Kidderminster Care Limited

Cambrian House

Inspection report

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Kidderminster
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Tel: 01562825537

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26 October 2017
02 November 2017
03 November 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Cambrian House provides accommodation and personal care for up to 25 people. On the day our inspection commenced there were 21 older people living at the home some of whom were living with dementia.

We previously undertook a comprehensive inspection of this service on 06 and 08 March 2017. At that inspection the provider was rated good overall with the well led question rated as requires improvement.

Since our previous inspection we have received information of concerns from different sources including the local authority. These concerns including the treatment people were receiving and issues regarding the safe care of people.

As a result we undertook a comprehensive inspection to look into those concerns on 26 October and 02 and 03 November 2017.

There was a manager in post but they had not yet applied to register with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered provider has continually not managed to have a registered manager in post.

People's safety had not always been taken fully into account regarding fire safety. Concerns were shared with the fire service who advised the manager on action which needed to take place. A lack of fire training and measures to ensure environmental and maintenance could have placed people at risk.

People were not always supported by staff who had consistently received the necessary training to fulfil the role of the work they were employed to do. People told us they were not always effectively supported by staff in a timely way.

The providers records were not always easy to retrieve to evidence checks carried out to ensure people were carried for safely.

People told us they received their medicines as prescribed but staff practices did not always ensure medicines were recorded as given at the time of administration. Staff did not always ensure items which were potentially hazardous were stored securely which could impact on people's safety.

People were able to access healthcare professionals to meet their needs. People told us they liked living at the home and liked the staff that provided their care and support. Some felt people had at times to wait for their needs to be responded to. Activities were provided for people to have fun and time was able to be spent with staff members. Staffing levels were seen as suitable to ensure people's needs were met although there was concern expressed about night staff levels and a lack of knowing who was leading the night shift.

There was an awareness of responsibilities regarding safeguarding and potential abuse. People felt safe living at the home and staff were aware of their responsibilities if they witnessed abuse. At the time of our inspection one safeguarding regarding care provision was under investigation with the local authority although the new manager had no knowledge of the on-going investigation and was not able to locate any records regarding internal investigation. People told us they were aware of how to complain about the service provided.

Risks to people's care and care plans were in place and reviewed. These had involved people and their family members. Although staff spoke about people's right to privacy and dignity these were not always seen to be put into place. People were able to access healthcare support as required. There were mixed comments regarding the food available to people.

There was a lack of recent and accurate quality monitoring. Documents requested to evidence people were living in a safe environment were available but difficult to retrieve. Many of the shortfalls identified during the inspection were not known to the registered provider as they had not identified them as part of their own monitoring systems.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

People were not provided with a safe environment in relation to fire prevention.

It was not always evident who was in charge of shifts to ensure people were safe. People told us there were not always sufficient staff available to meet their needs.

People were protected from unsuitable staff working at the home although supporting documents were hard to retrieve.

Medicines were not consistently recorded as given following administration.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not consistently supported by staff that had up to date training and the skills to meet their needs. Some staff had not received an induction programme when they started work at the home.

Staff had not received regular supervisions.

People were confident staff had contacted health care professionals when they needed to.

People's consent was sought before care was delivered.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People said staff were kind and caring but not always responsive to their needs.

People's privacy and dignity was not always protected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People told us staff did not always respond as needed.

People had interesting things to do with their time.

People who lived at the home and their relatives knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no registered manager at the home. A new manager was in post and going through the process to register with the Care Quality Commission.

Systems and processes to monitor, assess and improve the quality and safety of the care provided to people were not effective.

Audits did not always identify shortfalls within the service.

People found the new manager to be open with them.

Cambrian House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was conducted as a result of information of concern we had received from the local authority and members of the public regarding the standard of care some people had received. This inspection took place on 26 October 2017, and was unannounced. We returned to the home to complete our inspection on 02 and 03 November 2017. The final visit on 03 November was announced. The inspection was carried out by one inspector. An expert by experience joined the inspection on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service and looked at notifications the provider had sent to us. A notification is information about important events which the provider is required by law to send to us. We also checked information which had been sent to us by other agencies. We requested information about the home from the local authority and Healthwatch. The local authority has responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care. We used this information to inform our inspection planning.
Prior to the inspection we received information of concern about inappropriate care practices taking place at the home. We took this information into account as part of our inspection planning. .

