Grand Care Limited

Corbett House Nursing Home

Inspection report

40-42 Corbett Avenue
Droitwich
Worcestershire
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Corbett House Nursing Home is a residential care home providing personal and nursing care to up to 35 people. The service provides support to younger adults and older people, including people living with dementia. At the time of our inspection there were 24 people using the service.

Corbett House Nursing Home accommodates people is an adapted building, with care provided over two floors.

People's experience of using this service and what we found
Risks to people's health and wellbeing were not identified. Emergency healthcare was not sought for people in need of medical care. Peoples medicines were not managed safely and the guidance for their clinical needs was not always clear for staff. Care documentation was not updated and staff were not trained to meet people's specific healthcare needs.

The provider did not have robust risk assessments and had failed to identify environmental risks to people's safety and wellbeing. Staff were not always competent in areas related to people's healthcare needs. Staff received induction training; however clinical competencies were not well monitored.

The provider did not have a registered manager and there was no clear leadership of the service. There were no effective governance systems in place to identify shortfalls in the quality and safety of the service. Governance systems failed to ensure people were protected from the risk of harm.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was good, (published 31 October 2019).

Why we inspected
The inspection was prompted in part by information contained within a coroner's report which included shortfalls in management oversight of the service. Additionally, we received concerns about the management of people's medicines, people's healthcare needs not being met and poor recording of care documentation. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only. We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-Led sections of this full report.

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 COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety in protecting them from avoidable harm and to the quality and governance systems in place at this inspection. We found the provider was in breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not effective.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our safe findings below.

Corbett House Nursing 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.

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
The inspection was carried out by two inspectors and a specialist advisor who is a registered nurse.

Service and service type
Corbett House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Corbett House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
The first day of the inspection was unannounced. The second day of the inspection was announced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We asked for information from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spent time seeing how people were cared for and spoke with 7 people living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 8 staff, including care staff, a registered nurse, the chef, the home care manager and the nominated Individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at a range of records. This included 5 people's care records and multiple medicine records. A variety of records relating to the management of the service, including 3 staff recruitment files, fire safety, incidents and accidents. After the inspection we requested further records in relation to the management of the service. We also spoke with 3 relatives for feedback on their experiences of care.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Using medicines; Learning lessons when things go wrong

● The provider had failed to ensure risks were assessed and people were protected from potential harm. For example, there were no risk assessments in place for people's access to call bells or required observations. This meant some people were not able to seek assistance should they need to.

● The provider had failed to assess and identify other potential risks to people's health and safety. For example, wardrobes were not securely fitted to walls prevent the risk of avoidable harm and areas of the home environment were unclean. We found unlocked doors, with building items, a nail and hot pipes which could have placed people at risk.

● Competent staff were not always available to meet people's specific healthcare needs. Where people required catheter care, the provider had failed to ensure competent staff were consistently available. This meant some people had to wait for community healthcare staff to meet their needs.

● People's medicines were not consistently administered, stored and disposed of safely. Medicine administration records did not evidence people had received medicines as prescribed. We saw evidence where a person admitted to hospital because they had not received their medicine. This meant people were not supported to have the medicines they needed to remain well.

● Lessons were not always learnt. The provider's monthly accident analysis outcomes were recurrent over 3 months. This meant learning opportunities failed to prevent reoccurrence and mitigate risks of preventable harm.

The providers systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded to the concerns we identified in relation to people's access to calls bells by way of completing missing risk assessments to ensure there was guidance in place to mitigate the risk of harm for people living at the home.

● The provider has produced an action plan to address the home environmental risks we identified.

Systems and processes to safeguard people from the risk of abuse

● The provider's safeguarding policy did not provide staff with up-to-date guidance. For example, the policy did not clearly include details of the procedures for reporting concerns to external agencies such as the local authority to support the investigations of safeguarding incidents.

● Most people told us they felt safe living at the home. One person said, "I feel safe here".
● Staff knew how to recognise signs of abuse and how to report concerns to senior management.
Staffing and recruitment
● People and their relatives told us there were adequate numbers of staff. One person said, "I don't have to wait long when I need staff." Another person told us, "I can have a shower whenever I want. The staff can't do enough for you."
● There were enough staff to support people. One care staff member told us, "There is enough staff, colleagues are very helpful." During our inspection, we saw staffing levels met people's needs.
● The provider used an internal dependency tool to plan the required number of staff needed. The provider told us they used agency staff to ensure there were sufficient staff and there was an on-going recruitment campaign to fill vacancies.
● The provider checked the suitability of staff before they were employed. For example, checks were undertaken with the Disclosure and Barring Service (DBS). DBS provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found visibly dirty kitchen equipment, chipped paint on the kitchen serving hatch, exposed wires and toilet rolls stored in bathrooms. The provider has developed an action plan to rectify these shortfalls.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.
● The home was facilitating visitors in-line with government guidance. There were no restrictions on visiting the home and checks were undertaken to ensure visitors were following guidelines.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were not assessed in a timely manner. A person's care plan had not been reviewed for 16 days following their discharge from hospital. This meant the provider could not be assured care was being delivered in line with the persons current needs and wishes.
- Staff had good knowledge of people's care plans. One staff member told us, "The care plan tells us what we need to know and there's information about people in their rooms." Another said, "Care plans are easy to follow. It's all information about them (people living at the home), including preferences and their lives."

