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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Caradoc House Residential Care Home is a care home providing support with personal care needs to a maximum of 12 older people. Accommodation is provided in an adapted building and at the time of the inspection, nine people were using the service.

People's experience of using this service and what we found
Risks to people's safety and well-being were not always considered and plans to mitigate risks were not in place or had not been reviewed. People were not consistently protected from the risk of abuse. People were not protected by the provider's staff recruitment procedures. The provider failed to ensure staff received the required support to enable them to meet people's needs safely. Infection prevention and control procedures did not ensure people would be protected from the risk of infection. Accidents and incidents were not investigated to identify measures to prevent re-occurrences.
The service was not effectively managed and there were no systems in place to monitor the quality and safety of the service provided. The provider had failed to act on the breaches of regulations identified at our last inspection.
People received their medicines when they needed them, and systems were in place to ensure that medicines were stored and administered safely and that adequate supplies were available.

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 ratings for this service was requires improvement (report published September 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We undertook this focussed inspection due to concerns we had received that Caradoc House Residential Care Home did not have appropriate management of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. 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 deteriorated to inadequate.
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.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.
Ratings from the previous comprehensive inspection for those key questions we did not look at 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 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 safe care and treatment, premises and equipment, good governance and safe employment of staff at this inspection. 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 six 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 the safe section below.

Is the service well-led?

Inadequate

The service was not well led.
Details can be found in the well led section below.

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 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
This inspection was carried out by two inspectors.

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.
The service had a manager registered with the Care Quality Commission who was also the nominated individual. This means that they 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 the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with four members of staff which included the provider, who is also the registered manager. We also had discussions with a senior carer, carer and the cook.
We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment, supervision and training. A variety of records relating to the management of the service, including policies and procedures and quality monitoring audits were reviewed.

After the inspection
We used our enforcement powers which required the provider to provide assurances that action had been taken to address our immediate concerns relating to the safety of people who lived at the home.

Inadequate

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
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 (Safe Care and Treatment) 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

- The provider had failed to protect people against the risks associated with equipment servicing, fire safety, scalding and legionella. Environmental audits were not being carried out to ensure that risks to people were minimised.
- Monthly checks on bath hot water outlets were not being carried out to ensure temperatures remained within safe limits.
- There were no records to confirm people were protected against the risks associated with legionella. Appropriate risk assessments had not been completed and routine testing certificates could not be provided.
- Not everyone living at the home had a Personal Emergency Evacuation Plan (PEEP). This meant staff and the emergency services would not have access to important information to enable them to evacuate people safely in the event of an emergency.
- Risk assessments associated with people's health, well-being and personal care needs had not always been considered or regularly reviewed. Care plans were not always developed to manage known risks. This meant people could be at risk of receiving unsafe or inappropriate care.
- During the inspection we observed portable heaters being used in a number of people's bedrooms. The registered manager advised us that there was a problem with the heating and hot water system, and they were being used to keep people warm. The heaters were hot to touch and no risk assessment had been carried out in relation to their use and no control measures were in place to prevent people from burning themselves or from the risk of fire.

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

- The provider was unable to produce evidence that the stair lifts were safe to be used, as they had failed to carry out the periodic servicing of both stair lifts installed at the home.
- The provider had failed to carryout periodic servicing of the fire alarm, fire detection equipment and fire extinguishers.

This is a breach of regulation 15 (equipment and premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The provider failed to assess and manage risks associated with the control and spread of infection.
● Although cleaning schedules had recently been reviewed and updated to include COVID-19, these had not been commenced and no other cleaning records were kept. During the inspection we observed no regular wiping down of touch points to reduce the spread of infection.
● Bins provided for the disposal of personal protective equipment (PPE) were not foot operated. This increased the risk of the spread of infection.
● The walls in the laundry were not fitted with impermeable coverings which meant they could not be easily cleaned. The laundry room door, floor and washing machine were unclean. This meant there was an increased risk of the spread of infection.
This is a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Records of any accidents or incidents were maintained. However, the provider had not taken action to reduce the risk of the accident happening again. This placed people at risk of further harm.