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

We spoke with ten people who lived at the home and three relatives. We spoke with nine care staff including senior care. We also spoke with the manager and the registered provider. We looked at two people's support plans, quality assurance documentation, staff recruitment files, minutes for meetings and the complaints records.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in March 2017 we rated this question as good. Following this inspection this question is now rated as Requires Improvement.

We viewed some of the fire safety arrangements in the home and identified some serious concerns. We found three fire doors which did not close into their frame. One did not fit as the seal around the door prevented it from closing. This meant the door would not have prevented the spread of fire or smoke in the event of an emergency. We saw a fire escape from the building was inaccessible due to overgrowth from another property blocking the path and the means of opening a gate was unclear. Staff we spoke with were not fully aware of the action they needed to take in the event of a fire and how they would ensure people were safe.

As a result of the concerns we contacted Hereford and Worcester Fire and Rescue who came out to the home. The fire officer told the manager of the immediate action needed to be undertaken to keep people safe. These actions were carried out. The manager told us they would ensure a 'fire marshal' [a person who had attended suitable fire safety training] was on duty every shift following our inspection. The fire and rescue service informed the manager they would return to the home to carry out further checks.

We spoke with the manager and members of staff regarding who was in charge in the event of a fire. During the day time a senior member of staff would be on duty to take charge. However during the night we were told nobody held this responsibility unless it happened to be one of the senior staff working the shift. We brought this concern to the attention of the registered provider for them to take action. The manager undertook to look at the staffing arrangements during the night.

Senior staff were seen to check the medicine records and sign these. However on the first day of our inspection we saw the lunch time medicines were not signed for when we checked the records some 2 – 2 ½ hours after they were done. This presented a risk of medicine errors because it would not be evident to other staff members that these items had been administered. The provider agreed this should not happen and that medicines should be signed at the time of administration. The medicines trolley was not secured to a wall when not in use. Therefore there was a risk of the trolley been removed by an unauthorised person.

Staff confirmed they did not always have an identified senior on duty at night. As a result if anybody needed medicine the staff needed to call upon a senior who was not at work. The registered provider had not identified the need to have a person identified to take charge in the event of an emergency to ensure people were safe.

A sluice door was found to be open. This area should be secured at all times to prevent the risk of harm to people. However we saw the sluice door was open because a bolt had been removed. As a result a number of potential hazards such as cleaning fluids which were accessible to people. We brought these findings to the attention of the manager who asked for the room to be made secure. The manager who was not aware the bolt had been removed was aware these items could have caused avoidable harm to people who lived

at the home.

All of the above constitutes a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Safe care and treatment.

People we spoke with told us they believed there to be sufficient staff on duty throughout the day time. People we spoke with were generally complimentary of the care and support they received. The provider had introduced an afternoon shift in response to a need for additional staff to be available. However, there were some concerns raised whereby people who lived at the home and relatives told us staff did not always respond to the needs of people living at the home. One person told us they had to wait at times for staff support because the staff did not view them as urgent. Relatives we spoke with told us they had witnessed people asking to go to the bathroom and having to wait for a long time.

Some people made a comment about night times as two staff were on duty. As staff also needed to carry out domestic tasks such as laundry some people felt the number of staff to be insufficient. Relatives also made comments about the number of staff on duty throughout the night and at times such as weekends when they believed the home to be short staffed. Staff we spoke with raised concerns about the staffing levels at night. They felt the current arrangements to be too low to ensure people were kept safe at the same time as having other duties to attend to such as laundry.

Staff we spoke with confirmed recruitments checks had taken place before they commence working for the registered provider. We asked to see the recruitment information on newly appointed staff. Although the records we not always immediately available as they were disordered and were hard to retrieve. These checks including one to the Disclosure and Baring Check [DBS] check. A DBS check is performed to ensure potential staff members were of good character and suitable to work with people who lived at the home.

