Kilburn Care Limited

Kilburn Care Centre

Inspection report

Dale Park Avenue
Kilburn
Belper
Derbyshire
DE56 0NR

Tel: 01332880644

Date of inspection visit:
03 March 2021
09 March 2021

Date of publication:
23 April 2021

Ratings

Overall rating for this service	Inspected but not rated
Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Kilburn Care Centre is a care home providing personal and nursing care. Kilburn Care Centre is registered to accommodate 49 people. At the time of the inspection there were 32 people using the service. The service accommodates people in one building over two floors. The home is divided in to two areas; the main nursing unit and a 10 bedded residential unit. The residential unit was not used due to refurbishment work. Both areas had separate adapted facilities with lounge and dining areas on each unit. A garden and enclosed patio were also available that people could access.

People's experience of using this service and what we found
Risks associated with people's care had not always been identified, mitigated and monitored. Staff were not always following COVID-19 government guidelines and good infection control practices. Sufficient staffing had not always been deployed to ensure people's needs were met in timely manner. Systems and processes which had been implemented to monitor potential safeguarding concerns in the service had not been used effectively.

The home currently had no registered manager; however, a regional support manager was in post to support the running of the service. The provider had oversight of the service and carried out regular visits to monitor the quality of people's care, however actions had not always been taken to make improvements. Accidents and incidents were not always reviewed and thoroughly analysed to reduce the possibility of similar incidents reoccurring.

Relatives told us that staff were very caring, compassionate and knew people well.

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

Rating at last inspection
The last rating for this service was Good (published 16 June 218) This was under the previous provider. Ratings from previous comprehensive inspections for those key questions have not been used to calculate the overall rating at this inspection as these were awarded to a previous provider. The overall rating for the inspection will be inspected not rated.

Why we inspected
We undertook targeted inspection and 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 coronavirus and other infection outbreaks effectively.

We inspected and found there was a concern with infection prevention and control procedures and oversight at the service, so we widened the scope of the inspection to become a focused inspection which

included the key questions of safe and well-led.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kilburn Care Centre 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. We have identified breaches in relation to safety, staffing and governance 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Kilburn Care Centre

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 Care Act 2014.

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
Inspection was carried out by one inspector on day one and two inspectors on the second day.

Service and service type
Kilburn Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. There was a regional support manager who was overseeing the service.

Notice of inspection
This inspection was unannounced. We contacted the service on arrival this was because we wanted to make arrangements to enter the service safely during the COVID-19 pandemic.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

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. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
We spoke with nine members of staff including the regional support manager, deputy manager, a nurse, care workers and a domestic staff. We also spoke with visiting relatives. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at several staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We requested feedback from eleven relatives and received responses from six.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection under previous provider this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management, Lessons learnt

- Care and support was not always delivered in a safe manner, and action to mitigate risks had not always been taken.
- Risks associated with people who had specific health needs, such as diabetes or epilepsy, were not always considered or documented. People's care plans and risk assessments were not always kept up to date detailed and accurate We saw some care plans were completed in 2019 and had not been reviewed in detail since this date. This meant staff did not always have accurate information available to them on how to support people. The lack of information placed people at potential risk of not receiving the correct care and support.
- The service had used agency staff and there was no evidence on how staff were informed about people's needs. Staff relied mainly on information passed on to them during shift handovers. This put people at risk of not receiving appropriate care.
- Peoples hydration and nutrition was not consistently monitored. We saw food and fluid charts were not always completed or accurately reflect what people had eaten or drank. For example, there were no records of what one person had to drink after 4pm for several days. We discussed this with the manager who told us that people were offered drinks after 4pm and it was an omission in recording.
- Emergency plans to support evacuation were not detailed on how to safely evacuate people to the place of safety. This meant that staff or emergency services did not have a clear guidance on how to evacuate people in case of an emergency, such as fire.
- Lessons were not learnt from incidents to reduce ongoing risk. Reviews and investigations were not always thorough. For example, in February 2021 there were seven occasions where people had fallen. We saw no evidence of the actions taken to reduce the risk of people falling again. This meant people could be at risk of further falls.

