Mrs Kerry Ann Davies

Carden Bank Rest Home

Inspection report

16 Belvedere Road
Burton On Trent
Staffordshire
DE13 0RQ

Tel: 01283563841
Website: www.cardenbank.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Carden Bank Rest Home is a residential care home that was providing personal and nursing care to 13 people aged 65 and over at the time of the inspection.

People's experience of using this service:
People continued to be placed at risk of harm as medicines were not administered as prescribed. Risk assessments put in place to keep people safe were not followed. People were not protected from potential abuse as concerns were not raised with the safeguarding team. There were not always enough staff available and they did not always have time to spend with people.

There was a lack of governance and leadership in the service and the provider did not have effective systems in place to monitor the home. The provider did not have effective systems in place to learn when things went wrong.

People were not supported to have maximum choice and control of their lives and staff were not supporting them in the least restrictive way possible; the policies and systems in the service do not support this practice. Staff were not competent to administer medicines.

People enjoyed the food available and were happy with the staff that supported them. The provider had started to make improvements to care plans and other documentation in the home.

Rating at last inspection:
Inadequate (report published 23 May 2019).

Why we inspected:
This inspection was brought forward and was completed in response to information of concern we had received from the public and visiting professionals. We needed to check that people were supported safely and whether the provider was meeting the Regulations.

We found concerns during the inspection and identified breaches in regulations. We rated the key questions Safe and Well Led as inadequate. The key questions Effective, Caring and Responsive were rated Requires Improvement. The overall rating is Inadequate.

Enforcement:
Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals 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 remains 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.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 effective? The service was not always Effective Details are in our Effective findings below	**Requires Improvement**
Is the service caring? The service was not always Caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always Responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Carden Bank Rest 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection visit took place on 5 June 2019 and was unannounced. The inspection visit was carried out by two inspectors.

Service and service type:
Carden Bank Rest Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was not a registered manager at the service because this was not a condition on the provider's registration. The provider managed the service and 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:
We checked the information, we held about the service and the provider. This included notifications the provider had sent to us about incidents at the service and information we had received from the public. A notification is information about events that by law the registered persons should tell us about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Since our last inspection we have continued to receive information of concerns from the public and professionals visiting the home. We reviewed reports and action plans from other professionals including the infection control team and safeguarding team, that they had implemented in the home.

During our inspection we spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service. We spoke with three people who used the service, two relatives, three members of care staff and the new deputy manager. We also spoke with the provider. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at care records for all twelve people. We checked the care they received matched the information in their records. We also looked at records relating to the management of the service, including audits carried out within the home and staff recruitment.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were not safe and were at risk of avoidable harm. Some regulations were not met.

At our last inspection we found the service was not safe. People had been placed at harm as medicines were not administered in a consistent and safe manner. People were not safeguarded from abuse. Risks to people's health and wellbeing were not consistently identified, managed or risk management plans followed to keep people safe. We found there was a breach of regulations 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These relate to providing safe care and treatment and safeguarding people from abuse. We rated the key question of 'safe' as inadequate.

Using medicines safely

● At our last inspection, we found people were at risk as staff did not administer or record medicines safely and people did not receive their medicines as prescribed. At this inspection we found the same concerns. Since our last inspection the provider had made some changes for example, a medicine room was now in place and we saw medicines were now stored correctly.

● People did not receive their medicines in line with the medicines administration record (MAR). For example, one person was prescribed a medicine four times a day and they were receiving these three times a day. A second person was prescribed a medicine twice a day and they were receiving these three times a day.

● Other people did not receive their medicines as prescribed as it was out of stock. For example, one person had not received their medicines for constipation for seven days as it was not in stock. The provider had not identified this for five days. It was then reordered. On the day of inspection, the medicine remained out of stock. We checked records for this person and found they had not had their bowels open for four days. The provider had not identified this or taken action. This had placed this person at risk of harm. We told the provider to contact the GP for advice, which they did and the next day this was resolved.

