HC-One Oval Limited

Adelaide House Care Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service:
Adelaide House provides care and accommodation for up to 30 people, some have nursing and physical needs and some people are living with dementia. On the day of our inspection 23 people were living at the service.

People's experience of using this service:
People did not always receive care when they needed as there were not sufficient staff deployed at the service including care and nursing staff. Medicines were not always being managed in a safe way which put people at risk.

There were audits taking place however these were not always robust, particularly around the monitoring of staff levels. People and staff did not feel there was a strong leadership presence in the service.

The service was clean, and staff adhered to appropriate infection control measures.

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 requires improvement (published 27 January 2020) and there were multiple 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 identified continued breaches in relation to the deployment and numbers of staff, and the lack of robust quality assurances at the service.

Why we inspected:
We undertook a targeted inspection due to concerns we received relating to staff levels and medicine errors that had occurred, and to review the progress made by the service to become compliant with the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report only covers findings in relation to risk associated with staff levels, medicines, infection control and quality assurance. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on a Warning Notice or other specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 coronavirus and other infection outbreaks effectively.

Enforcement:
We have identified continued breaches in relation to staffing, the safety of care around the management of medicines and the quality assurance of the service. 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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 continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner. We will continue to work with the local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

Inspected but not rated.

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Details are in our Safe findings below.

Is the service well-led?

Inspected but not rated

Inspected but not rated.

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Details are in our Well-Led findings below.

Adelaide House Care Home

Detailed findings

Background to this inspection

The inspection:
This was a targeted inspection to check a specific concern relating to staff levels and the management of medicines. 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:
Our inspection was completed by two inspectors.

Service and service type:
Adelaide House 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 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:
We gave a short notice period of the inspection to ensure safety of all involved and assess risks around Covid-19.

What we did before inspection
Our inspection was informed by information we already held about the service including notifications that the service sent us. We checked records held by Companies House.

We asked the service to complete a Provider Information Return. 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 received feedback from the local authority. We used all of this information to plan our inspection

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with four members of staff including the registered manager and care staff.

We reviewed a range of records. This included five people's care records including risk assessments. 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 policies and quality assurance records. We called and spoke to a further four members of staff.

Inspected but not rated

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 this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

We will assess all of the key questions at the next comprehensive inspection of the service.

The purpose of this inspection was to follow up on concerns that related to the risks associated with staff levels and to review the progress which the service was making to address the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in relation to the management of risks associated with people's care.

At our last inspection of the service the provider had failed to ensure there was a sufficient number of staff deployed at the service to provide safe care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In their action plan they stated they were regularly reviewing the needs of people and ensuring appropriate levels of staff were on duty. However, not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

Staffing

- People told us there were not enough staff at the service. One person said, "I'm lonely, I hardly get to see staff." Another person said when asked if there were enough staff, "In a word no. Partly because we have more residents and they haven't increased staff levels. Sometimes at night I can go from 20.00 to the next morning and not see anyone. It makes me feel neglected."
- When we arrived at the service there was one nurse on duty who was undertaking the medicine round. In addition to this they were also the senior member of staff on duty. As such they were being interrupted frequently to assist with other matters such as the late notice absence of a member of staff. A member of staff told us, "Some of these residents you are almost bordering on needing one to one nursing. The nurses are at full stretch."
- The nurse told us that administering medication took up a large part of their day'. They told us they always prioritised the care for people, but they knew they were not up to date with reviewing care plans. This was confirmed when we reviewed people's care plans and found that people newly admitted to the service did not have a completed care plan. A nurse told us, "I would appreciate if we could have the senior carer to help with medication." The registered manager told us it took the nurse a long time to do the medicine round and that often its past 10.30 before the morning medication had been completed. They said, "I have raised it (with the provider) several times about senior carers doing meds and I am told that nurses should be able to manage their own workload."
- People had to wait long periods of time before the nurse was available to attend to their clinical needs. For example, one person showed us their dressing had fallen off from their leg that morning however they were having to wait for a nurse to come back and dress the wound once they had finished their medicine round. A person told us, "I have a problem with my leg. Nurse is going to come back as dressing feel off this

morning, but I know she is busy." The registered manager told us, "The nurse isn't always free to support the clinical time with residents."

● There were insufficient care staff to meet the needs of people. During the morning personal care was delayed. At 11.37 there were people still waiting to be supported, one member of staff told us there needed to be more care staff. Most people were in their bedrooms with very little interaction from staff other than assisting them with personal care or with their meals. Another member of staff said, "I think they (care staff) are quite rushed, a lot of the time."

● The registered manager told us four carers were required during the day split between three floors. There were times during the inspection where there were no staff present on the top floor where three people were being cared for. One member of staff told us that call bells needed to be responded to within five minutes. However, we reviewed the call bell audit for August 2020 and found on five occasions it took staff more than five minutes to respond, with one of these taking 18 minutes. One member of staff said, "I know we only have 23 residents, but we have four staff in the morning and the same in the afternoon and evening but the residents we have are all really quite demanding and have some really quite high needs."