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 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Government guidelines for reducing the risk of COVID-19 in care homes had not been followed. On day one of the inspection we observed two staff members entering the service without wearing appropriate face masks. Prior to our inspection visitors were not always screened for symptoms of infection such as a temperature check. Visitors were not asked to complete health screening questionnaires upon arrival at the

service. This meant measures had not been taken to reduce the risk of the infection from visitors.
● Staff and visitors were required to take Lateral Flow Device (LFD) test to check for coronavirus infection before they could enter the home. On day one of the inspection we saw two used testing strips left unattended, whilst waiting for the result, near the main entrance to the home. These tests were not identifiable; therefore, the provider was unable to confirm who took the test. On day two of the inspection we saw another two used testing strips left unattended. This meant that the systems for testing visitors and staff were not robust.
● Risk assessments in relation to COVID-19 had not been completed. For example, people with underlying health conditions, had not been assessed to reduce their risk. Measures were not put in place to reduce them catching the infection or consider any additional support they may require.
● Social distancing was not always followed. On day one of our inspection we observed several people sitting next to each other at the table. Other people who were walking around the service touching other people and attempting to enter people's bedrooms, including those who were self-isolating. This put people at risk of spreading the infection.
● Training had not been received to support staff knowledge in relation to COVID 19. Records showed, and staff told us they had not received any additional training to care for people during the COVID-19 pandemic. For example, staff had not been trained on how to safely put on and take off their personal protective equipment (PPE).
● The cleaning programme was not robust. There was no evidence enhanced cleaning was taking place, such as cleaning of high touch points. Some areas of the home were cluttered with old furniture and boxes.
● Domestic staff covered a range of cleaning tasks, however once their shifts had been completed there was no evidence to demonstrate additional cleaning took place, such as high touch point cleaning. This placed an increased risk of transmission of the infection, due to the people who consistently touched areas as they walked around the home.

The provider had failed to ensure people and staff were protected from the risk of, or, 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.

Staffing and recruitment
● There were not enough staff to ensure people received the care they needed. Regular checks and care tasks for people had not always been carried out in line with their plan of care because of low staffing levels. For example, one person returned from the hospital with the directive to be checked every hour with hourly mouth care. On the day of our inspection, daily records showed no one had attended this person for three hours. This meant this person had not received the care they required to ensure their safety and care needs had been met.
● There were not always enough staff in communal areas to ensure incidents between people were prevented. On day two of our inspection we observed there was only one staff member in the lounge to care for eleven people. We saw one person, who required support from two staff, requesting support from domestic staff to use the bathroom. It took staff approximately five minutes to summon another staff member to support them to provide the care request.
● The provider used a dependency tool to determine staffing levels, however this had not taken into consideration any support for ancillary tasks such as spending time doing activities or keeping people occupied during the day. It had also not considered number of people who required two staff for their support and the impact that would have on them getting the care they required in a timely manner.
● Staff we spoke with did not think there were enough staff on shift to consistently undertake timely and regular checks on people. The provider's dependency tool recommended four staff on duty at night. this equated to two staff members on each floor. There were several people who required two staff to support

them with personal care, this meant when staff were supporting people in their bedrooms there would not be another staff member available to support people in communal rooms or respond to people in a timely manner.

● External pressures caused by the COVID-19 pandemic meant there had been a reliance on agency staff. The provider was unable to provide us with the assurance agency staff had received an induction into the service or that they had received information about peoples care needs.

● Relatives told us they found staff to be compassionate and caring. One relative said; "Most of the carer staff and nurses are good, caring people, but are challenged by insufficient number of staff which does not allow them to do their job".

The provider had failed to ensure there were staff deployed to meet people's needs. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a safe recruitment system in place. Pre-employment checks were obtained prior to staff commencing employment.

Systems and processes to safeguard people from the risk of abuse

● People were not consistently protected from the risk of abuse and were at risk of being harmed by others due to low staff numbers. Some people showed distressed behaviours which impacted upon other people. For example, some people could become distressed and hit out at other people. Staff did not always have the guidance on how to reduce these risks or safely manage situations when they arose. We also noted several incidents were unwitnessed in the communal spaces, which reflected a lack of supervision at times when care tasks are being completed in people's bedrooms.

