Kevindale Residential Care Home

Caradoc House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Caradoc House Residential Care Home is a care home providing support with accommodation and personal care for up to 11 people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of this inspection 10 people were receiving accommodation and personal care, some of whom were living with dementia.

People's experience of using this service and what we found
People were not safe. The provider failed to ensure substances hazardous to health were safely stored, firefighting equipment was readily available or that window restrictors were in place on all windows.

The provider did not effectively analyse significant incidents to learn from them and to make changes to improve people's safety. The provider's infection prevention and control procedures were not effectively followed.

People were not always treated with dignity or respect. Confidential information was not secured and was accessible to those without authority. People's personal property was not safely or appropriately stored.

The registered manager did not model a positive example of interaction and engagement with people and did not value people's personal space. People were not protected from ill-treatment or abuse as the provider did not have robust systems in place to safeguard people.

People's medicines were not safely stored, and the provider did not have checks in place to ensure people received their medicines as prescribed.

The provider failed to ensure there were enough suitably qualified staff deployed at all times.

The provider failed to notify the CQC of all significant events as required.

The provider did not have effective quality monitoring procedures in place to drive improvements in the care they provided. The management team did not have clearly defined roles and responsibilities.

Staff members knew what to do if they suspected something was wrong. People were complementary about the staff who supported them on a day to day basis who they found to be kind and caring.

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

The provider followed safe recruitment practices.

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 10 September 2021).

At that inspection improvements were needed in order to keep people safe and on how the location was managed.

Why we inspected
The inspection was prompted by concerns about the management of the location. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only.

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 the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence the provider needs to make improvements. Please see the safe, caring and well-led sections of this report.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Caradoc House Residential Care 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 and will take further action if needed.

We have identified breaches in relation to keeping people safe, dignity and overall governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Caradoc House Residential 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
This inspection was completed by one inspector.

Service and service type
Caradoc House Residential Care Home 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. In this instance the registered manager was also the provider. This means they are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality.

During the inspection
We spoke with three people who used the service about their experience of the care provided and we spent time in the communal area observing the support people received. We spoke with six staff members including care staff, deputy manager, cook, registered manager and maintenance manager. We also spoke with the operations manager on the telephone. We looked at three people's care and support plans, several documents relating to the monitoring of the location and health and safety checks. In addition, we looked at two staff files.

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. The rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

●The physical environment was not safe for people. For example, the provider had failed to ensure windows had appropriate restrictors in place putting people at risk of harm from a fall from height. People accessed areas where large wardrobes, ladders, used doors and wooden pallets were not secured safely putting people at risk of harm from crushing.

● People had access to harmful substances. We found bleach, weed killer, cleaning chemicals and building materials which were left unsecured throughout the premises. People were independently mobile, including those living with dementia. This put people at the risk of harm from accidental or intentional ingestion of harmful substances.

● The provider had completed a legionella risk assessment. Legionnaires' disease is a potentially fatal form of pneumonia caused by the inhalation of small droplets of contaminated water containing legionella. However, they failed to review this following the building of an extension and subsequent creation of "dead leg pipes". These are pipes where water can gather and stagnate creating an increased risk of legionella. The provider failed to evidence regular water "flush throughs" of seldom used water outlets. These issues put people at risk of harm from legionella.

● There was not an effective record of who was in the building at any given time which would assist emergency services in the event of an emergency. For example, there was no record the registered manager, maintenance manager or two staff sleeping on the second floor were in the building. People had individual personal emergency evacuation plans but these were not updated to reflect people's changing needs and were kept in a locked office and not easily accessible. This emergency information did not contain any information for one person. This put people at risk of harm in the event of an emergency.

● Fire safety measures were not effectively followed. The fire door leading from the ground floor to the first floor did not effectively close and the fire door leading from the kitchen was wedged open. This put people at risk of harm from fire or smoke inhalation.