● We found another person had not received their prescribed medicines for sore skin for 11 days as it was out of stock. The provider had not identified this person was not receiving this medicine and had not taken any action. A third person had not received their medicines for three days as it was out of stock. This medicine had been reordered, however remained unavailable during our inspection.

● Some people's medicines were prescribed 'as required'. For some people we saw guidance known as PRN protocols were in place for staff to follow. However, for two people we saw this guidance was not in place. After our last inspection we told the provider to urgently ensure this guidance was in place for people. The provider had confirmed these had been completed.

● Since our last inspection staff had received training in medicines and their competency had been checked. However, as errors continued to occur within the home we could not be sure all staff were competent in medicines administration. There was no evidence the staff member carrying out competency checks had the skills or knowledge to do so.

●The provider had also introduced a weekly and monthly audit of medicines. This had identified some areas of improvement, however it had not identified the concerns highlighted above. Furthermore, for eight

people it had identified when there were gaps on the MAR and no action had been taken. We therefore could not be assured this medicine for these people had been administered.

Assessing risk, safety monitoring and management

● People were placed at risk of harm as risk assessments that were in place to keep people safe were not followed. We saw three people who were at risk of developing sore skin were not seated on a pressure cushion in line with their requirements. We alerted staff to this who took action.

● One person was at risk of choking. We saw two incidents documented where they had recently choked and required staff interventions. There was a risk assessment in place that stated, 'carers are to sit with [person] and prompt [them] to eat their foods slowly'. During breakfast and the evening meal, care staff did not sit with this person and they ate independently in the lounge where there were no staff present.

● Another person's records stated they required a fork mashable diet. The person did not receive a meal in line with these requirements at lunchtime.

● When incidents and accidents occurred in the home, action was not always taken. For example, we saw someone had an unwitnessed fall. It was unclear what action had been taken and staff we spoke with were unable to provide an explanation. Another person had rolled out of bed but the risk assessments in place were not reflective of this incident or action that had been taken.

●Call bells continued to not always be accessible to people when they were in their rooms and communal areas. This meant people were at risk of not receiving support when they needed it.

The above evidence shows a continued breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made some improvements since the last inspection. For example, the moving and handling we observed was safe and staff told us they had received training in this area. When people had behaviours that may challenge we saw these were now being recorded.

Systems and processes to safeguard people from the risk of abuse

● Staff demonstrated a clearer understanding of safeguarding and the actions they needed to take. One staff member said, "It is making sure people that live here are safe and that any abuse that happens is reported." Another staff member said, "If we are concerned we must complete a body map and record the information, we share it with the provider or manager and they will follow the right procedures."

● However, we could not be assured all incidents had been investigated or reported. For example, we saw body maps where unexplained bruises had been identified. There was no investigation, and these had not been referred to the local authority for consideration.

● When medicine errors had been identified, the provider had not considered this may need to be reported to safeguarding. We saw an incident documented where a person may have been at risk of financial abuse which had not been investigated or referred to the local authority for consideration.

● The provider had raised some safeguarding concerns in the home. However, professionals visiting the home had continued to identify safeguarding concerns that the provider had failed to address.

● Some people living at the home had safeguarding plans in place. We checked these as part of our inspection and found the immediate action the provider had been told to take had not always been completed. This meant the steps that had been put into place to protect people from harm were not always followed.

The above evidence shows a continued 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

● Staff did not always have time to spend with people. One person said, "They are always rushing, I haven't really seen much of them today." For long periods of time, people were unsupported in one of the communal areas without any interactions.

● The provider told us they had reviewed their staffing levels using a dependency tool but they were unable to show this to us during our inspection.

● The provider told us they had increased the morning staff numbers from two to three care staff. When we reviewed the rota, they showed us that managers were working flexibly from 0900 – 1530 as the third person. This meant the provider had not always taken action to ensure there were three staff on the morning shift. On the morning of our inspection, there were two care staff on shift plus the deputy manager.

● Furthermore, no consideration had been made to the staffing level on the afternoon shift or the night shift, despite concerns raised by us and the safeguarding team. These remained the same as at the last inspection.

