Care Quality Commission

Redcot Care Limited

Redcot Lodge Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate ●

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

Summary of findings

Overall summary

About the service
Redcot Lodge Residential Home is a residential care home providing accommodation and personal care. The service can accommodate up to 18 people in one adapted building. At the time of the inspection there were 16 people living at the service. Some people were living with dementia and some people had learning disabilities.

People's experience of using this service and what we found
Quality assurance and governance systems were not effective in making sure risks to people's safety were managed safely. For the past year the registered manager, had not been managing the service on a day to day basis. They had failed to have continuous oversight or scrutiny about what was happening at the service. They had failed to undertake any checks and audits to identify concerns and shortfalls. When they returned to the service on a more regular basis, they had found some of the issues but were unaware of the extent of the shortfalls and concerns we found at this inspection. Concerns identified at the previous inspection had not been prioritised and improvements had not been made and implemented.

People were not protected from the risk of avoidable harm. When concerns were identified about people's safety, information was not shared with appropriate stakeholders so investigations could be conducted. Risks were not managed. The registered manager had not ensured all risks associated with people and the service had been assessed and action had not been taken to make sure risks were mitigated. The registered manager was ensuring that people were protected from the risk of infection.

The registered managers lacked oversight of the incidents and accidents. Lessons had not been learnt when things went wrong.

Medicines were not always managed safely. Handwritten record had not been doubly signed by staff to reduce the risks of errors occurring. Staff did not have guidance for 'when required' medicines that were prescribed for people when they became distressed. Staff could not find any medicines audits to check that medicines had been given safely and any errors identified.

There was not always enough staff on duty to ensure care was delivered in a safe way. Staff received essential training to complete their role, but not all staff received training about people's specific health conditions.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of Safe and Well Led:

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
The model of care and setting did not always maximise people's choice, control and independence. People were not considered and involved in the planning of their care.

Right care:
Care was not always person-centred and did not always promote people's dignity, privacy and human rights. People did not always have access to meaningful and person-centred activities.

Right culture:
Ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services lead confident, inclusive and empowered lives.

People were supported with their health needs. GP's, district nurses and other specialists were contacted when they were needed. Staff were recruited safely. All safety checks had been completed before new staff started working at the service.

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 July 2019) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received from the local authority about lack of care planning and risks associated with people's care. A decision was made for us to inspect and examine those risks and to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Redcot Lodge Residential Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding, risk, medicines, lack of staff, and leadership, management, scrutiny and oversight of the service.

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

Follow up
We met with the registered manager following the inspection to discuss how they will make changes to ensure they improve their rating to at least good. They agreed with that they would not admit any new people to the service until improvements were made.

Following the meeting we were informed that the provider had made the decision to close the service and would be cancelling their registration with the CQC. The registered manager and the local authority were working with people and their relatives to make ensure people were moved safely to other services that were able to meet their needs.

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 until they are de-registered, if we do not propose to cancel the provider's registration. 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.

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 well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate** ●

Care Quality Commission

Redcot Lodge Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 one inspector.

Service and service type
Redcot Lodge Residential Care Home 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. Redcot Lodge Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We reviewed the information of concern we had received to ensure we focused on the appropriate areas during our inspection.

We used all this information to plan our inspection.

During the inspection
We spoke with four people to gain their views on the quality of care provided. 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 the registered manager, and three staff. We reviewed information held in four people's care plans, three staff recruitment files, medication records and other paperwork related to the running of the service.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found. We looked at minutes of meetings, duty rotas and quality assurance information.

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, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a failure to manage risks associated with people in a safe way.

No improvements had been made, we continued to find concerns at this inspection and the provider was still in breach of regulation 12.

