograph, list of medicines, dosage, frequency, preference for taking medicines and any known allergies.
● Records showed the number of medicines in stock matched with the number of medicines recorded and we found no discrepancies.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse. People and their relatives told us people were safe living at the home and they did not have any concerns about abuse. One relative told us, "I do feel [Name] is safe, even from a distance."
●The provider had a safeguarding and whistleblowing policy in place. Staff knew of the provider's policies and said they would escalate any concerns of poor practice to senior managers, the local authority or CQC.
● Staff had completed safeguarding adults' training and understood their responsibilities to report any concerns about abuse to their line manager.
● Managers told us they understood their responsibilities to protect people in their care from harm and to report any concerns of abuse to the local authority safeguarding team and CQC.
● Where there had been any concerns of abuse or neglect, the provider had acted to ensure people remained safe.

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 meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● 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.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 were systems and processes in place for assessing and monitoring the quality of the service. However, these did not identify the issues we found regarding care records, risk management, medicines records and staffing.
- Managers understood their responsibilities to be open and transparent when things went wrong. However, there was a lack of learning from incidents and accidents to drive quality and safety at the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concerns with the provider who told us they had identified issues with record keeping and staff engagement. The provider had plans to hold regular staff meetings from the following month.

- The manager had applied to register with CQC and was being supported in their role by the regional manager and a registered nurse.
- Representatives from each unit or department met each day, to receive updates on areas such as hospital admissions, staff sickness, training and any issues of concern. Managers outlined their expectations and each of the department representatives were responsible for disseminating information on to staff.

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

- The culture at the service was not always positive. Care and support was not always planned and delivered to ensure the needs of people from minority and ethnic backgrounds were met. For example, one person acquired most of their daily meals from a local restaurant or through relatives, because the home did not cater for their dietary preferences.
- Care plans included information about people's likes and dislikes; however, care was not always planned to ensure people's individual preferences were met. For example, one person who preferred to have a shower daily was not always able to.
- Staff morale was low. Staff told us they did not feel supported and were not confident in raising concerns

or providing feedback to managers. Some staff felt supported by managers, whilst other staff reported issues of favouritism, racism, threats and intimidation. A staff member commented, "I wish I do not have to go back there to work...it is terrible" and another said, "At the moment I don't feel like going into work, I am emotionally stressed."

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

- The provider did not take into account the views of staff to improve the quality of the service. Staff meetings had not been held and staff told us the culture was not inclusive.
- The provider sought people and their relative's views to improve the quality of the service. The provider held weekly relatives' meetings to update relatives with important information and gather their views about the service. One relative told us, "It is easy to speak to a member of staff or the manager, the new manager is very visible and easily accessible"
- The service worked in partnership with key organisations, including the local authority and other health and social care professionals to provide joined-up care.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People were put at risk of unsafe care and support because records were not accurate, complete and consistent. The systems in place to monitor and assess the quality of the service were not always effective in identifying and driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were put at risk of receiving unsafe care and support because sufficient numbers of staff were not effectively deployed to ensure people's needs were met.