● During our inspection a third member of care staff was called in to work the morning shift and arrived mid-morning, however we were advised this was due to our inspection.

The above evidence shows a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Since our last inspection, the infection control team had been into the home and completed an audit. They had raised concerns and had put an action plan in place.

● We saw some of the actions had been completed by the provider or were being worked towards, but further areas of improvements were needed. For example, we saw a dusty lamp shade, unclean commodes, empty paper towel dispensers, no toilet rolls in bathrooms and flies in one of the baths.

Learning lessons when things go wrong

● The provider had started to consider and implement some changes from feedback received from professionals. However, there were no effective systems or monitoring in place to identify concerns and learn lessons when things went wrong.

Requires Improvement

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection we found the service was not always effective. Staff did not have the sufficient skills and knowledge to support people effectively and care plans did not have sufficient information for staff to follow. There was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the key question of 'Effective' as requires improvement.

Staff support: induction, training, skills and experience

- Since our last inspection, staff had received some training in keys areas for example, in moving and handling and medicines. However, this training was not always effective as staff continued not to be competent in the administration of medicines.
- When new staff started working at the home they told us they had an induction. One staff member said, "I had the opportunity to shadow the other staff members for a few shifts so I could get to know the routine of the home and how things are done."

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

- Some of the care plans we reviewed had the necessary guidance staff needed to support people. For example, professionals had worked with the home to develop moving and handling plans for people. We saw and the provider confirmed this was an area they were continuing to work upon.

Supporting people to live healthier lives, access healthcare services and support and providing consistent care across organisations.

- People had access to health professionals. Since our last inspection, a range of professionals had attended the home. We saw when needed people had been referred to the falls team or speech and language team (SALT). People had plans and assessments in place for staff to follow.
- However, it was not always clear if the provider had identified the need for referrals. For example, when a person had choked we saw no action had been taken. A second incident had occurred and again we did not see any action had been taken by the provider. 10 days after the incident occurred a visiting health professional had attended the home and documented they had identified a referral to SALT was needed. This meant it was not always identified when people may need access to health professionals, in a timely manner.

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 Act 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● Some mental capacity assessments had been completed, however improvements were needed to ensure they were specific to the decision being made.
● When people had potential restrictions in place such as bed sensors or rails, capacity assessments had not always been completed.
● The provider had considered when some restrictions were in place and had referred people for a DoLS. They were awaiting assessments to be completed.

Supporting people to eat and drink enough to maintain a balanced diet
● People enjoyed the food that was available. For example, one person said, "Its lovely and warm that's all you need."
● People's food and fluid intake was monitored when needed. We saw people had access to drinks throughout the day to ensure they were hydrated.

Adapting service, design, decoration to meet people's needs
● The home had been adapted to meet people's needs.
● People had their own belongings in their bedrooms. Communal areas were decorated to people's preferences. There was some signage available to support people living with dementia.
● People could access an outside area and people told us they enjoyed using this in the summer.

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

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported

- People were not always treated in a kind and caring way as staff were not always available for people.
- One person told us, "I love to talk but you don't get much of that in here." In one of the lounges we saw people were asleep for long periods of time and one person was reading a book upside down. We also saw when staff supported a person with a transfer, they moved the person's table. After the transfer, they were called to do something else and did not return the table to them, meaning the person could not reach their belongings. This meant people were not always treated in a kind and caring way.
- People and relatives were happy with the staff that supported them. When staff completed tasks with people such as supporting at meal times, we saw they spoke nicely with people explaining what they were doing.