● Risks to people's safety, health and wellbeing were not managed. At the last inspection, there was no guidance for staff about how to manage people's health and welfare. Since the last inspection the care planning system used had been changed and new care plans had been introduced. However, information about people remained limited and there continued to be no information or guidance for staff to manage risks. This left people at risk of not receiving the care and support they needed to keep them as safe as possible.
● One person had a catheter in place to drain urine from their bladder. There was no care plan or associated risk assessment in place to tell staff how to support the person with their catheter care. There was no information about what action to take if the catheter was not working properly or the signs to look for if there was the risk of infection developing. People were at risk as some staff we spoke with did know how to recognise if there were concerns with the persons catheter.
● Some people had medical conditions like diabetes. There was no information in place about the signs and symptoms the person may present with if they became unwell. Some staff we spoke with were unsure about how people would present if they were unwell and what action to take.
● Other people were at risk of falling or at risk of developing pressure sores. There was no guidance or information for staff to inform them on how to mitigate these risks. People had fallen and hurt themselves, but nothing had been put in place to prevent it from happening again.
One person was at risk of choking. This was identified and staff were aware of the risk but there was no guidance in place to tell them what to do if the risk occurred.
● Some safety checks to environment had not been done. Fire door checks and fire alarm checks that were supposed to be done weekly had not be checked since the end of January 2022. Hoists and wheelchair safety checks had not been completed since the end of January 2022. Checks of the hot water temperatures had not been done since December 2021. There was a risk that the environment and the equipment used by people was not safe.

The provider had failed to ensure risks to people's care was managed in a safe way. This was a continued

breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements had been made but we continued to find concerns at this inspection and the provider was still in breach of regulation 12.

● Medicines were not managed safely, the shortfalls found at the last inspection remained. When medicine instructions were handwritten these had not been signed by two staff to confirm the medicine and amount were correct. This increased the risk of people receiving the incorrect medicine or the incorrect amount if errors were not picked up.
● Some people were prescribed medicines on a 'when required' basis such as pain relief and medicines for anxiety. There was guidance for staff about when to give the medicines for pain, however, there was no guidance on when to give 'when required' medicines to people when they were distressed or anxious. The was no guidance on how often to take the medicine and what action to take if the medicines had not been effective. There was a risk that people would receive these medicines inconsistently.
● When people administered their own medicines, there was no assessment to check that people were safe to do this. There were no guidelines about how staff should support people, check that they were taking their medicines as prescribed and storing them safely.
● There was a risk that people may not be receiving their medicines safely and as prescribed as no medicines audits or medicines checks could be found at the service.

The provider had failed to ensure the proper and safe management of medicines. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Incidences that had occurred had not been reported to the local authority safeguarding team.
● One person told us that another person shouted and was verbally abusive towards them. No action had been taken to prevent this re-occurring. Another person had unexplained bruising on their leg. This had not been investigated or reported. One person had fallen and broke their hip the registered manager said they were unsure if this had been reported to the local authority.
● Staff had not recognised these incidences should have been reported. The staff had not raised these as a safeguarding with the local authority and had not taken any action to prevent re-occurrence.
● Lessons had not been learnt from the last inspection when breaches had been identified. Action had not been taken to improve the service and risks remained.

The provider had failed to protect people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staffing and recruitment
● At times there were not enough staff on duty to make sure people were safe and received the care and support that they needed. Staff told us they just got on with things and did the best they could with the resources they had got. One staff member told us, "We have got used to working like this now. It's not ideal but what can you do. Its non-stop from the moment you get here till the moment you leave." Another staff member said, "We don't have time to sit down and have a chat with people. Yes, people are left alone."

● Four days a week there were three staff available for the early shift. Eight people needed two members of staff to support them with their personal care, medicines needed to be administered. Some people needed support to eat and drink. There was not enough staff available throughout the day to make sure people's needs were meet in a timely manner.
● We observed that people were left alone for long periods of time in the communal area as staff were busy supporting people in their bedrooms or doing other tasks. People were at risk of falling. There was a risk of people becoming distressed and upset. People had to wait for support with their meals and support to go to the bathroom. One person asked staff to support them to use the bathroom. They were told they would have to wait a few minutes as the staff member was in the middle of doing something else. There was no one else available to help. People were at risk of being injured and not getting the care and support they needed when they needed it.
● The service was also short of a cleaner. The registered manager was trying to recruit but had not been successful. In the interim period care staff told us they were cleaning rooms as well as their care duties. They had less time to care and support people. Following the inspection, the registered manager told us they had employed agency staff to cover the shortfalls.

The provider had failed to ensure sufficient numbers of suitably competent and experienced staff were deployed. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection the provider had failed to operate effectively established recruitment procedures to meet the regulations. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no-longer in breach of the regulation.

