Corvan Limited

Cordelia Court

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
Cordelia Court is a residential care home providing accommodation and personal care for up to a maximum of 34 people in one adapted building. The service provides support to adults under and over the age of 65 who may live with dementia or a sensory impairment. At the time of our inspection visit, there were 30 people living at the home.

People's experience of using this service and what we found
Risk management associated with people's care needs and the environment continued to need improvement. Risks were not always identified, monitored or acted upon in a timely way to ensure people's safety was maintained. There were some medicine discrepancies that had not been identified and acted upon to show medicines were always managed safely. Staffing arrangements were not always effectively managed to ensure people experienced person centred care. Staff understood their responsibility to report any concerns to protect people from the risk of abuse. However, records relating to incidents and accidents were not always effectively maintained to help identify and act on risks.

Our observations of people and review of comments received about the service confirmed people sometimes did not experience care that respected their privacy and dignity and needs. However, staff were observed to have a caring approach when supporting people and we saw some caring interactions. People were not always supported to have maximum choice and control of their lives; however, staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Governance systems, management and provider oversight of the service were inadequate. Systems and processes to monitor the quality and safety of the service were ineffective. Areas needing improvement were not always identified and acted upon in a timely way. Records were either not consistently maintained or were not in sufficient detail to show care and incidents had been safely and effectively managed. Staff were positive in their comments of the manager and felt supported in their roles.

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 24 May 2023). The provider completed an action plan after the last inspection to show what they would do and by when to improve: safe care and treatment, dignity and respect and good governance. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We carried out an unannounced comprehensive inspection of this service on 6 and 8 February 2023. Breaches of

legal requirements were found. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, caring and well led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cordelia Court on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care, people's privacy and dignity and the management of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

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
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well-led findings below.

Cordelia Court

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
The inspection was carried out by 2 inspectors and an expert by experience who made calls remotely to family members. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cordelia Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cordelia Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. However, a new manager had been appointed and had been in post for 7 weeks. They were planning to submit an application to register.

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 which included feedback from the local authority and professionals who work with the service 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 used all this information to plan our inspection.

During the inspection
We observed people who could not talk to us to help us understand their experience of the service. We spoke with 2 people who used the service and 6 relatives about their experience of the care and support provided. We spoke with 7 staff, including care staff, the manager, cleaning staff and deputy manager about their role and experiences of caring for people at the home. We reviewed a range of records. This included 2 peoples care records, multiple medicine records, training records, quality monitoring records, accident and incident records, and multiple records relating to the management of 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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 12.

- Risks associated with people's care and the environment were not effectively managed and records were not always clear to support staff in managing risk.
- One person who had experienced a fall and had been assessed as needing a sensor mat on the floor to alert staff if the person stood on it to mobilise. This sensor mat was not in place which put them at risk of not receiving support when they needed it and put them at continued risk of falls. The person was also to be observed by staff every 15 minutes. Records did not show this happened consistently to help keep the person safe.
- Several fire doors to people's bedrooms would not close which placed people at increased risk of harm in the event of a fire. People's personal evacuation plans (PEEPs) were not accurate to support emergency services in locating and supporting people safely in the event of a fire.
- The fire evacuation plan lacked clear guidance for staff. Staff did not understand what to do in the event of a fire. Those asked told us, "I would go to the panel but I'm not sure after that." Another said, "You follow the other staff or ring the new manager." This left people at risk of adequate care in the event of a fire.
- Risk assessments had not been completed to address 2 cracked windows in 2 people's bedrooms to ensure safety risks were managed to keep people were safe. One of these had missing glass.
- One person had a skin condition that required regular dressings to be applied. There was no care plan or risk assessment in place to manage the skin condition and the potential risk of skin damage.

Using medicines safely

At our last inspection the provider failed to ensure medicines were managed safely which placed people at risk of harm. 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 remains in breach of regulation 12.

● Medicines were not managed safely consistently.
● Discrepancies between medicine records and actual medicines available meant it was not clear people had received their prescribed medicines as required.
● Medicine fridge temperatures were not monitored in accordance with the providers instructions which stated the minimum, maximum and current operating temperature must be recorded. Fridge temperatures were in excess of the safe temperature for medicine storage which meant this could impact on the effectiveness of the medicines.

