Mrs Manny Wragg

Ashlands Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ashlands Care Home is a residential care home providing personal care to up to 30 people. The service provides support to older people and people living with dementia in one adapted building. At the time of our inspection there were 20 people using the service.

People's experience of using this service and what we found
Risks to people in relation to their personal care were not managed safely. Care plans were not accurate and did not reflect people's current needs. People were not protected from the risk of abuse. There were not enough staff to keep people safe. The provider had not ensured there were robust measures in place for managing the prevention and control of infections.

People's needs and choices were not consistently assessed in line with current legislation and guidance in a way that helped to prevent discrimination. Staff did not always have the appropriate skills and experience to support people safely and effectively. The provider had not ensured people consistently had access to a balanced diet that met their assessed needs and preferences. People did not always have timely access to healthcare professionals.

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.

People were not consistently treated with dignity and respect. People were not offered choices in ways which were meaningful to them. People were not involved in reviews of their care, particularly where they were less able to communicate their needs. The provider did not ensure people's confidential personal information was stored securely.

The service was not well led. People were put at risk because the provider failed to ensure suitable quality assurance checks identified issues with care and support. The provider did not have systems in place to identify when things went wrong. Feedback from people, relatives, staff and external professionals was not used to improve the quality of care. The provider was unable to demonstrate a commitment to continual improvement and was not delivering personal care in line with current best practice guidance. The provider had not ensured there was a clear set of values or vision of delivering safe, effective and compassionate care.

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 29 September 2021). This service has been rated requires improvement for the last five consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

The overall rating for the service has changed from Requires improvement to Inadequate. This is based on the findings at this inspection.

Why we inspected
The inspection was prompted in part due to concerns received about concerns about the quality of care for people, and the recent outcomes of safeguarding investigations. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. On the first day of inspection we decided to also include the key question of caring. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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 have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring 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 Ashlands Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to person centred care, dignity and respect, consent, safe care and treatment, safeguarding people from abuse, good governance, staffing and fit and proper persons employed. We also identified breaches in relation to the registered provider's statement of purpose, and notifications of incidents.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Ashlands Care Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector and one expert by experience. 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
Ashlands Care Home 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. Ashlands Care Home 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 no registered manager in post.

Notice of inspection
This inspection was unannounced.

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, the local clinical commissioning group, and from Healthwatch about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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
During the inspection we spoke with four people who used the service and observed how care and support was given generally. We spoke with two relatives and four care staff. We spoke with the manager and the provider. We looked at a range of records including three people's care records, how medicines were managed for people, and staff records. During the inspection visit we asked the provider to give us additional evidence about how the service was managed, including records relating to governance and staff training. Not all of the information we requested was provided.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks to people in relation to their personal care were not managed safely. Risk assessments and care plans were not accurate and did not reflect people's current needs.
- One person did not have a care plan in place to help staff monitor their catheter site. There was no guidance for staff on how to ensure the person's catheter site and skin remained healthy. Records of the person's care did not refer to the health of the person's skin at the catheter site, so the provider could not be assured staff were doing daily checks on skin integrity. There was a risk that early signs of infection would not be identified quickly.
- The same person's care records contained contradictory information about a serious health condition. Staff did not know whether this was a current or historic diagnosis. Staff confirmed there was no guidance in the person's care plans on what staff should monitor, or what signs would indicate professional advice was needed. This put the person at risk of not receiving medical intervention at an early opportunity.
- Another person was assessed at high risk of skin breakdown and needed to be supported to reposition every two hours at night. Their skin needs had not been re-assessed since June 2022, and the manager confirmed this should be done monthly. Records of the person's nightly repositioning support showed this was not happening, which put the person at risk of pressure sores. The provider could not be assured the person's skin care needs were being met.
- There was no written guidance for staff using the kitchen for food and drink preparation for people with specific dietary requirements. We saw one person consistently receive food prepared to a texture they were not assessed as needing. The person confirmed they did not like or need their food prepared this way. Four other people, who had diabetes which was managed by diet, did not receive the meals specifically prepared for them. This put people at risk of poor health as they were not receiving the diets they were assessed as needing.
- There were no systems in place to review accidents and incidents to identify trends and to prevent reoccurrences.

People continued to be at risk from personal care that was not assessed or delivered safely. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risk of abuse.

