Mrs Wendy J Gilbert & Mr Mark J Gilbert

Paradise House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Paradise House is a residential dementia care home that was providing personal care to 38 people at the time of the inspection.

People's experience of using this service:
The service had deteriorated since the last inspection.

The provider failed to ensure individual risk's for people who lived at the service had been assessed and this placed them at significant risk of avoidable harm.

Records of medicines administered and medicines stock levels did not always correlate and we therefore could not be certain that people were having their medicines as prescribed.

Staff were not always safely recruited; the provider did not always make sure checks were done in relation to their previous employment.

The service did not always follow safeguarding procedures when a person had fallen.

People were protected by the prevention and control of infection.

On the day of the inspection our observations found that the service was adequately staffed however, people's relatives told us that staffing levels were not always sufficient.

There was a system in place for measuring outcomes for people who lived at the service however, it was not effective and did not highlight the shortfalls found at the inspection. We found that the management team did not effectively quality assure the service. We received mixed feedback about the manager from people who lived at the service and their representatives. The service was not consistently well led. Staff told us that they felt supported by the manager and senior management team.

More information is in the Detailed Findings below.

Rating at last inspection: Good (report published 09 January 2018).

Why we inspected: This inspection was in responsive to concerns we received from people's representatives, external professionals and whistle blowing information received by the Commission and the local authority.

Enforcement: Please see the 'action we told the provider to take' section towards the end of this report.

Follow up: The overall rating for this service is inadequate and the service is therefore in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to

propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Paradise House

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:
The inspection team consisted of two adult social care inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case, older people.

Service and service type:
Paradise House 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.

The service had a manager in process of registering with the Care Quality Commission. This means that the provider's are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced.

What we did:
Prior to our inspection we looked at all of the information we held about the service. This included any safeguarding investigations, incidents and feedback about the service provided. We looked at any statutory notifications that the provider is required to send to us by law. We also looked at the Provider Information Return (PIR) from November 2017. 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. We also contacted professionals who provided feedback about their experiences of the service. We used a planning tool to collate all this evidence and information prior to visiting the service.

We spoke with four people who lived at the service and seven relatives. We also spoke with the cook, two support workers, the deputy manager, the manager, the regional manager and the compliance manager. We looked at a variety of records which included the care files for nine people who used the service and two staff recruitment files. We also reviewed a number of records relating to the operation and monitoring of the service.

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.

Using medicines safely:

- Records of medicines administered and medicines stock levels did not always correlate. For example, we checked medicines stocks for four people who lived at the service and found for three medicines the medicines stocks did not add up correctly indicating people may have missed medicines on seven, eight and eleven occasions. This meant we could not be certain people were having their medicines as prescribed and people's health and wellbeing was placed at unnecessary risk.
- The provider's records did not always demonstrate whether prolonged issues with people's prescribed medicines had been escalated. For example, we could not be certain that the provider had taken necessary steps to communicate with a person's GP when their blood pressure medicine had not been provided by the pharmacy. We also found the provider did not maintain a record of monitoring the person's blood pressure as specified by the person's GP when their blood pressure medicines had been increased.
- We asked the provider to raise safeguarding alerts for all identified medicine errors. The provider sent evidence after the inspection to show alerts had been made.
- The provider had failed to ensure that medicines were consistently managed safely. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management:

- Risk assessments to keep people safe were not consistently updated. For example, those at risk of falling and people with an allergy did not always have up to date risk assessments to guide staff on the support they required.
- We found that when a person had fallen the service had not always taken essential steps to safeguard the individual from further avoidable harm.
- The manager told us that they had been informed by staff about a bedroom door that had a faulty lock, this meant that people who lived with dementia were at risk of being trapped in a bedroom and unable to summon help. We asked for immediate action to be taken and the regional manager assured us the issue had been rectified.
- We looked at the care records for a person who lived at the service and found they had not been assessed against the risk of choking despite being observed to hold food in their mouth. Steps had been taken to refer the individual for speech and language professional support. We found that the provider had not implemented choking risk assessments for people with swallowing difficulties however, the manager told us that they had access to a risk assessment and would implement it for people identified at risk.
- We asked the provider to raise safeguarding alerts for all reportable incidents.
- The provider had failed to ensure that people were consistently protected against avoidable harm. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:
● There were systems in place to safeguard people from avoidable harm however, systems were not always followed as a safeguarding triage tool available at the service has not been completed.
● Staff had undertaken training in safeguarding vulnerable adults.
● Staff demonstrated understanding of what constitutes to abuse and how to report safeguarding concerns. However, safeguarding alerts were not always made. Before the inspection we received a number of whistle blowing concerns from staff and people who visit the service. This showed that staff were aware of how to whistle blow and had access to important contact details for the local safeguarding authority and CQC.
● We asked people who lived at the service and their representatives if they felt safe. People told us, "I stay in my room mostly and don't really like to get involved. I never use my call buzzer but whenever I ask any of the staff for help they are always all very good." And a relative told us, "I think [name] is safe here yes, staff are good."

