HC-One Oval Limited

Capwell Grange 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
Capwell Grange is a nursing and residential care home providing personal and nursing care to up to 146 people.

People's experience of using this service and what we found
We had concerns about how the service promoted people's safety. We identified significant shortfalls with how the management team and provider were responding to COVID19. Safe processes were not always being followed to try and prevent the spread of the virus. The service was not always adhering to government guidelines in relation to COVID19. After we had visited the service and identified these concerns there was an outbreak of COVID19 at the service.

We also found people's safety was not being considered in terms of injuries or when something went wrong. Investigations did not take place in a timely way and as a matter of course when potential harm had occurred. We needed to prompt the management team to complete investigations when something had potentially gone wrong. When we reviewed these investigation reports we found these were not always conducted in an open way.

There had been some safeguarding events at the service which had prompted us to inspect. Staff did not have a clear understanding about what abuse could look like. An internal investigation found some staff were aware of these concerns, but they had not told anyone in the management team or outside of the organisation such as the local authority or police about this abuse. There was a poor staff culture and we found evidence of institutional practice. People were not always valued and treated with dignity and respect, especially people living with dementia or with behavioural needs. We raised safeguarding referrals to the local authority about our concerns.

Concerns had been raised by the local authority about how people's general nursing care needs were being managed at the home. Some improvements had been made as a result of the local authority identifying issues with wound care. However, we still found shortfalls in this area of care. Nurses did not receive competency checks of their practice, despite these identified concerns. Other areas of clinical practice at the service were not checked by the provider to see if staff were actually effective in their work. We also identified shortfalls in staff's understanding and knowledge about abuse and harm.

Staff did not feel they could talk with the management team and raise issues. They did not feel supported or valued by the provider. Staff did not question practice or promote people's rights, to ensure they were safe and happy in their daily life. This increased the risk of abuse or harm occurring. There were a number of safeguarding investigations taking place at the service.

The provider had systems to assess the quality of the service, where issues had been duly identified and reported on. However, the provider did not have effective systems to respond to these. Meaningful action

plans were not created to make improvements, nor further checks completed to test if these plans had been successful.

As a result of our findings the provider placed a voluntary embargo stopping admissions for a temporary period. We were also given verbal assurances that the provider will be making positive changes to the service to improve people's experiences, in a timely way.

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

Rating at last inspection
The rating at the last inspection was requires improvement, the report was published on 25 May 2019. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Capwell Grange on our website at www.cqc.org.uk.

Why we inspected
We received concerns in relation to people's nursing care and how the service was promoting people's safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

The overall rating for the service has changed from requires improvement 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 see what action we have asked the provider to take at the end of this full report.

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 how the service is managed, how safe people are at this service, and staff knowledge and practice.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Capwell Grange 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 Care Act 2014.

Inspection team
This inspection was completed by five inspectors.

Service and service type
Capwell Grange 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. This means the provider only is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave thirty minutes notice so we could clarify the services COVID19 Personal Protective Equipment (PPE) practice for visiting professionals and identify persons who were shielding so we could respond accordingly.

What we did before the inspection
We gathered information from the local authority's quality assurance and safeguarding team and the Clinical Commissioning Group (CCG) - this is a department of the NHS. We used all of this information to plan our inspection.

During the inspection
Due to the national pandemic we completed a focused inspection therefore reducing the time we spent at the service. We spoke with four people who used the service and five relatives. We telephoned eight care staff and four nurses. We spoke with the deputy manager and the acting turnaround manager at the home.

At feedback and after the inspection we spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

During our time at the home we observed staff interactions with people. We looked at records relating to wound care management, catheter care, and Percutaneous Endoscopic Gastrostomy (PEG). We requested further information after our visit, this included various people's care plans and assessments in relation to their needs. We also requested competency and training records, audits relating to the care provided and plans the provider had completed to respond to the issues found.

After the inspection
We continued to request other documents in relation to people's care. We also sought assurances from the provider about further concerns raised during our inspection.

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 requires improvement. 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

● Systems were inadequate at promoting people's safety from abuse. There had been two significant allegations of abuse, prior to our inspection.

● Some staff and nurses had known about the abuse but not told anyone about this. Some staff were aware of the alleged abuser's concerning behaviour outside of Capwell Grange, but this had not raised their suspicions. Nor did they tell a manager about this. When we spoke with a sample of staff, most had a poor understanding about what abuse could look like and what they must do about it. This poor knowledge had put people at risk of harm. Staff also told us they were reluctant to raise issues with the management team. This also put people at risk of harm.

● When the senior management team were aware of the alleged abuse, they did contact the local authority safeguarding team and the police. However, their intended plan to deal with the concerns and shortfalls, identified through their internal investigation, was not sufficient. For example, they were only going to repeat the previous on-line training and place the provider's safeguarding lead in the home to chat to staff one afternoon a week. Additional robust measures had not been considered or implemented.