People we spoke with were positive about the care they received and how staff ensured they felt safe. One person told us, "Staff make me feel absolutely safe. It's knowing if anything here is not right, there is always someone to help me." Another person told us, "Feel safe. I have nothing to worry about." A further person told us they had never been mistreated. The manager was aware of their responsibility to report any safeguarding concerns to the local authority as well as to the Care Quality Commission.

A relative we spoke with told us they had not seen anything which gave them any concern about practices within the home or any member of staff regarding either their family member or anyone else living at the home. The same relative felt their family member would shy away from staff if they were worried or concerned and they had not witnessed this happen.

Staff were able to tell us what they would do if they believed abusive practice was taking place. One member of staff told us, "I have never seen anything I did not like. Everyone is well looked after."

Risk assessments were seen within people's care plans and staff were aware of these. These were regularly reviewed to ensure they contained up to date information. We saw members of staff involve people when they used a hoist to assist and involve in transferring people from one place to another. People we spoke with told us staff always used equipment to transfer them and felt safe when staff were undertaking this. We saw staff using a hoist safety. Staff were seen to use other equipment available to them to help prevent people developing sore skin such as special cushions.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in March 2017 we rated this question as good. Following this inspection this question is now rated as Requires Improvement.

People we spoke with believed the staff who cared and supported them to be trained in the work they carried out. However, when we spoke with staff we found some had not undertaken any fire awareness training. We asked staff what they would do in the event of a fire and found not everyone knew what to do or where to go to. One member of staff told us they were not told anything about fire safety when they started work at the home and had not been told anything since. Another member of staff confirmed they had received induction training however it had not included fire safety. This meant staff did not have the knowledge to effectively support people in the event of a fire.

We saw some staff had received induction training on starting work at the home while others did not receive this training. This meant staff did not always gain the knowledge and skills they needed on starting work for the provider. For example staff said they needed training on caring for people with a dementia as they had not all received this. Newly appointed staff told us they had not been registered to do the Care Certificate having done limited training via workbooks. However they felt this had not always provided the training they needed to fulfil their role. The Care Certificate is a set of standards that should be covered as part of induction training of new care workers.

Staff who work in the laundry in the afternoon as well as in the kitchen preparing tea told us they did not have different clothing other than a blue disposable apron for working in these two areas. In addition not everyone who worked in the kitchen had undertaken basic food hygiene training to ensure they had knowledge about the safe preparation of food to keep people safe. The provider undertook to obtain suitable clothing and the manager assured us only staff with food hygiene certificate would be involved in the preparation of people's food.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We reviewed how the manager had ensured people's freedom was not restricted. We found applications had been made to the local authority as needed. The manager was aware applications which had been granted by the local authority and when

these were due to expire.

We saw some best interests meetings had taken place when people were unable to make a decision which could affect their wellbeing. For example some people had their medicines covertly [disguised in a drink or food]. Where these decisions had taken place we saw these had involved suitable people for example the doctor and family members.

Staff had an understanding of people's rights and the need to gain consent from people prior to them providing care and support. We saw staffing obtaining consent before they provided care for people. For example we heard staff seek permission from people regarding the use of equipment such as a hoist to assist in moving people.

We saw the home environment had been adapted to meet the individual needs of people for example we saw signage to assist people to find their way around the home.

The majority of people told us they liked the food provided although one person described the food as, "Bland"" as they liked more spicy food which was supplied via their family. One person described the food as, "Very good. They [staff] give you a choice. If you don't like something they will bring something else." Another person said, "Given a choice and it's quite nice. I have never had a grumble." We saw a cooked breakfast was available for people if they wished. Catering staff were aware of people with individual dietary needs and of arrangements in place to meet these needs. For example people who had full fat milk and butters added to their food.

One person told us a doctor would come quickly if they were unwell. Another person told us, "If not well they [staff] look after you. If you feel you want to go to bed you're allowed." The same person stated they could ask for a doctor if they wanted. A relative told us a doctor would be called in the event of their family member feeling unwell. During the inspection we saw a district nurse visited to attend to people's medical needs where they required this level of intervention. People's care records showed other healthcare professionals such as chiropodists had visited people. We also saw letters sent to people from consultants containing outpatient appointments.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in March 2017 we rated this question as good. Following this inspection the rating is now Requires Improvement.