● Five local authority safeguarding investigations in the last three months concluded that abuse was substantiated, and the local authority made recommendations to improve the quality of care and reduce the risk of abuse reoccurring. All investigations related to allegations of poor care practices which had an impact on people at Ashlands Care Home.

● The recommendations made following these local authority safeguarding investigations were not implemented, leaving people at continued risk of abuse.

● The provider had no clear process to incorporate safeguarding investigation recommendations into people's care planning to reduce risk of further abuse, there was no clear process for any lessons learnt to be shared with staff team for wider learning. There were no additional checks put in place to ensure that poor care practices were identified quickly and dealt with.

Due to a lack of systems and processes to keep people safe from abuse, people were placed 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

● There were not enough staff to keep people safe. On the first morning of our inspection, there were only 2 care staff and 1 senior staff available to assist 20 people with personal care. We found 1 member of staff had not come into work, and the manager had not taken steps to try to get other staff or agency staff to come in.

● Our observations during the inspection showed us that generally, people were not supported by enough staff. This included when people needed support or reassurance or wanted to participate in an activity. For example, we saw several occasions where people were involved in verbal altercations with each other. There were no staff in the communal areas at the time, because they were assisting people elsewhere. Staff told us that, whilst it was easy to deal with incidents like this, there was not always enough staff to ensure people had supervision and support in communal areas.

● The provider's dependency tool, used to help calculate staffing levels, focussed on task-focussed care. It did not take into account people's emotional or social support needs.

● New staff, who were still in their induction period, should have been supernumerary and not counted in the actual staffing numbers on shift. We identified this was not the case for 1 staff member, who was at work during our inspection.

Due to a lack of staff, people were placed at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not always recruited safely. Checks were not consistently carried out on staff prior to employment to ensure they were of good character and fit to carry out their work. For example, some staff did not have appropriate references and gaps in employment history had not been explored on either application or interview. The provider could not evidence they had carried out the relevant right to work checks to ensure prospective staff could be legally employed.

Due to a lack of robust recruitment checks, people were placed at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The provider had not ensured there were robust measures in place for managing the prevention and

control of infections.
● Staff did not follow good infection control protocols when handling clinical waste.
● We saw staff did not follow guidance on safe handwashing techniques, or the correct wearing and disposal of personal protective equipment (PPE) such as masks and gloves.
● Areas of the kitchen were not clean, including food storage containers. For example, plate guards (used to assist people in eating more independently) were stored in a container which was dirty. One of the food guards had dried-on food on it.
● Therapy dolls used by people were soiled and dirty. There was no cleaning schedule in place for the dolls.
● Although the provider had policies in place to inform staff about the safe management and control of infection, staff demonstrated they were not following this.
● All this put people at risk of acquiring and transmitting infections.

Due to a lack of good infection prevention and control measures, people were placed at risk of harm. This 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
● There were no restrictions on people welcoming visitors to their home and the provider was following currently published visiting guidance by the Department of Health and Social Care.

Using medicines safely
● People received their prescribed medicines safely. Medicines were managed and stored safely. There was a system in place to ensure people were offered their medication as prescribed. Staff received training about managing medicines safely and had their competency assessed. Staff told us, and evidence showed that overall, medicines were documented, administered and disposed of in accordance with current guidance and legislation.
● Each person's medicines records had key information about allergies and how people liked to be given their medicines. The system for managing medicines ensured people were given the right dose at the right time.

Inadequate

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 Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs and choices were not consistently assessed in line with current legislation and guidance in a way that helped to prevent discrimination. For example, people's social needs were not assessed, and the provider did not deliver care in ways that met people's individual needs. People were not supported to take part in activities they enjoyed doing or found meaningful.
- There was little evidence that people's views about their care was sought, either at their initial assessment before moving to Ashlands Care Home, or at subsequent reviews of their care.
- People were not consistently supported to be able to express their views and wishes about their care. Where people had additional communication support needs in relation to their disability, the provider had not considered how those needs could be met. For example, one person who required support with using a communication aid did not have this available to them. This put them at risk of not being able to fully communicate what they wanted or needed.

