Mrs Kerry Ann Davies

Carden Bank Rest 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
Carden Bank Rest Home is a residential care home providing personal and nursing care to 13 people aged 65 and over at the time of the inspection. The service can support up to 14 people.

People's experience of using this service and what we found
People were placed at risk of harm because the risks to their skin had not been mitigated. People continued to be placed at risk of harm as medicines were not administered as prescribed. People were not protected from abuse because safeguards in place were not followed. There were not enough staff available to mitigate people's risks.

There was a lack of clear governance and leadership in the service. The provider did not have effective systems in place to monitor the service and mitigate risks to people. The provider did not have effective systems in place to learn when things went wrong. The provider had not consistently worked with professionals to make improvements to people's care. This meant people had continued to receive poor care.

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 Inadequate (report published 12July 2019) and there were multiple breaches of regulation.

We took enforcement action after the last inspection and asked the provider to complete an action plan to show what they would do and by when to improve.

At this inspection improvements had not been made and the provider was still in breach of multiple regulations.

Why we inspected
We received concerns in relation to the management of people's medicines, pressure care, staffing and the management of the service. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

The provider had not taken action to mitigate the risks to people. The overall rating for the service has remained as inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Carden Bank Rest Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the safe care and treatment of people, safeguarding people from abuse, staffing levels and management at this inspection.

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 therefore remains 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.

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

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.

Carden Bank Rest 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
The inspection was carried out by two inspectors.

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

There was not a registered manager at the service because this was not a condition on the provider's registration. The provider managed the service and they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection as this was a responsive 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 used the information we held about the service to formulate our planning tool. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, safeguarding concerns, serious injuries and deaths that had occurred at the service.

Before the inspection we contacted commissioners to gain their experience of working with the service.

During the inspection
We spoke with three people who used the service. We observed care and support in communal areas to assess how people were supported by staff. We spoke with three care staff, the acting manager and a consultant.

We viewed five people's care records. We looked at how medicines were stored, administered and recorded for eight people. We also looked at documents that showed how the home was managed which included staff recruitment and records that showed how the service was monitored by the provider.

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 two inspections this key question was rated as inadequate. At this inspection this key question has now remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• At our last two inspections, the provider had failed to manage people's risks to protect them from harm, people did not receive their medicines as prescribed and people were placed at risk 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. At this inspection, improvements had not been made.
• People were placed at risk of harm because staff had not supported people to manage the risk of a deterioration in their skin condition.
• We saw two people who were at risk of developing sore skin were not seated on a pressure cushion in line with their requirements. Staff were unable to provide an explanation as to why these people had not been supported in line with their plans of care.
• Staff had not identified and reported changes to people's skin condition. For example; staff had completed personal care records, which had not identified concerns with their skin.
• However, on the day of the inspection the visiting District Nurse identified a deterioration in five people's skin condition. For example; two people had a Grade 2 pressure sore, two people had untreated fungal infections and another person had a moisture lesion. These people had been subjected to harm because staff had not ensured their risks were lowered.
•Due to the serious risks to people the local authority took action to safeguard people from harm.

Using medicines safely
• People did not receive their medicines in line with their medicines administration records (MARs). For example, one person had not received their prescribed blood thinning medicine for 15 days. Another person had not received their prescribed blood pressure medicine for 12 days. Another person had not received their prescribed medicine to treat an ongoing infection for eight days. This had placed people at risk of a deterioration in their health and wellbeing.
• People who needed topical creams to maintain their skin condition had not been supported with the application of their topical creams as prescribed. This had placed people at risk and there had been a deterioration in five people's skin condition.
• People had not received their prescribed nutritional supplements to ensure they maintained a healthy weight. For example; one person had not received their prescribed supplements for a period of 14 days prior to our inspection. The weight records showed this person had lost 3.8kg since the 05 May 2019. The failure to ensure this person received their supplement may have contributed to their weight loss.
• Despite continued support from the local authority staff continued to make medicine errors and their competency to administer medicines had not been adequately assessed.

Preventing and controlling infection

• People were not protected from the risk of infection. The District Nurse told us that flannels were being used for people's personal care in a way that contributed to cross infection. The practice of providing personal care in a way that exposed service users to the risk of cross infection was endemic and had not been recognised as an issue by the provider. This demonstrates that risks to people's skin had not been mitigated due to the poor infection control practice within the service.

Learning lessons when things go wrong
• There were no effective systems or monitoring in place to identify concerns and learn lessons when things went wrong. Feedback received from previous inspections and from the local authority had not been consistently acted on. Improvements had not been made to people's care, which meant people continued to be placed at risk of harm.

