Karenza Limited

Canonbury Residential Home

Inspection report

19 Canonbury Street
Berkeley
Gloucestershire
GL13 9BE

Tel: 01453810292
Website: www.canonburycare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was unannounced. Canonbury Residential Home is registered to provide accommodation and personal care for up to 13 older people. At the time of our inspection there were eight people in residence. All bedrooms were for single occupancy. Nine of the bedrooms have ensuite facilities and for the others, there are bathrooms nearby.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. They were not available on the day of our inspection but we spoke with them after our inspection and told them our findings. The registered manager has employed a home manager who was in day to day charge of the service.

A significant number of improvements were required to ensure that people were kept safe. This was because unsafe recruitment procedures were followed, not all medicines were managed correctly and fire safety and maintenance checks were not being carried out regularly.

Improvements were also needed with the induction training programme for new staff. The current induction plan did not meet the requirements of the Care Certificate that was introduced in April 2015. The Care Certificate is a set of standards that social care and health workers must work to in their daily working life. All records relating to the running of the service and accounts of the care and support provided to people were not all up to date.

The arrangements in place to ensure that the service was well led were unsatisfactory. There were no formal processes in place to assess, monitor and improve the quality of the service. Although people were satisfied with the service they received, there were no records of feedback they provided.

Staff were knowledgeable about safeguarding issues and would act to protect people from coming to harm. They knew how to raise and report concerns if they witnessed, suspected or were told about any bad practice or abuse. All staff had received training in safeguarding adults. Staffing numbers on each shift were sufficient to ensure each person's care and support needs were met. There was a programme of refresher training that all staff had to complete. Staff were well supported by their colleagues.

Any risks were assessed as part of the care planning process. Where needed a care plan detailed how that risk would be managed. People received the care and support that met their specific needs. They were encouraged to express their views and opinions, the staff listened to them and acted upon any concerns to improve the service.

People were satisfied with the food and drink they were served with. They were provided with the sort of food they liked to eat and any preferences and dislikes were taken in to account. The staff monitored how much people ate where there were concerns about maintenance of a healthy body weight. Arrangements were made for people to see their GP and other health and social care professionals as and when they needed to.

The staff team had good relationships with the people they looked after. We found the staff to be caring and friendly. People were involved in making decisions about their care and support.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Staff recruitment procedures were unsafe and did not ensure that unsuitable staff were employed. Some aspects of the management of medicines were unsafe because some medicines were not stored or acounted for appropriately. Appropriate checks of the premises and facilities were not completed or not recorded to ensure they were safe.

Staff were aware of their responsibilities to safeguard people and to report any concerns. The number of staff on duty ensured people's care and support needs could be met.

Is the service effective?

Requires Improvement

The service was not effective in all areas.

The training programme for new staff may not prepare them for the role for which they were employed. People may be looked after by staff who did not have the necessary skills to meet their needs.

Staff sought consent from people before helping them. The service was aware of the principles of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.

People were provided with sufficient food and drink. They were supported to access healthcare services and to maintain good health.

Is the service caring?

Good

The service was caring.

People were treated with kindness and patience. They were satisfied with the way they were looked after and were at ease with the staff.

People were encouraged to be as independent as possible but were provided with the level of support they needed.Their

personal choices and preferences were taken account of and they were involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received the care and support they required. This was altered when their needs changed and they needed a different level of support.

People were able to take part in the group activities that were arranged. People were listened to and said the staff responded to any comments they made. Any concerns or grumbles people had were dealt with.

Is the service well-led?

Inadequate

The service was not well-led in all areas.

Improvements were needed with the records that the service was required to keep.

There is no formal plan in place to assess, monitor and improve the quality and safety of the service.

The registered manager was no longer in day to day charge of the service and had employed a home manager. There was no evidence to show how the registered provider/manager checked how things were going.

Canonbury Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

When we inspected the service in September 2013 we found there were breaches of legal requirements. When we visited again in February 2014 the breaches had been rectified.

The inspection team consisted of one inspector. Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We had not asked the provider to submit their Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

We contacted two healthcare professionals and the local authority quality assurance team as part of the pre-inspection planning process. Their feedback was included in the main body of the report.

During the inspection we spoke with five of the eight people who lived in the home and three staff members. We looked at four people's care records, four staff recruitment files, training records, staff duty rotas and other records relating to the management of the service.