● We identified that there had been 28 unwitnessed falls at the service between May and July, the majority of which had been in people's bedrooms. One member of staff told us, "Falls have increased. If there were five staff, we could have one staff member keeping a check on people."

As there were not sufficient numbers of staff deployed at the service to ensure safe delivering of care this is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection of the service the provider had failed to ensure people's care was managed in a safe way. 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 was still in breach of regulation 12.

Using medicines safely

● The management of medicines was not always undertaken in a safe way. There had been frequent medicine errors notified to us by the service prior to the inspection taking place. The registered manager told us these errors may have occurred due to the introduction of the new electronic Medicine Administration Records (MARS) and one nurse taking sole responsibility of administering the medicines that took a large part of the day. Medicine audits were undertaken monthly however they were not always effective in making improvements. The frequency of the audits had not changed despite the increase of errors identified.

● Medicine competency checks did not always take place to ensure that staff were appropriately administering medicines. There were five nurses working at the service. Based on the records provided by the registered manager only one of these nurses had been competency assessed to administer medicines and this took place in January 2018. Although errors had identified in the recording on the MAR and the introduction of the new electronic system no steps had been taken to assess the nurses' competency in using the system.

The failure to ensure the management of medicines was undertaken in a safe way was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were people that were independent with medicines and this had been risk assessed by staff at the service. One person said, "If I needed pain relief, I know I can get this."

● People's MAR had information about the person's allergies and GP. There was evidence that 'the use when required' (PRN) medications were being given appropriately for example when people were in pain.

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.

Inspected but not rated

Is the service well-led?

Our findings

We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to follow up on concerns that related to about the management of the service and the quality assurances processes and to review the progress which the service was making to address the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in relation to the management of risks associated with people's care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection of the service the provider had failed to have robust oversight of the quality of care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In their action plan the registered manager advised us that regular meetings and supervisions would be taking place with staff. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- People told us that they did not often see the registered manager, comments included, "I would like to see her more often", "I would like a manager that comes around daily. I would like a manager to take more interest in residents" and "I barely see the manager."
- Although residents' meetings were taking place this was not being used as an opportunity for people to be involved in the running of the service and decision making. Discussions were limited to whether they liked the food and activities. There were no discussions about whether people were happy with the laundry, the environment or reminders about how they could make a complaint.
- We saw a report about daily care completed each day by the management team which contained no feedback from people living there. This was despite there being a space on the report to include this. During the inspection the registered manager spent the majority of their time in their office.
- Staff fed back that although they had seen some improvements since the last inspection, they felt the providers representatives and the registered manager were not present enough on the floor. Comments included, "Management has improved, they are more friendly to the staff, but there's no empathy towards the staff", "There has been some improvement but not a lot" and "I don't find (management) to be approachable."
- We saw from staff meeting minutes from August 2020 that staff raised the concern over the staffing levels. The minutes stated, "Staff querying the staff levels to the number of residents. Explained the staffing grid process." There were no actions agreed on how the shortfalls on staff could be resolved and we identified on the day of the inspection that staffing levels were not adequate. This had also been previously identified at last inspection
- The provider had not ensured that there was a clinical lead at the service to provide support to the nursing staff. There had been no clinical supervisions taking place to provide support and guidance to the nurses.

One nurse told us they would appreciate there being a clinical lead at the service so they could talk through nursing concerns with the them. The registered manager told us, "The nurses do not get clinical supervisions as there is no one to do them." There was a risk that nursing staff would not be providing the most appropriate clinical care to people.

● Although there were some systems to assess the quality of the service provided, we found these were not always effective. Audits undertaken by the provider and the registered manager were not identifying the shortfalls around the deployment and levels of staff and the impact this had on people. Although call bell audits were taking place and falls analyses were taking place no actions had been taken to address why call bells were taking longer than required to answer and the high level of falls taking place.

● There were repeated shortfalls identified on the monthly MAR audits taking place for example in the audit for May 2020 and August 2020 shortfalls had been identified around the lack of opening dates being entered onto medical creams, the management of the fridge where medicines were stored and the safe management of medicine waste. However, there were no follow up actions to show how this had been addressed.

● Staff told us handovers of information at the service was not effective. They said, "There is very little communication as there is no time." The registered manager told us that head of department and nurses' meetings did not take place. These would be an opportunity to talk through improvements that could be made and how to achieve this.

● There is a history of breaches of regulation and lack of action by the provider to improve care. At the inspection on 13 December 2019 we identified breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider did not have effective systems in place to monitor the quality of care or to drive improvement. The provider and the registered manager had not taken responsibility to ensure that the appropriate work was being carried out.

As systems and processes were not established and operated effectively this is a continued 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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people's medicines were being managed in a safe way.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that effective and robust auditing had taken place at the service

The enforcement action we took:

We issued a warning notice in relation to this.

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 The provider had not ensured that there were adequate numbers of staff to meet people's needs.

The enforcement action we took:

We issued a warning notice in relation to this.