The above evidence shows a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• At our last two inspections, the provider had failed to safeguard people from the risk of abuse. This was a breach of regulation 13 (Safeguarding from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had not been made.
• Professionals visiting the service had continued to identify safeguarding concerns that the provider had failed to address.
• The provider had failed to put effective safeguards in place to protect people from the risk of continued abuse. We were notified by the provider of an allegation of alleged abuse which stated that a person would not be supported with personal care by the alleged abuser. However, the records showed that the alleged abuser had continued to support this person with personal care. The steps that had been put into place to protect this person from continued harm were not followed.
• The acting manager did not have a system in place to monitor staff to ensure the safeguards were followed to protect people from the risk of continued harm.

The above evidence shows a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• At our last two inspections, the provider had failed to ensure there were enough staff available to mitigate people's risks. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had not been made.
• There were not enough staff available and effectively deployed to ensure people's needs were met and to lower their assessed risks.
• Two people who were at high risk of falls needed constant supervision. We observed numerous periods where these two people were left without supervision, which put them at risk of harm.
• Two people were provided with hot drinks with no supervision from staff. A visiting social worker had to intervene to protect them from the risk of harm.
• Call bells continued to not always be accessible to people when they were in their rooms and communal areas. This meant people were at risk of not receiving support when they needed it.
• The provider had implemented a staffing tool to assess the level of staff needed to meet people's physical and emotional needs. However, the rota's we viewed showed the minimum staffing levels were not consistently met. This meant the system in place was not effective in ensuring people were supported by enough staff.

The above evidence shows a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 inadequate. At this inspection this key question has remained the same. 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.

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

• At our last inspection the provider had failed to ensure there was effective systems in place to manage the service and mitigate risks to people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had not been made.

• There was not a clear leadership and management structure in place. In response to our inspections the provider had appointed a consultant to help them make improvements to the service people received. However, the provider continually changed the arrangements with the consultancy firm, this included reducing the amount of time the consultants were at the service, which had been detrimental to them being able to make swift improvements.

• There continued to be a lack of effective governance systems in place to monitor the service and mitigate risks to people. For example; medicine audits had not identified the concerns raised at the inspection. There was a lack of monitoring of daily care records to ensure people received support from appropriate staff in line with their assessed needs and risks. People continued to receive poor care because of this lack of oversight.

• The staffing tool had been ineffective in ensuring there were enough staff available to provide support. There was a lack of leadership and direction provided to staff to ensure they were deployed effectively to meet people's needs.

• The system in place to check staff knowledge and skills was ineffective in identifying and rectifying poor care. At the time of the inspection two members of staff had been assessed as competent in medicine administration by the consultant. However, the remaining staff had received medicine competency assessments by the acting manager who did not have the required skills and knowledge to carry this out. This had led to continued poor practice.

• Records were not always accurate and had not been updated to reflect a change in people's needs. For example; one person had fallen at the service and we saw their care plans and risk assessments had not been updated to ensure their risk of falling was lowered. Another person's records contained contradictory information, which meant there was a risk this person would receive inconsistent and unsafe care.

Working in partnership with others; Continuous learning and improving care

• At our last inspection the provider had failed to work in partnership with other agencies to make improvements to people's care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had not been

made.
• The provider did not have an effective system in place to continually learn and make improvements to the care people received.
• The provider had been made aware of areas of risk by the local authority, and from our inspections carried out in March 2019 and June 2019. The provider had implemented an action plan to mitigate the risks to people. However, this had not been successful in implementing improvements to the care people received and effective action had not been taken to keep people safe.
• The service was placed in Large Scale Enquiry by the Local Authority. Since our last inspection there had been constant input from professionals. However, the provider had not engaged successfully with partner agencies to improve the quality and safety of care.
• The provider had not worked in partnership with other agencies. The local authority had suspended admissions to the service to protect further people from the risk of harm. The provider was advised not to admit privately funded people by the local authority. Despite the advice provided, the provider admitted a new person to the service. During the inspection we identified that this person had been exposed to the risk of harm.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider did not promote a person-centred culture that ensured people achieved good outcomes. People received poor care because the risks to their safety and wellbeing were not mitigated to protect them from harm.
• Feedback gained from people had not been acted on to inform service delivery and to rectify poor care.

The above evidence shows 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

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 People's risks were not mitigated to protect them from harm. Medicines were not administered as prescribed. Personal care practices within the service put people at risk of cross contamination and infection.

The enforcement action we took:

We served an urgent Notice of Decision to impose conditions on the provider's registration.

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 People were not safeguarded from the risk of abuse.

The enforcement action we took:

We served an urgent Notice of Decision to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor the service and mitigate risks to people. There was not a clear leadership and management structure in place. The provider did not consistently engage with other professionals to bring around improvements in the service.

The enforcement action we took:

We served an urgent Notice of Decision to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff available and deployed effectively to mitigate risks to people.

The enforcement action we took:

We served an urgent Notice of Decision to impose conditions on the provider's registration.