Due to a failure to consistently assess and deliver person centred care, people were at risk of discrimination. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff did not always have the appropriate skills and experience to support people safely and effectively.
- Staff were not able to consistently demonstrate that they put their training into practice to ensure good quality care. For example, staff induction training included the principles of good infection prevention and control (IPC). We saw staff were not consistently practicing these principles.
- From reviewing staff training records, not all staff had received the training the provider identified as needed in order to provide safe care. For example, 8 staff had not done basic first aid training, and none of the night staff were trained to give medicines. This put people at risk of not having medication if this was needed during the night.
- One staff member had no record of an induction and demonstrated on several occasions that they lacked knowledge of people's care needs.
- Staff meeting minutes from 15 September 2022 noted that staff did not have regular supervision. Supervision is designed to give feedback on performance and discuss training needs. This put people at risk from receiving care from staff whose skills and knowledge was not assessed or monitored.

Due to a failure to ensure staff had the appropriate skills and experience to provide safe care, people were at

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

● The manager told us they have now ensured all staff have had an individual supervision, so they could begin to identify what support staff needed. The manager also confirmed that all staff who were lacking any training the provider deemed necessary were now undertaking the relevant courses to ensure they had the skills needed.

Supporting people to eat and drink enough to maintain a balanced diet
● The provider had not ensured people consistently had access to a balanced diet that met their assessed needs and preferences. There was little evidence that people were supported to have choices about their daily meals and snacks. Information about people's likes and dislikes was not readily available to staff, and there was no evidence people or their relatives were asked about food and drink preferences in relation to their faith or culture.
● When one person was asked about their teatime meal choice, staff then changed that choice for them on the basis of which meal was easier to prepare. This did not respect the person's choice of meal.
● Staff showed a lack of awareness of the British Dietetic Association guidelines for people who needed food prepared to a specific texture. One person was given blended food, which was not separated out into individual ingredients, when they did not need this. The person confirmed with us they did not like their meals prepared this way.
● All people at Ashlands Care Home were on fortified diets, as confirmed by staff. There was no clinically assessed reason for this. This put people at risk from receiving fortified food they did not require or choose, increasing the risk of excess sugar and fat in their diets.

The failure to ensure people had access to choices in relation to meals put people at risk. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Care records in relation to contact with health and social care professionals were unclear. The provider could not assure themselves that staff were contacting professionals in a timely manner or documenting any advice to ensure all staff knew how to maintain people's health and wellbeing.
● Records relating to people's appointments with health and social care professionals were kept across different systems. This included the electronic care planning system, two diaries and paper records in people's care files. This meant staff did not have a good oversight of advice from professionals.

Due to poor governance of the service people were placed at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not consistently supported to have healthier lives.
● For example, one person's glasses were broken. The person told us they had been broken for some time. Records confirmed the person's glasses had been noted as broken in January 2021, but there were no further records indicating that staff had taken any action. Staff were not able to tell us if the person had seen an optician to ensure their glasses were fixed, or to check the health of their eyes.

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.

● The provider had not ensured staff understood the principles of the MCA, including how to support people to make their own decisions, and how to proceed if the person lacked capacity for a particular decision.
● Mental capacity assessments did not document the views of people or relatives. There was no information about how choices had been presented to people in ways they could understand. We saw that staff did not consistently offer people choices using their preferred communication style as part of everyday activities.
● People's access to some of the areas of the building was restricted by doors with keypad locks. For example, one of the corridors with bedrooms was not accessible for people unless they had staff support to unlock the doors. This meant some people were unable to make their own choices about going to their bedrooms unless staff gave them access. This restriction had not been assessed in relation to people's capacity to consent, or to see if less restrictive options were more appropriate.

People's consent to care and restrictions had not been sought. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Conditions associated with people's DoLS authorisations were not reviewed regularly to ensure they were met. This meant there was a risk people's restrictions were no longer relevant to their care needs and potentially disproportionate.
● The provider had assessed people to see if they were at risk of being deprived of their liberty and had made DoLS applications for a number of people.