Preventing and controlling infection

At our last inspection the provider failed to ensure Infection, prevention and control was managed effectively which increased the risk of the spread of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 12.

● Arrangements in place to prevent and control infection outbreaks were insufficient to protect people from catching or spreading infections. Although staff had received IPC training, this was not put into practice resulting in poor practice and a lack of cleanliness in the service.
● The door to a bedroom where a person was isolating due to an infection was observed to be left open. Staff exiting this room were seen not following the provider's infection, prevention, and control procedures for safely removing their personal protective equipment (PPE). Staff entering the home did not consistently wear PPE which left people, staff and visitors exposed to infection control risks.
● There were areas of the home that were unclean including debris behind one person's bed. There was equipment and furniture in use that was either dirty, or damaged making this difficult to clean and maintain good hygiene. This included equipment and implements used in the hairdressing salon.
● People were sharing incontinence products. There were unlabelled and discoloured net underwear being taken to people's rooms for their use. Staff confirmed these were shared across the home for people who needed them which was both unhygienic and poor infection, prevention, and control practice.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes to keep people safe from abuse were not effectively managed.
● One person had sustained an injury from an accident where they required hospital treatment. This had not been investigated to identify how it happened and any potential ongoing risks to the person. Safeguarding procedures had not been followed to help ensure actions were taken to keep the person safe.
● One person did not have access to a call bell in their room to alert staff if they needed help. The call bell connection was broken. We saw the person shouting for help during the morning. The lack of ability of the person to access staff placed the person at risk of harm.

Risks associated with people's health, safety and care continued not to be managed safely which placed people at risk of harm. This meant there was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
● Relatives felt that their family members were cared for safely. One person's relative told us, "I feel that they are safe. [Person's name] has become very difficult to get on with. I think they are getting good care and attention, as a family we have not seen anything that makes us think that they are not receiving the care they need."

Staffing and recruitment

● Staff were subject to recruitment checks to ensure they were safe to work with people. Staffing arrangements were not always effectively managed to ensure people's needs were met consistently.

● Staff gave mixed views of the staffing in the home with some feeling pressured due to the high level of support people needed. One staff member said, "The residents need a lot of support. They need a lot of encouragement." Staff told us sometimes the laundry or cleaning staff (with care staff training) helped to provide care which then impacted on ancillary services.

● A relative told us, "I think that at times they are short staffed, but they care for people well. I am aware that training goes on a regular basis."

● Recruitment checks were completed for permanent staff prior to them working at the home this included references and Disclosure and Barring Service (DBS) checks. 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

Open visiting was supported at the home. A visitor's room was available for those who wished to use it.

Learning lessons when things go wrong

● There continued to be areas where there was a lack of managerial oversight of the service, which meant areas needing improvement had not been identified to help ensure lessons were learnt when things went wrong.

● Staff knew to report accidents or incidents but the system in place to monitor, manage and reflect on incidents to prevent reoccurrence was not fully effective.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place or had been applied for, in regards to those people who lacked capacity.

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 requires improvement. At this inspection the rating for this key question has remained 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

At our last inspection the provider failed to ensure suitable arrangements were in place to protect people's privacy and dignity. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 10.

● Improvements were required to ensure people were treated with dignity and respect. People who required the use of continence products, had communal shared continence items in use. This included net underwear which was both unhygienic and undignified and did not show an adequate level of respect for people.
● Comments from people and relatives shared, told us one person had been left undressed whilst a staff member left the room to collect something leaving the person feeling exposed. This did not protect their privacy and dignity.
● Sheets on one bed in a bedroom occupied by a person were ripped and in need of replacement. This was not respectful of the person's dignity. A relative told us they had been provided with stained bedding for their family member.
● An ensuite screen in one bedroom was not fitted correctly to ensure ease of use and privacy.

We found there continued to be actions required to protect people's privacy and dignity. This meant there was a continued breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● A relative told us their family member was supported to be independent. They told us, "I have seen staff encouraging [Name of person] to do what they can themselves."

Ensuring people are well treated and supported; respecting equality and diversity
● Staff aimed to ensure people were well treated and recognised people's individual needs, but people were not always supported in accordance with their needs. For example, we were told about people experiencing long delays when they wanted to return to their room from the lounge which did not recognise people's preferences or ensure they were well treated.