Prior to the inspection we were made aware of concerns raised by some people about the care and support people received. For example inappropriate care practices and how staff responded to people's care needs to ensure they were well cared for. We discussed these with the provider who assured us the concerns had been addressed.

One person told us they believed they were always treated with respect. People confirmed staff would knock on their bedroom doors before entering. One person told us staff are, "Very good on that." However, when we were talking to one person in their bedroom a member of staff entered without knocking the door. We brought to the staff's attention on a number of occasions the need for them to shut a person's door while they were using their bathroom. Staff did not always notice this themselves to reflect there consideration to supporting people with their dignity.

Some relatives made comments about the care provided for family members they told us they were satisfied with the care provided. Other relatives were complimentary about their care, "I think its fantastic [the care received].I would not like to be anywhere else." Another person told us they were happy living at the home. A further person told us, "You are really well looked after." We heard one person who lived at the home say to a member of staff, "I wish you were my daughter" when the staff member had provided some support. One person told us they had a choice of when they went to bed and got up. Another person told us staff were good to them when they felt anxious. Therefore staff responding to people and making them feel better.

Although people told us the staff team were caring during this inspection we found areas systems and processes did not ensure people were cared for.

Relatives we spoke with felt able to visit their family member at any time, and felt they were made welcome by the staff team. One relative told us they believed improvements had been made at the home. These included supporting people to maintain their privacy and providing personal care behind closed doors. However our observations did not support this as we saw staff were not supporting people to maintain their dignity when using the toilet.

Staff were seen to be warm and friendly with people and engaged in friendly banter. One member of staff told us they believed people to be, "Well looked after." Another member of staff told us they would be happy to have a member of their family cared for at the home. A relative told us, "The best thing here is the interaction between all the residents." Another relative told us they liked how staff were always smiling and added they had no concerns about their family members care.

People were able to spend the day either in their own bedroom or the communal areas. One person told us

they were able to ask staff to take them back to their own room whenever they wanted. People felt involved in their care and believed they had the ability to say what they wanted to do and what they wanted to happen.

People had been supported with their appearance, with their individual likes accounted for. People had their hair done and where seen to be wearing jewellery. People were asked if they wanted their nails painting and were given a choice of colours to select from.

People were encouraged to maintain their independence where possible such as mobilising around the home without restrictions. We also heard staff offering reassurance and chatting to people while they used equipment such as a hoist to transfer them from one place to another. One person described the care provided as flexible and added, "It wouldn't be nice if we lost our freedom".

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in March 2017 we rated this question as good. Following this inspection this question is now rated as Requires Improvement.

There was an on-going investigation taking place by the local authority regarding allegations made on how staff had responded to one person's needs. The outcome of this investigation was not known at the time of our inspection.

We asked to see the complaints records maintained at the home. The newly appointed manager told us there had been none since the last inspection.

During our inspection people told us they were satisfied with the care they had received. One person told us they had not had cause to complain about anything. The same person told us they had not seen anything at the home which had made them worry. Another person told us they were confident the management would listen to them if they raised a concern. A further person told us, "If I wasn't happy I wouldn't stay." The same person told us they felt they could say if not happy with their care and were aware of who to complain to.

The manager told us they had displayed the provider's complaint procedure for people who were near to the front door so people were able to access this including visitors. This meant people could access the provider's complaint procedure. However this was not in an accessible format to ensure it was available to everyone.

Most people we spoke with told us they received the care and support they needed to meet their individual needs. These comments were not totally consistent and some people told us of times they needed to wait for care to be provided. Having appropriate support helps to ensure people's needs are met. During our inspection we did not see any delays regarding people receiving appropriate care and support.

People we spoke with told us there were things for them to do during the day which they enjoyed. We also saw people engaged in games such as bingo while another person was seen playing a board game with a member of staff. There were examples of art work completed by people on display in the home. People were seen having fun while involved in these interests. Staff told us they provided activities every day for people.