● Some areas of the home were poorly maintained. We saw several instances where carpets and carpet edging had been damaged and was lifted creating a trip hazard putting people at risk of harm from tripping over. An external door was poorly fitted and did not close compromising the security for those living in the premises.

● Radiators were uncovered and the hot water piping leading to them was exposed putting people at risk of harm from burns. A radiator in one person's room had its metal casing damaged exposing sharp edging putting people at risk of harm from injury.

● Not all risks associated with people's care and support were recognised or recorded. One person had a known health condition and had taken to spending large amounts of time in their bed. There was no mental health risk assessment or care plan in place to support the person's emotional wellbeing and staff did not know how to support this persons changing health needs. This put the person at risk of a deterioration in

their mental health.

Using medicines safely
● People did not have their medicines appropriately or safely stored. The medicine trolley was kept in an unlocked room and had not been secured to a fixed point. This put people at the risk of harm from potential access to unsafely stored medicines.
● People were at risk of harm from chocking as prescribed drinks thickeners were unsafely stored in an unlocked kitchen and in one person's room.
● Homely remedies, including paracetamol-based medication, were kept in a carrier bag in the conservatory. There were prescribed absorbent powders in the laundry area. This unsafe storage of medicines put people at risk of harm from accidental or intentional ingestion.
● Medicines may not have been administered safely. We found some people were prescribed medicines on an as required basis 'PRN'. We matched the medicines used to the amounts recorded and in several instances, we found there were less medicines in stock then there should have been. We were not assured people received their medicines as prescribed which exposed people to the risk of harm.
● The provider failed to take any action to understand if these were recording errors or if people had received excessive medicines. This put people at risk of harm from poorly managed and administration of medicines.

Preventing and controlling infection
● The provider did not promote safety through the layout and hygiene practices of the premises. We saw over chair tables which showed evidence of fluid ingress, rusted equipment, compromised bathroom flooring edging, compromised kitchen work surfaces, exposed plaster on walls, flaking paint on woodwork and food splatter on walls. These issues put people at risk of harm from communicable illnesses.
● We were not assured the provider's infection prevention and control policy was up to date or implemented appropriately. We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. For example, the provider failed to ensure items of furniture were replaced when damaged or their cleaning processes were effective. One staff member told us, "We have to do the cleaning as part of the other tasks. We can only do so much and this part sort of gets left as people come first. We just don't get the time"

Learning lessons when things go wrong
● Lessons were not learned. The provider did not have effective systems in place to learn when things went wrong. For example, we asked the registered manager if they looked at incident and accident records to identify any trends or patterns. They told us they did not look at the incident accident records and did not undertake any exercise to see if incidents could be prevented.

Systems were not robust enough to demonstrate risks and safety were effectively managed. This placed people at risk of harm. These issues constitute a breach of Regulation 12 (Safe Care and Treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We passed our concerns to Shropshire fire and rescue, Shropshire local authority commissioners and the local authorities environmental health department for their awareness.

Systems and processes to safeguard people from the risk of abuse
● People were not effectively protected from the risk of abuse and ill treatment. The provider failed to identify who was in the building at any given time and did not know whether staff living in the building brought in visitors. One staff member told us, "I have no idea who is in the building at any time. They just let

themselves in and walk through here like they own the place. Recently a midwife turned up and we didn't even know there was a baby living in the building. We just don't know who is in here." This put people at risk of abuse as the provider could not be assured those accessing or staying at the home did not place people at risk of abuse.

● People did not have information available to them should they need to raise a concern. When asked one person said," I wouldn't have a clue. I suppose I could say something but to who I just don't know." Another person said, "I think I could phone the police but who's going to take us seriously."

● People's personal property was not accounted for or accurately recorded. We saw a bank card had been stored in the provider's safe. This had not been accounted for in the provider's records of items they were storing. We saw the amounts of another person's money in storage had not been updated to account for money spent. The provider failed to identify the discrepancy or take measures to resolve it. The personal property of the deceased had been disposed of without any record of what had been disposed of or where. These issues put people at risk of financial and material abuse.

