

Bupa Care Homes (GL) Limited

Cleveland House Care Home

Inspection report

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Edgerton
Huddersfield
West Yorkshire
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Tel: 01484512323

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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

Cleveland House Care Home is a nursing home providing personal and nursing care to 27 people aged 65 and over at the time of the inspection. The service can support up to 45 people.

Cleveland House Care Home has three floors accessed by passenger lift with single rooms, shared toilet and bathing facilities on each floor. Outside there is a garden with seating areas.

People's experience of using this service and what we found

Infection Prevention and Control (IPC) measures were not consistent in the service. Some senior members of staff were not wearing personal protective equipment correctly. One senior member of staff wore clothes which increased the risk of infection transmission. Staff were not consistently socially distancing.

Audits were regularly completed but these did not consistently identify issues that needed addressing. Care plans and records were reviewed regularly. Care plans were person centred and clear in detailing what support the person required. People had not consistently been involved in the creation of their care plans and consent was not always sought.

People felt safe living at the home. People seemed relaxed and comfortable and staff knew people's preferences. Staff treated people with dignity and respect and staff had good interactions with people. People and their relatives spoke positively about the staff, service and the care people received. Staff members had been recruited safely and there were enough staff to meet the needs of people using the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff were able to demonstrate how they were meeting the underpinning principles of Right Support, Right Care, Right Culture guidance. People were treated with dignity and respect; people's choices and preferences were sought, and staff prioritised the happiness of the people using 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

The last rating for this service was good (published 28 June 2019).

Why we inspected

We received concerns in relation to infection prevention and control following a recent COVID-19 outbreak at the service. 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 required 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.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to regulation 17 (good governance) and regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Cleveland House 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 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

One inspector and a specialist advisor who had expertise in Infection Prevention and Control practices conducted the inspection.

Service and service type

Cleveland House is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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

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, professionals who work with the service and Healthwatch. 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 all this information to plan our inspection.

During the inspection

We spoke with two people who used the service and five members of staff including the regional support manager, registered manager, nurse, senior care worker and the chef. The inspection team minimised direct contact with people as they were self-isolating in their room due to the risk of COVID-19. The inspection team used techniques such as observing care interactions and staff engagement with people.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service including policies and procedures, accidents and incidents, lessons learnt and safeguarding referrals to the Local Authority were reviewed.

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 spoke with a further five members of staff including activity coordinators, care workers and administration workers. We also spoke with two relatives of people using the service.

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.

Preventing and controlling infection

- Measures were not consistently applied in the management of infection prevention and control which put people at risk.
- Overall, most staff wore personal protective equipment (PPE) correctly with designated points in the service to put on and take off PPE. One senior member of staff was not wearing a face mask correctly on several occasions during the inspection. This placed people at a greater risk of acquiring an infection.
- Hygiene standards were not consistent during the administration of medicine. One senior member of staff misunderstood PPE requirements by changing PPE between each person rather than sanitising their hands. This increased the risk of infection transmission and exposed people to a greater risk of COVID-19.
- Medication was not consistently administered in line with infection prevention and control measures. One medication trolley was contaminated with debris which was not cleaned by the dispensing member of staff.
- There were systems in place to promote social distancing. For example, the preparation and delivery of people's food and drink was organised where staff social distanced in the dining room with a "one in one out" system.
- There was an incident where at least six members of staff and a senior member of staff were not socially distanced. This increased the risk of infection transmission and the spread of infections, and this was not in line with national and internal guidelines. There was one senior member of staff who was not dressed appropriately to prevent and control the spread of infection.

This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Assessing risk, safety monitoring and management

- Quality audits were carried out but these did not identify weaknesses highlighted during the inspection. For example, the inspection team identified care plans were not always created with the person's involvement. There were examples of daily notes which did not refer to the person with dignity and respect or in person centred way. Internal checks on infection prevention and control concerns did not detect poor practices and creams and ointments were not consistently dated when opened. The latter was raised on the last inspection.
- Risk assessments were in place, up to date and contained detail specific to that person. Documentation regarding nutrition, hydration, falls and skin care were completed and updated regularly. One relative told us "[I'm positively] blown away by the care" and "all the staff are lovely with [person]."
- Moving and handling equipment was clean, and safety checked in line with guidance.
- Equipment used to keep people safe, such as bed rails and hoists, had risk assessments and care plans in

place. This included consideration as to whether this was the least restrictive option and what alternatives could be used to promote the person's independence.

