Care 24-7 Leicester Limited

Bodnant 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
Bodnant House is a residential care home registered to provide accommodation and personal care for adults who may be living with a learning disability, autistic spectrum disorders, mental health needs, and sensory impairments. The care home accommodates up to nine people in one adapted building. At the time of the inspection there were eight people living at Bodnant House.

Services for people with learning disabilities and or autism are supported. The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. People did not always receive person-centred care and treatment that was appropriate to meet their needs and reflected their personal preferences. Their care and support did not always promote enablement, independence, choice and inclusion. The systems in place to prevent and respond to crisis situations, including training in positive behaviour support, safe use of restrictive interventions and learning from incidents was not always used safely and effectively.

People's experience of using this service and what we found
There was a registered manager for Bodnant House. However, they were not available to support the inspection. A new manager had been in post for a week and they were being supported by the area manager.

People were not always protected from the risk of harm or abuse because the systems and processes in place to safeguard people were not effective. Incidents of abuse were not always identified, reported to safeguarding, the police or notified to the Care Quality Commission.

Care plans and risk assessments did not contain adequate information for staff to know how to support people to manage their behaviours safely. Physical intervention techniques were not always carried out safely and in line with best practice guidance.

People's care did not support them to learn new skills, become more independent and achieve good outcomes. Care plans did not record people's goals or celebrate their achievements.

Robust recruitment checks had not been completed to ensure only suitable people were employed to work at the service. Systems in place to audit medicines were not comprehensive and did not include medicines to be given 'as needed' (PRN) or controlled medicines.

There were no lessons learnt protocols in place so the provider could learn from incidents and accidents,

safeguarding concerns and complaints to improve the quality of the service. Following incidents where physical intervention had been used there was no debrief for staff so that lessons could be learnt.

There was a lack of quality assurance processes in place to monitor the quality and safety of the service. There was a clear lack of provider oversight and they had not ensured effective and competent management was in place.

Feedback from people was not sought on a regular basis. When feedback had been gained the provider had failed to act upon it to drive improvements 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
The last rating for this service was Good (published 18 March 2018)

Why we inspected:
We received concerns in relation to the safe use of restrictive interventions and safeguarding people from abuse. In addition, we received concerns about a lack of consultation with people about changes to their care, a lack of notifications in relation to incidents and insufficient staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bodnant House 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 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.

We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, poor recruitment processes, good governance and a failure to send legally required notifications to the CQC.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always 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**

Bodnant 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. 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.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Bodnant 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 period of notice for the inspection because we wanted to be sure the provider had an Infection Control procedure and Covid 19 risk assessment in place . We did this so we could adhere to their policies and follow government guidelines in relation to social distancing.

What we did before the inspection
We reviewed information we had received about the service since the last inspection as well as recent safeguarding concerns that had been raised. We sought feedback from the local authority and other professionals who worked with the service. We used all of this information to plan our 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.

During the inspection
We contacted three people who use the service and four relatives by telephone on 13 July and 15 July 2020 to gain feedback about their experience of the care provided. During the site visit on 13 July 2020 we had discussions with the area manager, the manager and the deputy manager and spoke with four care staff. We also spoke with three care staff by telephone.

We reviewed a range of records. These included three people's care records and risk assessments. We looked at four staff files in relation to recruitment, training certificates and staff supervision. A variety of records relating to the management of the service, including quality assurance checks, safeguarding information and accident and incident information.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data including a medication and MAPA training matrix, a copy of one person's diet and nutrition care plan and a conflict of interest's policy.

Inadequate

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People and their relatives did not feel that Bodnant House was a safe place to live. One person said, "Staff 'deliberately provoke situations" and then followed this statement by adding," Staff will try and restrain instead of talking with people properly."
- Records showed that some people living at the service had called the police because they felt unsafe.
- Another person told us that they hadn't invited their family members to the home because they couldn't guarantee any of their visitor's safety.
- Physical intervention techniques were not always carried out safely and in line with best practice guidance. One staff member confirmed they had to restrain a person on their own on one occasion, this placed people at risk of harm. This should only be carried out by two appropriately trained staff.
- There were no clear systems in place to see what actions had taken place following a safeguarding incident and the out-comes achieved. The providers safeguarding guidance identified protection plans would be completed if an incident was raised. There was no evidence this had taken place.
- People's risk assessments and care plans were not reviewed following incidents of abuse to identify lessons learned and to implement measures to reduce risk to people. Opportunities to learn from incidents were missed. This meant that the lack of investigation and analysis of safeguarding incidents failed to ensure lessons were learnt and improvements made to service users care.