● We observed examples of institutionalised abuse during our inspection. For example, one person was screaming while they were having a shower. Staff did not talk to the person to calm them and they continued to provide the care in the same manner. After the shower, they pushed this person in a wheelchair from the communal shower room to their bedroom, via the public hall way, with only towels draped over them. We later noted this person's bedroom floor was wet, suggesting this person was also wet as they were supported to their bedroom. During the inspection, we saw staff taking another person from the bathroom to their bedroom only covered with towels. This suggested this was common practice, which had not been recognised as possible neglectful abuse and uncaring practice by staff.

● At the inspection we identified one person's bedroom as having a strong odour of urine. We found a person laying on their bed, the top sheet was heavily soaked in urine. Their t-shirt was also very wet. They were not wearing any incontinence under wear. Staff had not responded to this odour and supported this person. Not only was this neglectful, it also posed a risk to their skin breaking down.

● At this inspection we raised four safeguarding referrals to the local authority because of these concerns.

Assessing risk, safety monitoring and management

● We looked at how COVID19 was being managed at the home. We found serious shortfalls. The manager, unit lead and staff told us a person had COVID19. Their bedroom door was open when we visited. Next to the person's room a PPE station was set up for staff to wear the right equipment when entering this person's room, however visors were not made readily available as per Public Health England's (PHE) guidance. The

guidance advises staff to wear full protective equipment including visors when they deliver care and support to a person who has Covid19. A person in the same unit had a fan on in their bedroom and their bedroom door left open. This can increase the risk of this virus spreading. Also, the person opposite this bedroom had health needs which put them at very high risk of becoming ill or dying if they contracted the virus. The provider later told us this person did not in fact have COVID19 when we inspected, but staff were not aware of this.

● Specific staff were not allocated to work with people who had COVID19. The staff supporting the person with COVID19 were also supporting other people, who did not have this virus. Staff also told us they were being moved on a regular basis from different units. Therefore, the risk of spreading the virus was significantly increased.

● The management team had not created individual risk assessments to identify who were most at risk, if they contracted the virus. For example, people with a tracheostomy, a PEG, breathing complaint, people who were diabetic, from a Black Asian and Minority Ethnic (BAME) background, and people who were obese. The providers view was everyone was at risk, but this did not help to manage this risk. National and local best practice guidance was not being followed to try and reduce the spread of this virus. Following our inspection, we were informed that there had been an outbreak of the virus at the service. We were not confident every practical action had been taken to minimise this risk.

● The local authority had identified concerns about the clinical care delivered at the service. Significant shortfalls had been found with how nurses and staff managed pressure wounds to people's skin. Actions had been taken to respond to this, but these had not been effectively embedded, which placed people at potential risk of harm.

● Risk assessments for people who had a breakdown to their skin, or who were known to be at risk of this, did not show why a certain cause of action had been decided. For example, there was no clinical rationale given for a four hour turn or a two-hour turning regime.

● People's pressure mattresses were being routinely checked. However, we found checks were not completed for one person who was at risk of developing a pressure wound, who did not have a self-alternating mattress. Their record did not show what their mattress setting should be, yet staff continued to tick it was set correctly.

● Another person had marks on their skin which was not being monitored via their wound tracking system. This meant the management team did not have full oversight about how this injury was being managed.

● We noted a person with lower leg and feet issues did not have their feet elevated and their feet were left to rest against the bed board. Staff only responded to this when we identified it. Another person was at risk of a breakdown to their skin. The nurse in charge was aware of this but there was not a care plan showing staff what to do to manage this risk, instead they had a piece of paper stuck to the wall reminding staff to respond to this risk, but not how to do this.

● We identified one person had a bruise on their leg, this person was cared for in bed and needed to be hoisted to leave their bed. A nurse told us they had raised this with the unit manager, but when we checked no one was aware of this injury. No investigation had been carried out to see how the bruise had occurred and to check this person was safe. There was no review of staff competency in moving this person.

● During our inspection, a person was admitted to hospital due to a problem with their specialist equipment. No investigation was planned to explore what had happened and identify any lessons which could be learnt from this. We raised this with the provider. Six days later an investigation took place which found that staff had not managed this person's specialist needs in a safe way. The competencies of the nursing staff around managing this need had not been re-tested.

● An instruction was provided by the hospital for staff about how to prevent any future fault to this equipment in the future. The management team did not consider reviewing other people's care who used this equipment.

Learning lessons when things go wrong

● There were no clear processes or a culture at the service to learn from mistakes. We found there was a reluctance from the management team to investigate issues and staff told us they were reluctant to raise issues in relation to people's care. This made it very difficult for lessons to be learnt.

All these issues had placed people at risk of harm. Systems and staff practice had placed people at risk of harm. This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We identified shortfalls in staff's understanding and knowledge of key areas of their work. Staff lacked a good understanding and knowledge about how to protect people from harm and abuse, respond to injuries and changes in people's needs. Staff had received training in these areas but this training had not been effective.

● The management team were not routinely assessing the competency of all staff and responding to shortfalls in their knowledge in an effective and proactive way.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not received adequate training to always meet people's needs.