Learning lessons when things go wrong:
● The service did not adequately evidence lessons learnt because the manager had not reviewed incident and accidents in line with the providers policy and procedure.

Staffing and recruitment:
● People who lived at the service and their representatives consistently told us there were staffing shortages at busy times such as in the evening and meal times. However, we observed throughout the inspection and found that communal areas were always supervised by staff and people were provided support in a timely manner.
● Staff told us the service was suitably staffed to provide safe care.
● The provider used a dependency tool to ascertain staffing levels in relation to people's needs. We were informed by the regional manager that the tool was under review and that staffing was continually considered in line with the needs of people who lived at the service.
● We found a senior staff member had not been safely recruited. The provider did not ensure that previous employment checks were undertaken. We checked a second staff recruitment file and found references were requested from their previous employer however the return reference did not provide information about their character or conduct. The manager did not source any further previous employment checks to ensure that they were suitable for the position.

Preventing and controlling infection:
● The service was clean and staff followed infection prevention and control procedures.
● There was a policy and procedure to guide staff around best practice in the prevention of infectious disease.

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.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

- The manager failed to ensure they promoted consistent person-centred, high quality care and support. For example, we found people were not always assessed in a person-centred way in relation to individual risk and this meant that they were at risk of avoidable harm. People did not always receive their medicines as prescribed and records in relation to changes to people's medicine regimes were not always updated.
- There was inconsistent learning from accidents or incidents. The provider did not demonstrate how service user accidents and incidents were monitored or analysed to prevent avoidable harm.
- Care records were not always up to date and did not always reflect people's needs.
- The provider did not always act on their duty of candour responsibilities in relation to escalation of people's change in health needs and reporting of incidents. For example, one person was prescribed an increase of their blood pressure medicine and staff did not follow important guidelines specified by the GP to check the individuals blood pressure and organise a medical review in the time frame specified. The service also failed to inform the person's GP when the medicine was not administered as prescribed for 16 consecutive days. Another person sustained a head injury after a fall at the service and the provider failed to report this to the individuals GP or the local safeguarding authority until the incident was highlighted during a review of accidents and incidents at the service by visiting safeguarding officer 32 days after the incident.
- The provider failed to maintain an accurate record in respect of each person using the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

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

- Breaches of the Health and Social Care Act 2008 (Regulated Activities) found at this inspection showed that the manager failed to fulfil regulatory requirements in line with legislation and best practice guidance.
- The manager told us they were not aware of areas within the service that had failed and placed people at risk.
- We received mixed feedback about the manager. Some people told us that the service was well managed and the manager was approachable however, others told us that the manager lacked experience.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

- The manager provided evidence after the inspection, at our request, in relation to staff meetings. Since the manager was promoted in May 2018 they had held one staff meeting and one senior staff meeting. Meetings were infrequent.

● Care records did not evidence consistent and effective liaison with people who received support or their representative when their needs had changed or after an incident had occurred. This showed that the provider did not always involve people in decisions about their care.
● People who lived at the service and their representatives told us that the manager communicated with them and they were satisfied with their level of involvement. However, we found that resident and relative meetings were not held on a regular basis.
● People's feedback had not been sought. The provider had not issued stakeholder surveys.

Continuous learning and improving care:
● Quality assurance processes were not effective and did not identify the issues we found during this inspection.
● The service had not adopted a learning culture.
● Failings identified and reported by the local safeguarding authority were not sufficiently acted upon to prevent further avoidable harm.
● The provider failed to assess, monitor and improve the service and was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others:
● The service evidenced liaison with external agencies and people were referred to health care professionals. However, we found that external professional recommendations were not always followed.
● The service was not accredited to any best practice schemes.
● The manager told us about plans to improve partnership working, this included access to a medicines optimisation scheme run by the NHS.

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 provider did not ensure people who lived at the service were protected against avoidable harm. Medicines management systems were not safe.

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 effective systems in place to assess, monitor and evaluate the service. Regulatory breaches found at the inspection had not been identified by the provider. Record keeping was not sufficient.