● Staff had received regular safeguarding training and knew how to raise any safeguarding concerns. Safeguarding incidents had been investigated by the manager and actions had been taken to reduce the risk of the incident happening again.

● Safeguarding incidents were reported to the local authority and CQC.

Using medicines safely

● Medicines were safely managed. Medicines were stored securely and at the correct temperatures.

● People received their medicines as prescribed. The Medicine Administration Records (MAR) were well completed, which meant we were assured medicines had been administered.

● The regional manager carried out audits to check people received their medicine correctly.

Requires Improvement

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 the last inspection under previous provider this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

- There was no registered manager in post. Interim arrangements for the management of the service were in place and the regional support manager was in post to oversee the service.
- Quality assurance systems had not always been effective in identifying areas for improvement and driving quality. Despite the provider having a number of quality audits and checks there were no systems or processes to respond and action those appropriately and without delay. For example, we were unable to find records of fire checks for January 2021. A number of fire drill had been completed with the result recorded as, 'unacceptable, more training needed'. Actions were not taken to ensure staff were re-trained in fire procedures.
- Monthly reviews on people's care plans were not effective at ensuring they contained accurate and up to date information about people's changing needs. The care plans were still in the style of the previous provider and had not been reviewed to consider the needs of each person or any changes which may have occurred. For example, one person required a specific pureed diet and thickened fluid. There were no detailed care plans in place to reflect these needs.
- Daily care records were not detailed and there was no evidence they were reviewed by the management team. These records were used to formulate the handover information, this meant there could be omissions in transferring information about people's current care needs.
- The service had changed provider in September 2020. We found that the provider had failed to review and replace people's care plans and health and safety related documents and were still using documents with previous provider branding.
- Accidents and incidents were not effectively analysed; therefore, any themes or trends were not always identified to mitigate risk and ensure lessons were learnt. For example, when people had a fall or an accident, measures were not always put in place to reduce further risk or the same incident from happening again.
- The provider's infection prevention and control policy was up to date, however it had not been implemented or shared with staff. This was reflected in the concerns we have identified in the safe section of this report.
- The provider had implemented a service improvement plan; however, the plan was not detailed and had not identified issues raised by CQC such as ineffective care plans and concerns regarding infection prevention. The improvement plan was not time bound, therefore there were no clear expectations when the improvements would happen.

The above was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Regular staff meetings were held which gave staff the opportunity to raise issues of importance to them.
● The provider had appointed a peripatetic nurse who was supporting the service two days per week to make future improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives had mixed reviews in relation to the care people received. Relatives felt people received appropriate care, and staff were friendly, however improvements were required in relation to communication and updates from the management team.
● One relative told us they were kept up to date about their loved ones via telephone calls and through regular newsletters. A relative told us; "I was kept fully informed about COVID19 and anything to do with [name]". Another relative told us; "It is very difficult to get information, it always felt like I had to chase them, they have never returned my calls when I have asked, I always have to keep trying to call them."
● Relatives told us they felt confident in raising concerns with the service manager. A relative told us; "We have always felt confident to raise issues with the manager and have done so. Any concerns have been responded to appropriately".

Working in partnership with others
● The manager and provider engaged and worked in partnership with others. They had acted appropriately in response to concerns to peoples changing health needs. For example, when peoples weight had decreased, the service sought support from the GP to refer the person to the dietitian service.
● People who were at risk of choking had been assessed by Speech and Language Therapist to ensure risk assessments were in place to prevent the risk of choking.

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
● The manager and provider understood their responsibility to be transparent and inform relevant organisations of any incidents, including those incidents that are notifiable to the Commission.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were insufficiently robust and failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not always sufficient to meet service users' needs.

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
Treatment of disease, disorder or injury	Care and treatment people was not always provided in a safe way

The enforcement action we took:

We served a Warning Notice.