● We looked at a sample of staff recruitment checks and found staff were safely recruited

Preventing and controlling infection

● We had concerns about how COVID19 was being managed at the home.

● The home was clean, and staff wore PPE when they were working. However, we found there were chips and marks in the paintwork around the home. There were marks on the arms of the chairs. The veneer of bedside tables and side tables were exposed. These are all potential infection control risks.

Using medicines safely

● Audits of medicines were being completed at the service. However, the local authority had recently received a medicines audit from the provider where errors had been identified, but no action had been taken about this.

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 requires improvement. 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;

- There was a poor culture at the home which placed people at risk of harm. Some staff and nurses had not acted when they were aware alleged abuse had taken place.
- Staff had not acted or raised questions to the management when injuries were found or when a person's needs had changed. For example, when an outside professional incorrectly documented the management of a person's PEG feed, staff administering this care did not question this or raise this issue. This could have led to this person experiencing harm.
- We found examples of institutionalised practices where staff had not considered people's feelings or if they were promoting their dignity. These practices were neglectful and could cause emotional harm.
- Staff did not engage routinely with people in a friendly social way. Staff did not advocate for people when they were unhappy about something in their daily life. For example, one person had stopped engaging with an aspect of their support plan as they were low in mood. We were told why this person was low in mood, but no action or plan had been made with this person to respond to this need.
- Another person expressed distress when they were being showered. There had been no review to consider alternative ways to promote their hygiene and manage their distress. One person 'chose' not to wear clothes and they were cared for in bed with their door left open. No consideration or plan had been made to promote this person's dignity.
- The environment was in a poor condition. It was dark and tired with stained items of furnishings and chipped walls. No action had been taken to address this, nor was there a meaningful plan to address these issues in the future.

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; Continuous learning and improving care; Working in partnership with others

- During this inspection we identified concerns with how the provider and management team was managing the risk of COVID19. We identified many shortfalls in managing the spread of this virus which put people at risk of harm.
- We needed to prompt the management team to complete investigations where potential harm had occurred. The management team were not following a process when these types of events took place, nor did they realise they needed to do this as standard practice in order to ensure people were safe and well cared for.

● The local authority had raised concerns about the clinical care of wound management in March 2020. Some improvements had been made in this area, but the provider had not been effective in fully resolving these issues. We still identified shortfalls in the risk assessments and care plans for these people. For example, one person did not have a risk assessment or care plan, when they had a complex and known risk of skin breakdown on a particular area of their body. Also, when people were assessed as independently moving in bed, and not needing intervention in this area, there was no evidence of how this judgement had been reached.
● Only three nursing competency checks had been completed for clinical wound management, despite the management team and provider knowing this was an area of concern. Other aspects of nursing clinical care had not been competency assessed, despite concerns being raised to the provider about the quality of nursing care at the home. This posed a risk to people using the service.
● There was not a culture of responding to issues at the service or responding to events when things went wrong. Nor were situations investigated in an open way. For example, one person had become sun burnt which required GP involvement. We also needed to ask for this to be investigated. When it was investigated, the investigator did not speak with the person themselves who had capacity to share their views about what had happened.
● Staff said they did not feel supported from the management team. They told us they had a negative experiences of raising issues with management, so they were now reluctant to do so. This poor culture had put people at risk of experiencing harm. Staff also said they did not receive feedback about their practice. Staff said they did not receive regular supervisions or attend meetings where broader topics of practice would be discussed.
● We also had concerns about the quality of the provider's response when issues were raised with them. When we spoke about our concerns relating to the recent acts of alleged abuse, we found the response of the services senior management team was not robust enough to fully respond to the concerns identified. Solutions to the shortfalls in staff's understanding of safeguarding, the effectiveness of the safeguarding training delivered historically and ways to promote good practice in this area had not been considered.
● There was a quality monitoring process, where representatives of the provider would assess the service. These had identified issues. However, no effective action was taken to resolve the issues identified. No action plan was in place to resolve identified shortfalls and so no action had been taken. The provider's ability to respond to issues was inadequate and did not bring about a resolution.

We found the leadership at the home at management and provider level was not effective in bringing about positive change at this home. Nor were they effective in creating a positive person-centred culture at this home. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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's representative responded to our concerns by placing a voluntary embargo on new admissions and informed us they would be reviewing their quality monitoring processes in light of our findings.

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 People were not supported by the staff and provider to be safe. In terms of the risk of abuse and injury. Staff were not responding to concerns about people's care. The provider's own understanding of this was limited.

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 Staff lacked a good understanding and knowledge about protecting people from abuse. There were shortfalls in staff practice in identifying and responding to injuries and a change in people's needs. The provider did not have effective ways to ensure staff were well trained and knowledgeable in their practice.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have effective systems to monitor the quality of care provided and take effective action to respond and resolve matters appropriately and in a timely way in order to ensure people received good quality care.

The enforcement action we took:

To impose conditions on the locations registration to develop effective quality monitoring processes which enable positive change and solutions to shortfalls and failures.