Each person we spoke with was able to express their views verbally and tell us about their experience of living at Canonbury Residential Home.

Inadequate

Our findings

People said, "I am safe. There is always someone around who can help me", "I never have to worry about things because everything is done for us" and "All the staff are polite and kind to me. They understand that I am a bit slow these days and are patient with me".

Despite the people who lived in Canonbury saying they felt safe, there were a number of significant improvements that the registered provider/manager must implement to ensure people were protected from harm.

Unsafe recruitment procedures were followed which may mean that unsuitable staff could be employed. One staff members records we looked at had no written references on file and the DBS check had been issued in July 2015 to another employer. A DBS check (Disclosure and Barring Service allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. The home manager was uncertain whether the references had been received. For a second member of staff there was only one written reference from a previous employer and no evidence of DBS or Adult First Check. An Adult First check is a check of the 'barred from working with vulnerable adults' list and provided by the Disclosure and Barring Service. This shortfall could mean that the provider had employed staff who were barred from care work.

This is a breach of regulation 19 Health and Social Care Act (Regulated Activities) Regulations 2014.

Some aspects of the management of medicines were unsafe. Not all hand written entries on the medicine administration records had been countersigned by a second staff member. There was the potential for errors to be made because the person's medicines may be transcribed incorrectly. The service did not have the correct storage facilities available for controlled medicines (also known as controlled drugs or CD's). The secure storage of controlled drugs is specified in the Misuse of Drugs (Safe Custody) Regulations and all care homes must store controlled drugs in a CD cupboard. Staff did not have a CD register and were using a hard backed book to record CD's received in to the service and CD's returned to the chemist. Staff were arranging for the supply and delivery of CD's but were not using a CD register to record receipt of drugs in to the service, each administration of the medicine to the person and any subsequent disposal of unwanted controlled drugs. They were required by law to do this. This is a breach of regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014.
There was a schedule of checks of the premises, facilities and equipment however some of the records were blank. Monthly checks of the emergency lighting and fire extinguishers had not been recorded and staff did

not know if they had been undertaken. There were no records of fire instruction or recent fire drills for the staff team. Water temperature checks had been completed up until December 2015 but many of the recordings were greater then 43°C. One of the wash hand basins in the bedrooms was regularly recording temperatures of 45°C whilst the bathrooms were recording 50°C. The temperature of the water to the wash hand basin in the downstairs toilet was also 50°C. This room was used during the day by each person living in the home. At the top of the form used to record the water temperatures, it stated that water temperatures should be no greater than 43°C. Weekly water flushes and shower head de-scaling had been completed regularly up until 11 January but the member of staff who did these checks no longer worked at the home. The senior member of staff we spoke with was unaware this would need to be picked up by someone else.

This is a breach of regulation 15 Health and Social Care Act (Regulated Activities) Regulations 2014.

All staff completed safeguarding training as part of the mandatory training programme for all staff. Those staff we spoke with were aware of their responsibility to protect people from being harmed. They would report any concerns they had to the registered manager but knew they could report directly to the local authority, the Police or the Care Quality Commission.

The eight people in residence had minimal care and support needs therefore risk assessments were not required. However, care plans were in place where the person needed very minimal support with bathing, occasional help to get up from a chair or to use the stair lift. These provided adequate information. Personal emergency evacuation plans (PEEP's) had been prepared for each person and recorded what support the person would require in the event of evacuation of the building. For one person who had sensory impairments this was clearly identified on their plan. The home manager planned to review these assessments to ensure these remained accurate and to keep them altogether in a designated place.

The service had a business continuity plan in place. The plan detailed what to do in the event of fire, flood, loss of utility services, if appropriate staff were not available and if alternative accommodation was needed. The fire risk assessment report for the premises was written in 2013 and we recommend this be revisited.

The numbers of staff on duty for each shift was based upon people's needs. The service currently had a number of bed vacancies and therefore staffing numbers had been reduced. The home manager worked during the week and covered care shifts and should have office days. Because of staff vacancies the home manager had been covering care shifts. There was no use of agency staff. This meant that people were looked after by staff who were familiar with their needs and preferences. Care staff also covered all housekeeping and catering duties. Staff said the staffing arrangements were sufficient. We could find no evidence of a negative impact upon people with the reduction of staffing numbers.