● The registered manager did not oversee any safeguarding concerns to see if any action needed to be taken to keep people safe from harm or abuse.

Systems were not robust enough to safeguard people from abuse and improper treatment. This placed people at risk of harm. These issues constitute 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.

We passed our concerns to Shropshire local authority commissioners for their awareness.

Staffing and recruitment

● There were not enough staff with appropriate skill and training available. We found only one staff member had been allocated to work during the nights. This staff member was not trained to assist people with medicines. This created a delay in access to PRN medicines should they be required. The provider failed to identify people's needs were at risk of not being met. This exposed people to the risk of harm.

● Night shifts were not adequately staffed. The provider's fire risk assessment stated there were two staff members available to support people in the event of an emergency. However, they failed to ensure the minimum amount of staff were available during the night putting people at risk of harm in the event of an emergency.

● There were not enough staff deployed. Care staff were expected to complete cleaning tasks along with their care duties as there was no designated domestic support. This resulted in parts of the home being visibly dirty putting people at risk of harm from communicable illnesses.

● However, people told us they felt safe at Caradoc House. One person said, "I think it's alright here, can't complain really and its better than being on the street."

The provider failed to provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service. These issues constitute a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We passed our concerns to Shropshire local authority commissioners and Shropshire fire and rescue for their awareness.

● The provider followed safe recruitment checks. This included checks with the Disclosure and Barring Service (DBS). Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make

safer recruitment decisions.

Visiting in care homes
● The provider was supporting visits in line with the Governments guidance.

● We were assured the provider was meeting shielding and social distancing rules.
● The provider told us they had measures in place to mitigate the risks associated with COVID-19 related staff pressures.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured that the provider was using PPE effectively and safely.

Requires Improvement

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 requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity.

- People were not always treated with dignity and respect. People were expected to eat their meals at tables which had broken curtain poles and confidential information on them. This did not provide a dignified dining experience and was not valuing to the person.
- People were expected to meet their personal care needs in bathrooms where the window coverings were missing. One area contained a broken bin, broken radiator parts and the window frame was heavily soiled with visible dirt. One person's shower room was heavily soiled with mould. The environment within which people were expected to meet their personal care did not demonstrate a dignified, respectful or caring approach.
- People's property was not treated with respect. We saw one person's personal grooming product had been gifted by their family. This was found at the back of a cupboard in the laundry area. No one could tell us why it was there or even if the person themselves had seen it. We saw a collection of people's personal items had been left grouped together on the floor in a storage room. One staff member told us, "Oh those people died a long time ago. Don't know what we are going to do with them." The lack of action to respectfully store and keep safe people's belongings was uncaring and undignified.
- People's privacy was not respected. We saw the registered manager enter a person's room without seeking their permission. The staff member moved an item of furniture in the room but ignored the person. It was not until the person said, "Hello" that the staff member acknowledged them. The same staff member was observed entering another person's room again with them present and again without announcing themselves. This demonstrated a complete lack of respect for the person or their privacy.
- People's confidential information was not secured safely. We saw personal information left in communal areas where anyone in the area could read it. Information included a person's MAR. Health records and personal correspondence were left lying around the building. The provider failed to demonstrate an understanding on privacy, confidentiality and respect. The provider did not understand the impact on people's wellbeing as a result of not promoting these values.

These issues were degrading to people and did not demonstrate people were treated with dignity or respect. These issues constitute a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We passed our concerns to the local authority for their awareness.

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

● People told us they felt the staff supporting them on a day to day basis were kind and friendly. One person said, "They are angels." Another person told us, "They [staff] treat me just right. I have no complaints."

● People's protected characteristics under the Equality Act 2010 were known by staff members. These included gender, sexuality, disability, ethnic origin etc. People felt they were supported by staff who knew them as individuals.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question 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. Continuous learning and improving care.