● Relatives gave mixed feedback about staff. They told us, "Sometimes I ask for things to happen, and I am not sure that they do happen" and more positively another relative told us, "Good atmosphere in the home, kind and caring, staff respond to needs".
● People had access to health professionals such as GP's when needed. Delayed access to dental support had been followed up the new manager.
● One staff member told us, "I really care about our residents and do the best I can for them. I think we all care."

Supporting people to express their views and be involved in making decisions about their care
● Service users were involved in day-to-day decisions about their care and family members were involved in more complex decisions when required.
● One relative told us, "They ring me and ask me about things. They ring me if they need to."
● Staff were seen to be respectful of people's daily choices. One staff member told us, "Even though they (people) have dementia, we make sure they have choices and can-do things they like, how they like."

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained 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

At our last inspection, the provider failed to operate effective systems to monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 17.

- The provider failed to have effective oversight of the service to identify risks and drive improvement. Monitoring systems were ineffective.
- The provider had failed to take sufficient action to address the regulatory breaches we had identified at our previous inspection or to ensure person centred care was at the forefront of the service. This demonstrated lessons had not been learnt.
- Systems to identify environmental risks continued to be ineffective placing people at risk of potential harm. For example, there were several fire doors within the home that would not close in the event of a fire and some doors were in need of repair.
- Audits of medication and care plans had not identified risks we had found. It was not evident some people's medicines were administered safely as prescribed, which posed a risk to their health.
- Systems to record accidents and incidents were insufficient to ensure regulatory requirements were met. Information recorded following accidents was not always investigated and reported to other agencies to ensure risks to people's health and wellbeing were safely managed.
- Insufficient arrangements were in place to check staff fully understood their roles following training. This included how to respond to risks, what to do in a fire emergency and how to follow correct procedures in relation to infection, prevention, and control.
- Relatives told us improvements were needed across the service to improve people's experiences and quality of care. This included, increased staff accessibility, staff engagement and increased person-centred activities and social stimulation. One relative commented, "They are so very busy, the staff can't be doing everything." They went on to explain their relative usually had to wait for support to be provided to meet their needs.

Systems to improve the quality and safety of the service people received were not sufficient and placed

people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had introduced some new systems and processes to improve governance of the service. These were still being embedded at the time of our visit.
● At the time of our inspection, the manager was new in post and therefore was not registered with us. The provider had taken the necessary steps for a registration application to be submitted for our assessment.
● Management staff advised us both during and following our visit of actions they had taken to ensure immediate safety risks were addressed. This included adjusting the fire doors to enable them to close to keep people safe.
● Relatives felt assured the new manager listened and acted upon concerns raised that impacted on people's quality of care. One family member told us, "I had some concerns… I got a reply from them quickly. I am reassured that they are taking my concerns seriously."

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
● Systems and processes to identify when things went wrong were not effective. They had not resulted in learning from incidents to educate staff to prevent reoccurrence. The new manager was open and honest about things that had gone wrong and told us of plans in progress to make the necessary improvements.

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
● Not all people experienced person centred care, areas of improvement were needed to ensure good outcomes for people consistently.
● Relatives told us there was a lack of social stimulation based on people's wishes and interests. For example, one person enjoyed a particular activity but was unable to do this as staff were not accessible to them to support them. It was felt this impacted on the person's wellbeing.
● Many people living at Cordelia Court were not able to comment on their care or experiences of living at the home due to their dementia. Families told us they were involved in important decisions about people where needed.
● One relative told us, "The atmosphere is nice and friendly."

Working in partnership with others
● The management team worked with other agencies such as the local authority and health authority, to support people's needs.

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 10 HSCA RA Regulations 2014 Dignity and respect Suitable arrangements were not in place to ensure people were treated with dignity and respect consistently. Regulation 10 (1).

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not sufficiently robust to ensure risks associated with people's health and safety were effectively managed. Regulation 12 (1) (a) (b) (c) d) (g) (h)

The enforcement action we took:

Impose conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Risks associated with people's care and the environment were not sufficiently managed to keep people safe.

The enforcement action we took:

Impose conditions on the providers registration