Requires Improvement

Our findings

People said, "I am well looked after", "I get all the help I need", "They asked me what I liked to eat and if there was anything I cannot eat", "I am helped to have a bath. I hadn't had a bath for a long time before I came here. Heaven" and "I didn't want to go into a home but I had to. I am glad I could come to Canonbury and my family could visit easily".
The service had recently recruited new staff but only had a basic induction programme for them to complete. This programme covered instructions about the premises, fire safety, health and safety issues, employment matters and care tasks. The programme was for three days. One new member of staff had completed day one on 30 November but days two and three had not been signed off as completed. A second staff member had all three days signed off but the checklist was signed by the home manager. The new member of staff had not signed to say they understood and accepted the providers policies and procedures.
Neither the registered manager or the home manager were aware that the induction training programme had to meet the requirements of the Care Certificate which was introduced in April 2015. They were also not aware that the programme had to be completed within 12 weeks of their start date of employment. This shortfall may mean that people could be looked after by staff who were not familiar with the set of standards that social care and health workers must work to in their daily working life. This is a breach of regulation 18 Health and Social Care Act (Regulated Activities) Regulations 2014.

All other care staff had a programme of mandatory training to undertake and those we spoke with said their training was up to date. A new on-line training programme had been introduced towards the end of 2015 and moving and handling, safe administration of medicines, food hygiene and fire safety was included. The home manager was in the process of implementing a training matrix to record when training had taken place and when refresher training was due. The staff training programme ensured staff were able to meet people's needs.

There was an expectation that staff would complete a recognised qualification in health and social care (previously called an NVQ and now called a health and social care diploma). We were told that the new staff will be enrolled for the training after their induction and probationary period had been completed. The home manager was in the process of working towards the level five in leadership and management but already had achieved other management qualifications. Five other staff had completed an NVQ in health and social care.

The staff team was small and they each supported their colleagues to do their jobs. They had a handover

report at the start of their shifts. This meant they were informed about any changes in peoples' health or welfare and any events that were happening during their shift. The supervision and support for the staff team was provided on an informal basis and staff felt this was sufficient.

The home manager had attended training about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care. The home manager was aware of the principles of the MCA and the staff were aware of the need to ask for a person's consent before they provided any care. People in residence at the time of the inspection were able to consent to be looked after at Canonbury.

Mental capacity assessments were completed as part of the care planning process. However for one person this had not been reviewed and recorded since 2012. We spent a long time speaking with this person and they still had capacity to make their own decisions. The assessment was correct but did not record recent reviews. Throughout the inspection we heard people being asked to give consent and to make decisions about things that affected their daily lives.

People were assessed regarding any risks of malnutrition or dehydration. People's preferences for food and drink were recorded. One person told us about food items they could not eat and said, "I have never been given them". Staff maintained records each day of the meals provided. Staff said they were concerned regarding one person's eating and therefore monitored how much was eaten at each meal. They also regularly measured their body weight and would refer to the GP if there was a significant weight loss.

People said they were provided with plenty of food and drink. They said, "I can ask for a hot drink at any time", "I enjoy the meals. They are always well cooked" and "The food is alright and I can eat anything really". People were provided with a traditional menu consisting of 'meat and two veg' but they were encouraged to make suggestions of meals to be served. The main meal was served at lunch time – on the whole the eight people would receive the same meal. On a Wednesday each week one person would choose what the main meal was going to be. At tea time people had a choice of sandwiches, soup, hot snacks or salad.

Each person was registered with the local GP practice who visited when people were unwell or when they had asked to see the doctor. The GP visited each person for a six monthly review. District nurses visited when people had nursing care needs, for example wound care management or catheter care. When possible people were escorted to see healthcare professionals at the Vale hospital or the doctors surgery. People were supported to see opticians, dentists and chiropodists, social workers, occupational therapists and physiotherapists as needed.

Good

Our findings

People said, "The staff are very kind and patient with me", "I am looked after very well" and "I am keeping very well. The staff care about us all". One person said "It has always been like one big happy family here but the staff changes have affected this". They clarified this by adding that some long term staff had left and been replaced with staff who did not stay long. This was discussed with the registered manager after the inspection because the person was anxious about what was happening.

Staff spoke about people in a kind and respectful manner and were aware of the different ways people liked to be looked after. They called people by their first name and said this had been agreed with the person. Staff provided support that took account of people's specific wishes and what was important to them for example, one person was served their morning coffee in a mug whilst the others had a cup and saucer. Those staff we spoke with were committed to treating people well and developing good working relationships with them.