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

- People were encouraged to make choices about their daily routine. Staff told us they encouraged people to make daily choices, including what clothes to wear and if they would like a bath or a shower.
- People were offered some choices throughout our inspection. For example, we saw the chef come around to people in the morning and ask they what they would like to eat at lunch time. People were provided with this meal but food was plated in the kitchen so we did not see if people were offered a choice of vegetables for example. Furthermore, everyone was offered blackcurrant squash with their lunch.
- Some of the care plans we looked at had started to consider people's choices and preferences.
- People were encouraged to maintain relationships that were important to them. We saw during our inspection that relatives visited freely. Relatives we spoke with told us the staff were welcoming and they could visit anytime.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was promoted. Staff gave examples of how they promoted people's privacy and dignity and treated people with respect. One staff member said, "We always knock the bedroom door before going into someone's room."
- Records we looked at had started to be reviewed to consider how people's privacy and dignity could be upheld.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People continued to tell us they were bored. One person said, "The days can be long." We saw in one of the communal areas more activities were taking place, for example a film was on the TV and some people had hand held games and objects.
- In the other communal area, no activities or interactions took place. The TV was on but people commented they could not hear it.
- Some of the care plans that had been put in place were improved and considered people's preferences. The provider had considered people's choice, sexuality and cultural needs. This was an area the provider told us they were developing.
- Other records were not always accurate of people's current needs. For example, when some people had personal evacuation procedures in place these had not always been updated to reflect their most up to date mobility needs.
- Information was not always clearly documented or recorded consistently. For example, when people were required to be weighed weekly, there was inconsistent information as to when this was last completed. The provider reassured us this was completed and recorded but was unable to demonstrate this to us.

Improving care quality in response to complaints or concerns

- Since our last inspection, no complaints had been made.
- The provider had tried to be more open and transparent with people and had put a sign up in the home encouraging people to raise concerns.

End of life care and support

- There was no one receiving end of life care at the time of the inspection.

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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At our last inspection we found the service was not well led. There was a lack of governance and leadership in the service and the provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not identified and rectified by the provider exposing people to the risk of harm. We found there was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the key question of 'Well Led' as inadequate.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

● Insufficient systems and processes were in place to monitor the quality of service. For example, when incidents occurred in the home there was no audit or over sight of this in place.
● Since our last inspection, the provider had introduced a weekly and monthly medicines audit. This had failed to identify the concerns we found during our inspection and therefore was not effective in identifying areas of improvement.
● The systems in place to ensure staff were competent in administering medicines was not effective as errors continued to occur. Since our last inspection, staff competencies had been assessed but the staff member completing these competencies did not have the relevant training, knowledge or experience to do so.
● The provider had not ensured staff were competent to administer medicines and there was no effective system to identify and take action following medicines errors. Staff continued to make repeated errors and no action was taken.
● The local authority had worked with the provider and a clear action plan was in place. Where action had been marked as completed, we saw this was not always accurate. For example, it was marked as completed that PRN protocols for as required medicines were in place, however we found two people did not have these.
● The infection control team had completed an audit of the home and had provided an action plan. Where action had been marked as completed, this was not always accurate. For example, we saw a dusty lamp shade, unclean commodes, empty paper towel dispensers, no toilet rolls in bathrooms and flies in one of the baths.

Working in partnership with others; Continuous learning and improving care
● After our last inspection, we imposed urgent conditions on the provider's registration as people were exposed to harm. The provider is required to send us weekly and monthly actions plans. The conditions we

had put in place had not been effective as the provider has failed to identify concerns in the home. For example, the provider had not identified the medicines errors we found and notified us of these as part of their condition as required.

● The provider had also failed to safeguard people when needed to ensure they were not exposed to potential harm.

● The provider did not have an effective system in place to continually learn and make improvements to the care people received.

● The Local Authority has instigated a Large Scale Enquiry regarding the service. However, the provider had not worked successfully with partner agencies to improve the quality and safety of care. We found that people continued to be at risk of harm due to the continued shortfalls we found at the inspection.

●The provider was not displaying their rating in the home in line with our requirements.

The above evidence shows a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since our inspection, the provider had employed a consultant within the home. They provided us with a comprehensive action plan and have carried out a full medicines audit of the home identifying areas for improvement and the actions they intend to take.

Planning and promoting person-centred, high-quality care and support with openness; Engaging and involving people using the service

● The provider had not gained feedback from people who used the service since our last inspection.

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 18 HSCA RA Regulations 2014 Staffing There were not enough staff available for people.