Staff support: induction, training, skills and experience

- Staff were not always competent in areas relevant to the needs of the people they supported. We saw evidence where staff could not support catheter care or administer specific medicines. This meant staff could not meet people's healthcare needs.
- Monitoring of staff competencies was not effective. Staff medication competencies had expired, and clinical competency records for nurses were not easy interpret. This meant the provider could not always be assured of staff competency.
- Staff completed induction training, including shadowing an experienced senior care staff member to build their knowledge and skill. One staff told us, "Training was good and then I was with the team leader. I was introduced to people and got to know the paperwork." Staff told us this process enabled new staff to learn people's care preferences.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People did not always have access to emergency healthcare services. Staff did not always seek help for people in need of emergency care. This meant people were not supported to receive timely care and live healthier lives.
- The provider had links with a GP service, community pharmacists, older people's mental health team and other healthcare professionals.
- Referrals were made to an advanced nurse practitioner for specialist healthcare professionals, such as speech and language therapists and occupational therapists. This supported people to receive the right support.

Adapting service, design, decoration to meet people's needs

- We found there were aspects of the provider's policies and procedures to ensure the home environment

was suitably maintained were not consistently followed. For example, unlocked doors had varied items stored including building materials which could potentially place people at risk. Some people enjoyed walking around their home and having these items in an unlocked room increased risks to their safety and wellbeing.
● Parts of the building required refurbishment and the provider had plans to address this.
● The home environment is designed to meet the needs of people with physical disabilities to easily navigate around the building, including access to outside area.
● People's rooms were personalised to their wishes and tastes.

Supporting people to eat and drink enough to maintain a balanced diet
● The lunchtime experience was positive and calm. People were offered a choice of food and drink in line with their dietary needs. One person told us, "The food is excellent, I get a choice." Another said, "The [food] is so good."
● The cook listened to people's preferences and food served was appealing. The cook told us, "All the food is fresh, and people have a choice. I have a sheet which details everything they like, including allergies. I see people and ask them what they like." A relative said, "We've seen [person] being offered different choices of meals and if they don't like anything on the menu, the cook will make them something different."

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
●Covert medicines (hidden in food or drink) were administered safely. Protocols were in place to evidence MCA had been completed and best interest meetings had taken place. A pharmacist was consulted to support safe administration of medicines to keep people well.
● Staff understood their responsibilities for ensuring people could make decisions about their care and support. One staff member told us, "I give them (people) choices, I ask people what they would like. People always have choices." If people were unable to make a decision; protocols were in place to evidence MCA had been completed and best interest meetings had taken place.
● DoLS applications and authorisations for people were being monitored and the provider notified the Care Quality Commission of approved DoLS authorisations.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The provider did not have a registered manager. The home care manager was supported by the provider.
- There was a lack of effective management oversight of the service. The provider had failed to identify shortfalls in the quality of care provided, including in the management of people's medicines. The providers assurance systems had placed people at risk because clinical improvements were not identified.
- The providers checking systems were not effective. Audits repeated the same identified concerns over several months. There were no meaningful actions or reviews to address and resolve concerns. This meant there was no learning to improving people's care.
- The provider and the management team failed to identify environmental risks. We were told management completed daily checks of the home environment. However, these checks failed to address risks to people's health and safety. For example, unclean areas within the home environment, exposed wires and unlocked doors placed people at risk from avoidable harm.
- The provider's governance systems failed to identify risk assessments had not been completed for people's use of call bells. There were no call bell audits available. This meant the provider could not be assured support was provided to people in a timely manner with people's safety maintained.
- A daily management meeting was held to discuss people's needs and the management of the home. However, the provider and management team at this meeting failed to identify shortfalls in environmental risks to people's safety. Additionally, there were missed opportunities to safely and effectively meet people's healthcare needs.
- The management team were not always visible to people living at the home. One person told us, "I don't see management" and another person said, "I don't know who the managers are."
- The feedback from some relatives was similar to what people told us. Relatives did not feel consistently involved and or updated in relation to their loved one's care and changes in management. A relative told us there were no relative meetings to enhancing communication and share of views.

The provider's governance systems were not effective in areas including quality assurance and auditing systems. These shortfalls placed people at risk of harm. This was a 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 providers systems did not support duty of candour. Whilst management understood their duty of candour responsibilities, the providers quality monitoring systems did not allow them to effectively identify and respond to concerns. This meant when things went wrong, they did not always identify the need to follow the duty of candour process.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Staff felt there was a supportive culture. One staff member said, "Whenever we need help from management, they are good." Another told us, "My senior [care staff member] is very supportive and gives me advice. They help me with anything."

● Care staff received regular supervisions. Spot checks were completed with care staff and learning shared during individual meetings. Group staff meetings had also taken place to communicate improvement needed to people's care. However, training competencies were not always up to date.

● The provider understood their role in terms of regulatory requirements. For example, notifying CQC of events, such as safeguarding's and serious incidents as required by law.

● People's feedback was sought to develop the service. People gave suggestions for improvements through regular resident meetings and surveys. However, we did not see evidence of actions taken following people's feedback. The provider acknowledged this and gave assurance they address this an area for improvement.

● People's equality characteristics were supported. For example, a diverse staffing team supported people who required translation.

● The management team had links with other health and social care professionals. This included GPs, advanced nurse practitioners and social work teams. Any advice was recorded in people's individual care plans for staff to follow.

● The provider acknowledged they needed to make improvements to their governance and management systems. They had an action plan to address areas of shortfalls in the service. The provider was being supported by the local authority and integrated care board to drive improvements.

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 providers systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) 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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

The enforcement action we took:

We issued an warning notice.