Staff encouraged people to be as independent as they were able. They told us one person whose mobility had deteriorated had been encouraged to move into a ground floor bedroom so they could continue to get around independently. Staff told us this helped the person's sense of well-being as they knew this was important to them. It was evident the staff team got on well with people. There was a relaxed atmosphere in the home and we observed caring interactions between the staff team and people living in the home.

People would be able to remain at the service if their health deteriorated and they had end of life care needs. Healthcare professionals would need to support the staff team to be able to achieve this.

Good

Our findings

People said, "I get all the help I need. I would prefer to be in my own home but I need too much help now. I am quite content here", "Everything is fine. I still try and do as much as I can by myself but I have the comfort of knowing there is always some one available" and "The staff are always checking that I am okay with things".

An assessment of a person's care needs was undertaken before they were offered a placement at the home. This ensured the care staff could meet their care needs and any specific equipment was available. Information gathered in the assessment process was used to develop a plan of care. Plans provided details about people's personal care needs, their mobility, the support they needed with eating and drinking and where appropriate managing continence. The plans included people's likes and dislikes and what was important to them.

The plans we looked at provided sufficient information about the person's particular care needs and how they were to be met. People were asked to sign their care plans and to state they were in agreement with the contents of the plan. The plans were reviewed on a monthly basis. Any changes to the person's care needs were recorded in the review account and the care plan was not updated. This may mean that the person's new care needs could be overlooked. The plan for one person stated they were independent in managing a specific health care need but one of the reviews detailed how the care staff had to assist them. These arrangements were confirmed by the staff we spoke with.

People were asked about their previous life, hobbies and interests and a detailed account of their life history was recorded. The service did not have a dedicated activity person but there was a plan of activities posted on the noticeboard. The registered manager or the care staff led the activities. Examples included dominoes or card games, music and movement, bingo and sing alongs. One person said, "I join in some things. It helps pass the time of day". A hairdresser visited the service on a weekly basis – another person said, "I like to have my hair done, it makes me feel better". Staff maintained a record of any activities that people participated in. Birthdays were celebrated with tea and cake in the afternoon, and any special occasions were marked, for example Easter and Mothers Day.

'Residents' meetings were held on an ad-hoc basis the last one being held on 10 December 2015. The notes had not been written up but the home manager said there had been discussion about food, activities and the garden. Previous meetings had been held in June and April 2015. Because of the smallness of the service the registered manager, home manager or the deputy would see each person every day and speak

with them individually – no records were made of these discussions. Records would provide evidence that the service listened to feedback and took action where appropriate.

People we spoke with felt able to raise any concerns or complaints they had with the staff and said they were listened to. Comments we received included, "I would say if I wasn't happy", "We are always being asked if we are happy" and "There is nothing really to complain about. Everything is top notch". People were asked to share their views or make comments about things during their care plan reviews, during resident's meetings and when activities were taking place. People were provided with a copy of the complaints procedure but this was also displayed on the noticeboard in the hallway.

Inadequate

Our findings

People said, "I miss seeing the manager (the registered manager/provider). She used to come and see me every day when she was in. She doesn't now", "There is a new manager now (the home manager), she seems OK" and "I think the care home is run very well and everything is in order".

The service did not keep records of any feedback they received from people. Comments from any residents meetings had not resulted in any action plans. The service was missing the opportunity to make any changes based on people's views and opinions. However people were satisfied with the service they received and the way they were looked after.

Improvements were needed to ensure that the service was well led and that people received safe care which met their needs. Not all the records the service were required to keep were in order. Whilst care plan reviews had taken place on a monthly basis, any changes to the person's care and support needs were recorded as part of the review. The relevant care plan was not updated with the changes to the person's needs. This had the potential to mean that people could be provided with care and support that did not meet their needs. For example, the nutrition plan for one person had not been amended to reflect their current needs. The staff team however were fully aware of the person's needs. Another person did not have a pain management plan in place and for a third person the support they needed with managing a medical condition was different from that included in their care plan.