Failure to establish and operate systems and processes effectively to prevent abuse of service users and failure to investigate and report any allegations of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment

Assessing risk, safety monitoring and management

- People were at risk of harm. Systems in place to update people's risk assessments and care plans were ineffective. One person living at the service was refusing support with their basic care needs. However, their care plan and risk assessment did not reflect their current situation. There had been no review of their care involving family and relevant health care professionals.
- People's risk assessments had not been reviewed and updated following incidents where people needed to be supported with their behaviours or where physical intervention had been used.
- Risk assessments and care plans did not contain enough guidance for staff to know how to respond to people's behaviour to keep themselves and people safe.
- People were not included in the development of their risk assessments. This meant that they were at risk of receiving care that focused on what a person could not do rather than taking a positive risk-taking

approach which focuses on what people can do. For example, one person told us they would like to cook their own meals, but when they had offered, they were told the staff do all the cooking.

The provider had not ensured that essential information was recorded in care plans and risk assessments to protect people from harm. Risks to people had not been reviewed following incidents putting them at risk of further occurrence and possible harm. These concerns constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Staffing and recruitment

● People were placed at potential risk as recruitment processes and procedures were not followed. Staff had been recruited without the appropriate pre-employment checks being carried out.

The provider had failed to ensure staff were recruited safely which put people at risk of receiving care from staff who were not suitable to work with vulnerable people. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed

● There was no dependency tool in place to determine staffing numbers at the service. Three people required either 1 -1 or 2-1 care so their needs could be met. The systems in place did not demonstrate how many hours of care people received. We did not receive any feedback that people were not supported to go out because of a lack of staff.

● All the staff we spoke with said there were sufficient staff working at the service. One said, "There are enough staff on duty both day and night.

Learning lessons when things go wrong

● Systems and processes were not in place to ensure lessons could be learnt from incidents and accidents, safeguarding concerns and complaints to improve the quality of the service.

● Accidents had occurred at the service but had not always been recorded. However, they had not always been recorded in the accident book. This meant that the investigation and analysis of work-related accidents and incidents could be missed resulting in a failure to take positive steps to put things right.

● There was no system in place to identify any themes or trends in relation to safeguarding incidents to see what actions had taken place following a safeguarding incident and the out-comes achieved. This meant that the lack of investigation and analysis of safeguarding incidents failed to ensure lessons were learnt and improvements made to service users care.

Using medicines safely

● Systems in place to ensure the proper and safe management of medicines were not robust.

● Medication audits did not demonstrate that medicines to be given 'as needed' (PRN) or controlled medicines had been checked.

● Stock counts for controlled medicines were not completed. This did not ensure the management and use of controlled drugs was in line with best practice guidance and put people at risk of not receiving crucial medicines.

● At the time of our inspection there were five staff who had not completed any form of medication training. Following our visit, the manager sent us a training matrix to show that four of these staff had undertaken on-line medication training. The matrix however showed that ten staff had not had their competencies checked to ensure they were safe to administer medicines and a further three staff had not had their competencies checked since 2017. This put people at risk of receiving medicines from staff who were not trained or competent to administer medicines safely.