Adapting service, design, decoration to meet people's needs
● The provider had not ensured the environment was suitable for people's needs.
● The service was not designed in a way which made it friendly and accessible to people with dementia. There was a lack of clear signs around the building to help people orientate themselves. For example, bedroom doors were a uniform colour and design, which meant people with dementia would have difficulty identifying their own room.
● Lack of consideration for the building design and decoration put people at risk of being disoriented. This had the potential to reduce people's independence skills. For example, there was a risk that people could not locate the toilet due to lack of signs they could understand.
● People were encouraged to make choices about decorating their personal space, and their bedrooms were personalised. There were also adaptations for people with mobility needs, for example, handrails in corridors and bathrooms.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not consistently treated with dignity and respect. We heard staff use undignified terms to address people. We also saw staff behaving unprofessionally when supporting people. For example, swearing in front of a person, or using a derogatory word to refer to a person.
- We saw that some staff were very task focussed, with little attempt to engage people in conversations to put them at ease. For example, one person was supported by staff to transfer from their wheelchair to a chair using a rotunda. The staff member supporting them only spoke using one-word instructions, and with no attempt to reassure the person or talk with them in any other way.
- We saw the same person had an aspect of their personal appearance neglected. Their glasses were dirty and smeared with dried food. When they were coughing during a meal, staff did not support them to clean their hands and face afterwards.
- People were not treated with respect as they did not always have a choice of whether they had male or female care staff to support them with intimate personal care. One relative said their family member did not like personal care being provided by male staff. On the first morning of our inspection, male staff were supporting people with personal care, as the female staff member was busy with medication and other duties.
- People were not offered choices in ways which were meaningful to them. For example, meal options were given to people verbally and there was no use of pictorial menus or visual cues to aid people in making a decision about what they would like to eat or drink. People were not involved in menu planning and were only given one meal choice. People who had difficulty expressing their views were not supported to choose an alternative meal option.
- We spoke with the manager about people not being treated in a dignified or respectful way. The manager said they were aware of this and would take action to address these concerns. This put people at risk of receiving support that was not dignified or respectful.

Due to a culture that did not uphold people's dignity and respect, people were placed at risk of harm. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

- People were not involved in reviews of their care, particularly where they were less able to communicate their needs and wishes. Staff said reviews of people's care plans were not always completed with people, and records confirmed this. People were not given information about their care plans or reviews of care in

ways that were meaningful to them; for example, in easy read or pictorial formats. The provider had not ensured people who required additional support with communication had their needs met.
● Staff were not always familiar with people's communication styles. For example, 1 person's care plan said they used an aid to enhance their communication. The person confirmed they did not have the aid with them, and that they did not know where it was. Staff confirmed the aid was not used. This meant the person was left without their communication support, and they could not effectively tell staff what they wanted or needed.

Due to a failure to support people to be involved in making decisions about their personal care, people were placed at risk of harm. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence
● The provider did not ensure people's confidential personal information was stored securely. For example, paper-based care records were kept in a small staff office, which was not secured when not in use. We found numerous occasions on this inspection where this office door was unlocked. This meant information about people's health needs was not kept confidential and compromised their right to privacy and dignity.

Due to poor governance of the service people were placed at risk of harm. This was a breach of regulation 17 (Good governance) 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 Requires improvement. At this inspection the rating has changed to 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.

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
At our last inspection the provider had failed to ensure robust governance procedures were in place. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The service was not well led. People were put at risk because the provider failed to ensure suitable quality assurance checks were in place to identify issues with care and support.
- Audit systems were not comprehensive or robust and had failed to identify the issues we found on this inspection. This meant people were placed at risk because issues with the quality of care were not identified, and there was no opportunity for learning and improvement of care.
- The provider did not have systems in place to identify when things went wrong. This meant they lacked sufficient information to improve the service and failed to encourage a culture of continuous improvement.
- The provider's service action plan did not incorporate information about how the actions needed would be measurable, achievable or realistic. The action plan allocated tasks to staff who were no longer employed there, meaning there was a risk no-one was responsible for these actions. The action plan did not contain any measures that the registered provider themselves would take to ensure they had robust oversight of the governance of the service.
- The provider's action plan did not incorporate feedback from people, relatives or staff. It was not clear how the provider would demonstrate that everyone's feedback about the quality of care was important in driving improvements.
- Feedback from external checks and audits was not used to improve the quality of care. For example, the fire risk assessment carried out by an external professional, had a number of recommendations required to ensure fire safety systems were robust and compliant with the law. These had not been incorporated into the provider's action plan, and we found evidence that some actions had not been done. This put people at risk.