Any accidents and incidents were logged however there was no evidence of analysis to identify any triggers or trends so that preventative action could be taken. Looking at the records it seemed that some of them had taken place in the bathroom. Because of the lack of analysis the service have missed the opportunity to take action to prevent a reoccurrence.
Some of the weekly and monthly fire records were blank and staff were unaware whether the checks had been undertaken or not. There were no records of any fire drills having taken place although the home manager knew these should be done on a three monthly basis. There were no records of any recent supervision sessions or staff meetings. There was no improvement action plan following a quality assurance questionnaire completed in April/May 2015.
There were no records of the weekly meetings between the home manager and the registered manager. The last available notes of these meetings were dated 22 May 2015. In the 24 April 2015 notes a number of maintenance tasks had been identified in one of the bedrooms. It was evident that the carpet had been replaced but there was no record that the radiator had been attended to. There was no evidence of any health and safety audits of the premises.

In July 2014 the environmental health officer had required that a digital probe be used to check food temperatures and the results be recorded. Staff were not using the digital probe and had continued to use an ordinary probe. They were not recording the food temperatures so there was no evidence they were completing the checks.
There was no programme of audits in place to assess, monitor and improve the quality of the service.
This is a breach of regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014.

Despite these shortfalls, there was no impact upon the people who lived in the service. Staff said the home manager was in charge of the home on a day to day basis and that the registered manager visited the service at least twice a week. The rest of the staff team was made up of an assistant manager and the care staff. Because there were several vacant rooms in the service the registered manager had made some changes to the staffing structure and numbers. There was no longer a dedicated member of staff to do the housekeeping and this task was now incorporated into the care staff role. Care staff also prepared all meals and drinks for people. They said they had sufficient time to meet all the tasks and meet people's care needs.

The home manager has been in post since April 2015 and was familiar with the service, the staff and the people who lived there. They worked as part of the care team, with care shifts and also had some 'management' time. They told us for the last two months they had not had any management time because of staff sickness and the need to cover care shifts.
The home manager had begun the process of reviewing all policies and procedures. Some of them had not been looked at since 2012. The home manager was aware that the policies needed to be aligned to the fundamental standards and the Health and Social Care Act 2008. At the front of the policy and procedure manual there was a sheet for staff to sign to say they had read and were aware of the policies of the service. This had only been signed by four staff members.

The home manager was aware when notifications had to be sent to CQC. A notification is information about important events which had happenened in the service and providers were required to send us by law. CQC used the notification process to monitor the service and to check how any events had been handled. The service had not needed to send in any notifications since October 2014.

One whistle blowing concern was reported to us in September 2015. This were in respect of training, the care experience of a new employee and the behaviours of one person, and their relationship with others, who was having a respite stay in the service. These concerns were passed to the registered manager to respond to. The registered manager was able to provide evidence to refute the allegations and the concerns were dealt with appropriately. The service had a whistle blowing policy but this had not been reviewed since January 2013. They also had a copy of the CQC guidance on whistle blowing. The home manager was unaware of when the whistle blowing policy was last discussed with the staff team.

A copy of the complaints procedure was displayed in the hallway and stated that all formal complaints would be acknowledged within two days, investigated and responded to within 20 days. Information was also given to people about the complaints procedure. In the previous 12 months the service had not received any formal complaints and CQC had not be notified of any concerns either. The registered manager did not record any grumbles and may be missing an opportunity to identify trends and take action to prevent a reoccurrence and review their practice.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person must ensure there is proper and safe management of medicines. Some medicines were not correctly stored and the records kept of receipt in to the service and administration did not meet the relevant legislations. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person must have safe recruitment procedures in place to ensure persons employed are of good character and have the necessary skills and experience. Regulation 19(1) and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person must have an induction programme in place that prepares staff for their

role. The current arrangements did not meet the Care Certificate standards therefore staff may not be competent to carry out their roles.

Regulation 18 (2) (a).

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 15 HSCA RA Regulations 2014 Premises and equipment The registered person must ensure the premises and equipment are safe and properly maintained. The arrangements in place to check fire safety and the water supply were not good enough and did not safeguard people from potential harm. Regulation 15 (1) (d) and (e).

The enforcement action we took:

We have issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person must have systems in place to assess, monitor and improve the quality and safety of the service. There were no formal processes in place meaning that shortfalls may not be identified and improvements not implemented. Care records ere not fully accurate. Care plans were reviewed but amendments were not clearly recorded. Records relating to the management of the service to evidence good governance were not being maintained. Regulation 17) (1) and (2) (a), (c) and (d).

The enforcement action we took:

We have issued a Warning Notice