Preventing and controlling infection

● Measures were in place to control and prevent the spread of infection. Staff completed training and were knowledgeable about the requirements.
● We observed staff using personal, protective clothing and equipment safely.
● We observed a COVID 19 audit and cleaning plans in place. Care staff were required to clean every two hours and records confirmed this took place.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Continuous learning and improving care

- A person-centred and inclusive culture was not promoted. People using the service told us they were not involved in their care planning. One said, "I'm not allowed to see my care plan."
- Meetings for people using the service were not held regularly so they could contribute to the running of the service. One person told us, "There has been one meeting but nothing has been acted upon."
- Four relatives told us that communication was poor, and all confirmed they were not invited to be involved in their family members care and support.
- Care plans did not record that service users, families and relevant health professionals had been involved in the planning, reviewing and evaluating all aspects of a person's care and support.
- People's care did not empower them to gain new skills, become independent and achieve good outcomes. Care plans did not record people's goals or celebrate their achievements. One person told us they had offered to help with cooking, but staff had politely declined. They were told that cooking was the role of the staff.

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

- There was a registered manager in post, however at the time of the inspection they were taking extended planned leave. The provider had recruited a new manager to oversee the service in the absence of the registered manager. The manager had been in post for a week at the time of our inspection and were being supported by the area manager.
- There was a lack of provider oversight to ensure systems in place were being followed and used to drive improvement at the service.
- Accidents and incidents had not always been recorded and the providers quality assurance systems in place had not identified this shortfall.
- Complaints were not always recorded and investigated in line with the providers complaints procedure. One had been recorded at the service but CQC were aware of at least one other complaint that had been raised from a concerned person.
- There were no lessons learnt protocols in place so the provider could learn from incidents and accidents, safeguarding concerns and complaints to improve the quality of the service.
- Systems in place to audit medicines were not robust enough ensure the proper and safe management of medicines.

● Staff recruitment files demonstrated a lack of required employment checks. The providers quality monitoring checks had not identified the gaps.
● The provider failed to have effective systems in place to assess, monitor and improve the overall quality of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Working in partnership with others
● The provider did not effectively involve and engage with people. One person told us there had been one meeting for people to raise any concerns and air their views. We looked at the minutes of the meeting and saw recorded that four people stated they were unhappy living at Bodnant House. There was no evidence of any actions taken to explore why people were unhappy.
● Family members confirmed they were not asked for their views about the service and said communication with staff at Bodnant House was very poor. One relative described how their family member had been taken to hospital but nobody from Bodnant House had notified them.
● Staff meetings were not consistent. We found the terminology used in the minutes of the staff meetings to be unprofessional and derogatory about people. This does not demonstrate the provider has a system in place to review staff competency and that staff have the experience and skills that is expected or appropriate in staff who are trained to work with vulnerable people.
● The provider, manager and staff did not always work in partnership with key organisations such as the local authority, safeguarding teams and clinical commissioning groups, the police and multidisciplinary teams, to support care provision. This meant that people using the service did not experience joined up care based on good practice and people's informed preferences.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. The provider failed to seek and act on feedback provided or concerns raised to drive improvement at the service. This was a breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance

● Systems and processes were not in place to ensure notifications had been reported to the Care Quality Commission (CQC).
The provider had failed to notify the Care Quality Commission of incidents of all incidents that affect the health, safety and welfare of people who use services. This was a breach of Registration Regulation 18, of the Care Quality Commission (Registration) Regulations 2009

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 provider had not been responsive to issues and concerns. Incidents were not shared with people using the service and their families in line with the duty of candour.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure systems and processes were in place to send notifications of other incident to the Care Quality Commission

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 has failed to establish and operate systems and processes effectively to prevent abuse of service users and failure to investigate and report any allegations of abuse

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure robust recruitment practices were undertaken to ensure they only employed staff suitable to work with vulnerable people.

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 The provider had not ensured that essential information was recorded in care plans and risk assessments to protect people from harm. Risks to people had not been reviewed following incidents putting them at risk of further occurrence and possible harm.

The enforcement action we took:

We issued a warning notice in relation to regulation 12.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were at risk of receiving care that was not personalised to meet their needs so they could achieve good outcomes because the provider failed to promote a culture that was open, inclusive and empowering. The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. The provider failed to act on the duty of candour when incidents occurred. The provider failed to seek and act on feedback provided or concerns raised to drive improvement at the service.

The enforcement action we took:

We issued a Warning notice against Regulation 17 to the provider