- Since this location was first registered with the CQC they have been inspected five times where they have received a rating. On four of these occasions they have failed to achieve the rating of good and on three occasions they have been in breach of regulation. The provider has failed to maintain a good rating since their first inspection in 2017. The provider does not have effective systems in place to identify improvements or drive good care and accommodation for people.
- The quality monitoring systems were inadequate in identifying and mitigating risks to people. For example, the registered manager failed to identify and mitigate the risks from hazardous substances, breaches in confidentiality, multiple trip hazards and risks from crushing. They did not check water flush throughs were completed properly and they did not check medicines were administered safely or stocks matched the medicines given. The provider had not identified or acted to rectify these concerns. These issues put people at the risk of harm from receiving unsafe care and accommodation.
- Systems and processes to ensure monitoring checks were completed were not in place. We asked to see evidence of quality checks and monitoring, but the registered manager told us they didn't have any they could show us. However, they told us they walked around the building. We asked if there was an action plan following these "walk arounds" but they told us they didn't produce one. The registered manager did not have a clear plan for improving people's experiences of care.
- The registered manager told us they did not keep their individual learning up to date. For example, they did not know the relevant health and safety legislation on how to maintain a safe care environment. They did not have quality checks in place and did not understand the principles of good quality assurance and the service lacks drivers for improvement.
- The registered manager failed to act when risks were identified to them. For example, on day one of this inspection we identified the risks of trips and falls, the risks from unsecured wardrobes and storing heavy items off the floor. When we returned, we saw wardrobes had not been secured, flooring had not been repaired and some heavy objects were still stored off the floor. These issues put people at continued risk of harm.
- There was no oversight at the service. Management structures including an operational manager were in place, but not effective in ensuring the service was managed, or that people received safe care and treatment. For example, People did not know who the registered manager was and staff told us they rarely saw them. Staff did not have direction or guidance from the provider on how to drive improvements and there was not a plan to improve people's experience of care.

● The day to day running of Caradoc House was left to the deputy manager and overseen by the operations manager and registered manager. However, staff told us they very rarely saw the registered manager and there was little or no direction from them. One staff member told us, "We never see [registered managers name] or [operations manager] for that matter." Staff felt there was a lack of direction and leadership from the senior management team involved with Caradoc House Residential Care Home.
● The service was not well-led. There were significant shortfalls within the management team which impacted the day to day running of the service. For example, during a period of annual leave tasks allocated to the registered manager in the deputy manager's absence had not been completed. No one was accountable and the lack of coordination exposed people to the risk of harm from their current needs not being met.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager was not visible. All those we spoke with told us they found the deputy manager to be engaging and supportive. However, no one we spoke with could tell us who the registered manager was. One person said, "I have no idea who they are. To be honest I don't know what they do here, but you don't like to ask."
● The registered manager failed to demonstrate dignified and respectful attitudes towards people and did not lead by a good example. For example, we saw them enter one person's room whilst the person was present and failed to acknowledge or engage with them. They repeated this when entering another person's room. This lack of respect demonstrated to others an inadequate regard for people's privacy and dignity.

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.
● Although the provider was aware of their responsibilities under the duty of candour they failed to complete investigations into significant events. They did not have systems in place to identify learning or what could be done differently. The duty of candour is a regulation which all providers must adhere to. Under the duty of candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

Managerial oversite and environmental assessments were not robust enough to demonstrate their quality monitoring was effective. These issues constitute a breach of Regulation 17 (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager failed to report significant events to the Care Quality Commission. For example, we found evidence an abusive act had been reported by staff to the management team. However, the management team had not passed this onto the CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People told us they felt involved in decisions about where they lived. One person told us they found music playing during mealtime to be distracting. We saw this had been addressed.

Working in partnership with others
● The management team had established and maintained links with the local communities within which people lived. For example, GP practices, district nurses and social work teams.