Staffing and recruitment
● The provider failed to ensure people were protected by their procedures for staff recruitment.
● We found that a staff member had commenced work at the service two months before their criminal records check had been received. This meant they could not be sure of their previous conduct or suitability to work at the home.
● We looked at two staff files and found the provider had obtained criminal records checks from Disclosure Scotland. Anyone being employed for a job in England requiring a disclosure check must apply to the Disclosure and Baring Service as a conviction is spent quicker in England and Wales than in Scotland. If a basic disclosure is obtained in Scotland for a job in England, that employer may see information they are not entitled to. This becomes a breach of the UK's Data Protection Act 1998 and of General Data Protection Regulations (GDPR)

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate people were protected by the provider's recruitment procedures. This is a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider failed to ensure staff were skilled and competent in their role. Staff did not receive regular supervisions to discuss their performance.
● We saw that staff were completing training multiple training courses on the same day, the registered manager confirmed they were not carrying out competency assessments on staff to monitor whether this learning had been embedded in their work practises.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate people were supported by staff who were skilled and competent in their role. This is a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● During the inspection we saw staff respond to peoples needs in a timely manner.
Systems and processes to safeguard people from the risk of abuse
● During the inspection we found two incidents where people had been harmed through acts of aggression from other people living in the home where the registered manager had failed to notify the local

safeguarding authority of the incidents. The registered manager did not review or update care plans and risk assessments after the incident to prevent a re-occurrence. After the inspection we notified the safeguarding authority retrospectively.

● The provider had a policy for responding to concerns of abuse, however this was not being consistently followed.

People had not been protected from the risk of abuse. This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

● Staff received training in recognising and reporting abuse and knew who to contact if they had a concern.

● One told us," I feel very safe here. I have no complaints at all. I could talk to any of the staff if I wasn't happy."

Using medicines safely

● Senior care staff took responsibility for administering medicines and they received training to carry out this task.

● Systems to manage medicines were organised and ensured safe and timely administration of medicines to people. Staff were following safe protocols for the receipt, storage and disposal of medicines.

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 now deteriorated 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.

Continuous learning and improving care
At our last inspection the provider was unable to demonstrate safety, or the quality of the service provided was effectively managed. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Improvements had not been made and the provider is still in breach of regulation 17.
- The provider had failed to assess and monitor the quality and safety of the service and failed to make improvements to the service provided.
- The provider was not carrying out any audits on staff or service user records or audits on medicines, the environment or equipment. Accidents were not being reviewed which meant risks to service users were not considered or mitigated.
- Accurate and complete records in respect of service users were not maintained. Risks had not been considered and care plans did not reflect the needs of peoples.
- The provider failed to follow safe recruitment procedures by allowing a member of staff to work for two months without a criminal records check.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
- The provider was also the registered manager. The provider was not operating effective systems or processes to ensure compliance with the requirements of the regulations.
- The provider spent limited time at the home, and they failed to ensure that the home was effectively managed in their absence.
- Staff were not provided with opportunities to discuss their role or performance through regular supervision sessions.
- The provider failed to ensure staff were appropriately trained or skilled in their role as they did not complete assessments of their competency and was therefore unable to ensure that the training had been embedded into their work practice.
- The provider failed to notify CQC of events that had happened in the home as required by law.

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
- The provider failed to ensure service users were involved in planning and reviewing the care they received. This meant that people were not able to express their choice or opinion into how they wished to be supported.

● People were not provided with opportunities to express their views on the service they received through meetings and surveys.

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

● There were no effective systems in place to investigate, feedback or learn when things go wrong.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate safety or the quality of the service provided was effectively managed. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● Staff told us they had good support from visiting professionals such as doctors and district nurses.

● Care plans showed that people saw other healthcare professionals to meet their specific needs. These included speech and language therapists and mental health professionals.