Staff were seen to know people well and knew what they liked to do. Staff told us they attended handovers to ensure they were aware of how people where and any changes in their care requirements. Staff also told us they spoke with people and read their care plans to find out about them. One person told us, "The staff are very good and get you what you want". Although the person was not aware of any consultation they had had with staff about their plan of care they felt staff looked after them well. We saw care plans and risk assessments were regularly updated. There was evidence on some care plans of people having involvement with these reviews. One relative told us they had been involved in their family members care plan in the past and attended a review. This was so people could make their views known and express their preferences.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in March 2017 we rated this question as requires improvement. Following this inspection this question is now rated as Requires Improvement.

The rating at the time of the previous inspection was due in part to the provider not having a registered manager in post. At that time a manager was in post however they had not registered with the Care Quality Commission (CQC) as a result of them needing additional documents in order to do this. An accepted application was not received by the CQC. Shortly before this inspection the person resigned as manager and the provider had appointed another person to carry out this role. This person had been in their role four days when the inspection commenced. They were aware of the need to make an application to become registered and had taken the initial action to commence the process.

Systems in place to monitor the quality of the service were insufficient and were ineffective to keep people safe. We saw a lack of oversight in the registered provider's arrangements to monitor the service. Shortfalls noted as part of the inspection had not been brought to the provider's attention by staff carrying out these checks. The provider's own checks had also failed to identify areas needing attention. For example the provider was not aware of three fire doors which failed to close into their frame. A member of staff we spoke with told us one door had not closed correctly when the tests had been done although recorded they did. This meant the records maintained were inaccurate. Therefore, the provider's own checks had not identified faults in their own fire prevention procedures.

Systems to ensure people were provided with a safe means of escape had not identified overgrowth in the garden which blocked a safe passage in the event of an emergency. As a result people were placed at potential risk if an evacuation had been needed. The provider had not identified through their own monitoring the need to install emergency lighting in an area designated as an escape route in the event of an emergency to mitigate risks.

The registered provider was not able to produce important records needed to demonstrate the service was well run when we asked for them. Some of these were found unsecured within the office as they had not been filed correctly. Other records were held on registered provider's e-mails which needed to be sent to the manager to print off. Other documents had to be collected from off site at another location managed by them. This meant the manager was unable to access these documents. The filing of documents in the office was disorganised. The registered provider had not taken into account the need to have important documents available to their manager to evidence people were safe and had not ensure records were held securely.

The provider's systems were not effective in identifying the shortfalls and gaps in training. For example staff had a lack of training and knowledge regarding fire safety and food hygiene so that they had the understanding and awareness needed.

Audits and checks to improve the quality of people who lived at the home were previously undertaken.

However we found the majority of these had stopped taking place earlier in the year. The monitoring systems in place had not identified concerns raised during this inspection to ensure the home was consistently and effectively managed.

All of the above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

The manager was on their fourth day at the home. We saw them speaking with people who lived at the home. The manager was aware of who people were and was seen to be kind and considerate when in their company. Many of the people we spoke with were aware she was the new manager. Staff we spoke with told us they had found the manager to be approachable in the few days since they had started. The manager told us they had met with senior staff and planned to introduce improvements, such as body charts to highlight were creams and ointments needed to be applied as these were currently not in use. In addition the manager informed us they were going to send out questionnaires to people and their family members to seek their views about the quality of the service provided.

Staff were spoke with were confident with the care provided and told us they liked working at the home. Although only in post a few days they and relatives spoke highly of the new manager and the open culture in place at the home.

Accident and incident forms were reviewed each month in order to look for any trends to help in reducing similar incidents and reduce risks to people's safety and welfare. Accidents records were completed and highlighted the incident and the action that was taken to prevent similarly incidents.

The previous manager had held staff meetings and the new manager stated they would continue with these. Staff we spoke with confirmed these had taken place and felt able to raise any matters they wished. Staff told us they had in the past received supervision with the previous manager and had felt supported in their work. They told us they liked the new manager and believed they would be well supported by them.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured people were protected from the risk of harm.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have suitable systems in place to ensure good governance of the service provided to people.

The enforcement action we took:

Warning notice