Using medicines safely

- The management of medication was not always safe. Robust audits were not completed, and medication was not consistently stored correctly.
- There were gaps in some staff knowledge regarding the oversight and storage of medication for a person who had decided to administer their own medication. This was not identified on the medication audits.
- One person had been prescribed a cream. This was found by the inspection team in their room and not stored in a locked cabinet. The cream had been dated as being opened two months previously, but the bottle was still full even though it has been signed by staff as being applied every day. Members of staff were unable to identify which cream had been used and why there was a full bottle of cream in the person's room.
- Controlled drugs, which are prescription medicines controlled under Misuse of Drugs Act 1971, were stored securely, logged in a register and managed appropriately. A random sample we checked found the amount of medicine remaining was correct and tallied with the register.
- The registered nurse had a good understanding of the medicines and had a high level of skill and experience regarding the medicines people were prescribed.

Systems and processes to safeguard people from the risk of abuse

- Systems were not effective enough to protect people from the risk of abuse or harm. The inspection team informed the registered manager of three incidents which required an internal investigation to understand what had happened.
- Staff had training to recognise the signs of abuse and neglect.
- The provider reported incidents of alleged abuse or neglect to the local authority when this was identified.

Staffing and recruitment

- Staff were recruited safely and there was enough staff to meet the needs of people living at the service.
- The provider used a dependency tool which identified people's needs and the amount of time each person needed to keep them safe. This linked with the staffing rota which showed there were enough staff available.
- Staff did not raise concerns regarding low staffing levels.
- We asked relatives if they felt there was enough staff around and one relative told us, "There is enough staff. There is a strong work ethic amongst the staff team."

Learning lessons when things go wrong

- The provider did not always learn lessons when things went wrong.
- The registered manager had a record of accidents and incidents and a corresponding record of lessons learnt but the inspection team found that not all incidents were captured in this record. This left some people's complaints and allegations unresolved and not subject to an internal investigation.

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

- The registered manager did not have consistent oversight of what was happening within the service. Tasks such as spot checks, audits and reviews were completed on a regular basis, but these were not robust in picking up weaknesses.
- The provider failed to recognise through IPC audits the risk a senior member of staff posed through their choice of clothing. It was not compliant with infection prevention and control guidelines. This was raised to the provider following the inspection, however, the senior member of staff continued to wear similar clothing at a subsequent meeting. This posed a risk of infection transmission to people using 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 was thorough in the recording and reporting of COVID-19 incidents. Furthermore, the registered manager was prompt in keeping partner organisations up to date with the progress of COVID-19 within the service.
- The registered manager had submitted statutory notifications to CQC promptly. An example of a statutory notification is where the service is required to inform us of an accident where there was a serious injury. The submission of statutory notifications allows us to effectively monitor the service.
- We saw the ratings from last inspection were clearly displayed at the service and also on the provider's website.

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

- People benefitted from a positive culture where people had good relationships with staff.
- Staff routinely spoke with people to check their welfare and discuss any concerns that the person had. Relatives advised us they received regular updates from the service. One relative told us "[member of staff] is brimming with energy. [They] are amazing," whilst another relative confirmed they had regular video calls with their relative. One person told us they routinely contacted the registered manager with any concerns they had and received a satisfactory response.
- Positive interactions were observed between people and staff. Staff knew people well and prompted the person to have choice, control and independence over their life.

- The provider had received one complaint in the last 12 months which was responded to.

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

- The provider acted within its legal responsibility to be open and honest when things went wrong.

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

- The service has experienced a challenge in the management of COVID-19 to keep people safe whilst maintaining people's involvement in the service. The activity coordinator and other staff continued to spend time with people who were self-isolating in their rooms to provide social stimulation and companionship.
- Due to the challenges of COVID-19, the service engaged with people and their relatives on an individual basis to involve people in decisions about the service and care delivery.
- Short staff meetings were held each morning to discuss any issues or updates within the service.
- Staff told us the registered manager was approachable and they felt listened to.

Continuous learning and improving care

- The provider did not consistently learn lessons to improve care when things went wrong.
- The registered manager held extensive and detailed records of accidents and incidents within the service. However, the registered manager was not aware of all incidents which required further investigations. This left concerns raised by some people unresolved. Feedback was given following the inspection and the registered manager started an internal investigation.
- There were regular updates shared from the provider to the staff throughout the week in relation to changes in guidance, policy or practice to ensure that the service provided high quality care.

Working in partnership with others

- The service had good working relationships with commissioners, the local authority and external healthcare staff. This ensured people received the right care. Staff engaged with partners to provide a multi-disciplinary approach to support people living at the service.