Due to poor governance of the service people were placed at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was aware of the requirement to notify CQC of certain incidents, but our records showed that

these notifications were not always sent in as required. For example, notifications in relation to abuse or allegations of abuse were not submitted. This meant the provider was not informing us about events that occurred in the service which assist us to monitor the quality of care.
● The provider had not provided CQC with an up to date statement of purpose. A statement of purpose describes what the provider does, where they do it and who they do it for. Providers must notify CQC of any changes to their statement of purpose and ensure it is kept under review and notify CQC when there are any changes. We asked the provider to notify CQC of their updated statement of purpose but the provider had not done this.
● The provider was displaying their ratings from the previous inspection as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others
● The provider failed to ensure issues highlighted in previous inspections were addressed, such as managing risks in relation to people's personal care safely.
● Ashlands Care Home has a history of breaches of regulation going back to 2016, which demonstrates an ongoing failure of leadership and governance to meet the fundamental standards.
● There was no evidence that the provider gathered and used information on the day to day delivery of the service such as completing care plan reviews, resident meetings, or monitoring safeguarding incidents and accident data to learn and improve the care provided to people.
● Poor record keeping was identified as an issue at the last inspection. This had not improved, and the quality of care records was such that staff did not have access to clear accurate information about people's needs. This put people at risk of receiving inconsistent care that did not meet their assessed needs.
● Feedback from the local authority's quality monitoring audits was not used to drive improvement.
● The provider was unable to demonstrate a commitment to continual improvement and was not delivering personal care in line with current best practice guidance.

Due to a failure to learn from previous inspections and audits, people were placed at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us they had not felt well supported to carry out their roles. However, they spoke positively about the new manager, and expressed hope that the quality of the service would improve. Relatives also spoke positively about the new manager, with one saying things were improving, but they hoped it would not take too long for positive change to happen.
● There was no evidence that the provider regularly sought feedback from people, relatives or staff to help drive improvements in the quality of care.
● The provider lacked effective systems to ensure staff were kept involved and informed about key issues relating to the quality of the service. There was no evidence of, for example, regular staff meetings prior to September 2022.
● The provider had not ensured there was a clear set of values or vision for delivering safe, effective and compassionate care. Overall, the principles of good quality care were not embedded at Ashlands Care Home.

Due to poor governance of the service people were placed at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

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 9 HSCA RA Regulations 2014 Person-centred care People's needs and choices were not consistently assessed in line with current legislation and guidance in a way that helped to prevent discrimination. Where people had additional support needs in relation to their disability, the provider had not considered how those needs could be met. People were not involved in developing or reviewing their care. People were not given information about their care plans or reviews of care in ways that were meaningful to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect. We heard staff use undignified terms to address people. People did not always have a choice of whether they had male or female care staff to support them with intimate personal care. Some staff were very task focussed, with little attempt to engage people in conversations to put them at ease.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured staff understood the principles of the MCA, including how to support people to make their own decisions,

and how to proceed if the person lacked capacity for a particular decision. Records of assessments of capacity did not document the views of people or relatives. There was no information about how choices had been presented to people in ways they could understand. Conditions associated with people's DoLS authorisations were not reviewed regularly to ensure they met the principles of the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured people consistently had access to a balanced diet that met their assessed needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider could not assure themselves that they had recruited staff safely. Checks were not consistently carried out on staff prior to employment to ensure they were of good character and fit to carry out their work. The provider could not evidence they had carried out the relevant right to work checks to ensure prospective staff could be legally employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to keep people safe. Staff did not always have the appropriate skills and experience to support people safely and effectively.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications in relation to abuse or allegations of abuse were not submitted.

The enforcement action we took:

We have issued the provider with a fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people in relation to their personal care were not managed safely. The provider had not ensured there were robust measures in place for managing the prevention and control of infections.

The enforcement action we took:

We have issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse. The provider had no clear process to incorporate safeguarding investigation recommendations into people's care planning to reduce risk of further abuse, and no clear process for any lessons learnt to be shared with staff team for wider learning. There were no additional checks and balances put in place to ensure that poor care practices were identified quickly and dealt with.

The enforcement action we took:

We have issued the provider with a warning notice.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were put at risk because the provider failed to ensure suitable quality assurance checks identified issues with care and support. The provider did not have systems in place to identify when things went wrong. Feedback from people, relatives, staff and external professionals was not used to improve the quality of care. The provider was unable to demonstrate a commitment to continual improvement and was not delivering personal care in line with current best practice guidance. The provider had not ensured there was a clear set of values or vision of delivering safe, effective and compassionate care.

The enforcement action we took:

We have issued the provider with a warning notice.