● Staff were recruited safely. Recruitment safety checks were completed, and action had been taken when concerns about staff suitability had been highlighted.
● Checks had been completed with the Disclosure and Barring Service (DBS)to check for any criminal records or professional misconduct.
● Safety checks contained a full employment history and two references. One of the files

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or

managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visits to people living at the home in accordance with current guidance.

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 Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection the provider had failed to assess, monitor and improve the quality of the service provided. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had not been made and the provider was still in breach of Regulation 17

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

● Since the last inspection there had been no improvement in the service. We found repeated breaches of regulations and additional breaches had occurred since the last inspection. This placed people at risk of harm to their health, safety and well-being.
● There was a lack of leadership and oversight at the service resulting in poor outcomes for people. The registered manager had failed to monitor, audit and check the service was providing people with safe, effective, compassionate, high-quality care.
● Until recently the service had been managed on a day to day basis by a manager who was not registered with the CQC. The registered manager had taken a 'step back'. They were not at the service on a regular basis. Staff told us that that they had felt bullied and undervalued during this time. They said they had not been listened to. Staff had left the service. The day to day manager had recently left and the registered manager was now at the service on daily basis during the week. There had been a 'blame' culture at the service. Staff told us they realised that 'things were not right' but for reasons they were unable to explain but they had not contacted and informed the registered manager. Staff said that improvements were being made and they now felt more involved and appreciated.
● Since returning to the service on a more regular basis the registered manager had identified some of the shortfalls we found at the inspection. However, as the registered manager they have legal responsibility to continually monitor, audit and check the service. They had not done this and the safety of people and the care and support they received had deteriorated.
● Recent audits and checks had not been completed on fire safety, water temperatures and the equipment

used to support people to transfer safely. Audits for medicines, care plans and risk assessments and pressure sores had not been completed.
● Record keeping at the service was poor. Care plans were not detailed and did not reflect the care being given to people. Risk assessments were basic or not completed at all. People were at risk of not receiving the care and support they needed in a way that kept them as safe as possible.
● Deprivation of Liberty Safeguards (DoLS). application could not be found. 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 2005 (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called DoLs. Staff said some people were subject to DoLs. When people are subjected to DoLS the CQC are supposed to be notified. CQC had not been notified of any DoLs restrictions.
● Assessments of people's needs were inadequate. The registered manager had failed to ensure that people's needs were known and met. People with learning disabilities had recently been admitted from hospital. A full assessment of all their needs had not been carried out. No consideration had been given to the right care, right support, right culture to make sure the service could meet their complex needs. We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. This had an impact on people's safety, their quality of life and the quality of care they received. The outcomes for people were poor and they were at risk of inappropriate care and treatment.
● Some incidents had not been recorded. One person old us that another person shouted at them a lot. There was no record of these incidences. We could not be assured that the provider had complied with the requirements under the duty of candour. Incidents were not always analysed for trends to identify patterns and take action to reduce these. For example, there was no analysis of incidents of behaviour that occurred between people.
● People were at risk because staff did not have the skills to support people with their health needs. The registered manager had not provided staff with training to give them the skills to support people with diabetes, epilepsy and catheter care, as recommended at the last inspection. Incidents had not been recorded and reported to the local safeguarding authority. We could not therefore be assured the registered manager had complied with the requirements under the duty of candour to apologise when things had gone wrong.
●There was no evidence of continuous learning. The registered manager had not made improvements follow the last inspection and the breaches identified.

Working in partnership with others
● The provider did not have effective partnership working with key agencies such as health and social care professionals. This had a detrimental impact on the care and support people received.
● The registered manager had contacted clinical nurse specialist on occasions. However, they had not always recognised when they had required support. For example, support with developing care plans and risk assessments.

The provider had failed to assess, monitor and improve the quality of the service provided. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. The provider had failed to mitigate risks relating to the health, safety and welfare of service users. The provider had failed to improve This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 had failed to do all that is reasonably practicable to mitigate risk. The provider had failed to ensure the proper and safe management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality of the service provided. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. The provider had failed to mitigate risks relating to the health, safety and welfare of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably competent and experienced staff were deployed.