Cavista Ltd

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Inspection report

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Date of inspection visit:
15 June 2021

Date of publication:
05 August 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cavista is a residential care home providing personal and nursing care to 20 younger and older people, some who may live with dementia. There were 18 older people living at Cavista at the time of the inspection. The care home accommodates people across two separate floors and has use of a stair lift.

People's experience of using this service and what we found
Call bells were not used safely or effectively. Moving and handling techniques placed people at risk of harm and equipment was not used safely. The environment was not always safe and secure. Medicines were not managed in line with good practice. Sufficient staff were not always deployed to ensure people's safety. Infection prevention and control procedures were not followed to reduce the risks from infection. Systems to learn lessons when things went wrong were not effectively operated. Staff knowledge of safeguarding was mixed and not all staff had complete recruitment checks.

People's privacy and dignity was not respected or promoted by staff. People were not always well-treated and supported and interactions with people were mostly when they needed care. People were not always supported to be involved in decisions about their care.

Governance and oversight for the quality and safety of the service and the identification and management of risks was not effective. Systems to learn lessons and improve care were not operated effectively. Records were not accurate, complete or made in a contemporaneous manner.

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 Requires improvement (published 16 January 2020)

Why we inspected
We received concerns in relation to the management of medicines, staffing, infection prevention and control and governance of the service. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only. During the inspection we found concerns with how people's dignity was promoted and so we included the Key Question of Caring in the inspection.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from the previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

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.

We have found evidence that the provider needs to make improvements. Please see the safe, caring 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.

Following our inspection, the provider told us they would take action to mitigate the risks found.

The overall rating for the service has changed from Requires improvement to 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 Kiwi House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and 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 four breaches in relation to safe care and treatment, staffing, dignity and governance at this inspection.

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 request an action plan from 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 caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Cavista Ltd

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.

This was a focussed inspection of the Key Questions Safe, Caring and Well-led. We will assess all of the key questions at the next comprehensive inspection of the service.

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
This inspection was completed by two inspectors.

Service and service type
Cavista 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 registered manager was no longer working at Cavista at the time of the inspection. A new manager had recently been appointed and was in post at the time of the inspection. Registered managers and providers 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
We reviewed information we had received about the service since the last inspection. We sought feedback

from partner agencies and professionals including the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service. We spoke with four members of staff including the manager, senior care worker, care worker and apprentice. We spoke with one visiting health professional. Following the inspection, we spoke with the provider's nominated individual and one of the directors. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included the relevant parts of three people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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.

Assessing risk, safety monitoring and management

● The call bell system used by people to request staff help was not effective. We found two people in need of staff help, one whose call bell was out of reach and another who told us their call bell did not work. Both people required staff assistance. One told us they were, "Ever so hungry," and, "I don't want to wet the bed and I need a wee." The call bell units had a long cord attached to them and staff told us they left them next to people at night. The long cord presented a potential entrapment risk and had not been risk assessed. People had been placed at risk from the use of equipment that did not always work and had not been risk assessed.

● People were not assisted to move safely. We saw care staff lift a person under their arms from a chair into a wheelchair. They moved the wheelchair without the person's feet being safely positioned on the footplates. The person's care plan did not include an assessment for wheelchair use. People had been placed at harm as people used equipment that had not been assessed as suitable for them and staff used unsafe moving and handling techniques.

● Risks were present in the environment. Wardrobes were not always attached to walls. Large pieces of furniture can present a risk to people living with dementia as they can be toppled over onto people. Window restrictors and methods to keep windows open were not always robust or safe. One person's bedroom ceiling had a water stain and they told us in bad weather the water leaked down the wall. A fire door had been propped open so that it would be ineffective at keeping people safe should there be a fire. A door that should have been kept locked had been left open by staff. Recent records to show health and safety actions such as water temperature checks to help reduce risks from legionella and emergency lighting and fire door checks were not available, therefore we could not be assured that these checks were being completed. Risks in the environment were not identified, assessed and reduced. This placed people at risk of harm.

Using medicines safely

● Medicines were not kept securely. We found prescribed creams had been left out in people's unlocked bedrooms and communal bathrooms. Controlled drugs were not kept in line with guidance to ensure their security. Temperatures where medicines were stored had not recently been checked to ensure medicines were stored at the correct temperature. Medicines were not kept in line with good practice guidelines.

● People did not receive their medicines as prescribed. On one occasion this was because staff could not find their medicine. On another occasion staff had recorded it was because medicines administration record (MAR) charts were full. MAR charts for prescribed creams were not always in place to show people received topical medicines as prescribed.

● Not all medicine had pharmacy labels on, or these had become unreadable. Photographs of people on their medicines records, used to help staff identify people, were not up to date. This meant staff were unable

to complete checks that the right person was receiving the right medicine.
● Handwritten MAR charts had not always been checked and signed by a second member of staff. This meant checks to ensure the MAR chart had been accurately written to reflect the prescription were not in place. Staff recorded they had administered medicine even though the MAR chart stated it had been previously signed for. Checks on staff competency to administer medicines were not dated and so the provider could not demonstrate these had been completed in line with the recommended frequency. Safe medicines management and administration practises were not followed.

Preventing and controlling infection
● People were not protected from the risks associated with infection. At the time of our inspection, staff were not providing care to anyone with COVID-19. However, staff did not use personal protective equipment (PPE) correctly and social distancing guidelines were not considered; this placed people at risk of harm and increased the risk of any COVID-19 transmission.
● We were not assured staff had up to training in infection prevention and control and on the use of PPE.
●We observed staff carried used bedding from a bedroom to the laundry without placing in a bag first. Areas of the home had not been routinely cleaned; we found rubbish and debris on top of a bedroom wardrobe.
●Waste bins in bathrooms were overflowing and were not effective at reducing the risk of infection. There was no waste bin in the staff toilet. Personal wash sponges, toiletries and other items had been left in communal bathrooms. A catheter bag had been left in a person's ensuite shower tray. People were not protected from the risks of infection as infection prevention and control measures were not followed.

Learning lessons when things go wrong
● Accidents and incidents were not always effectively reviewed in order to reduce recurrence. The manager had been in post five weeks at the time of the inspection. They told us they had not yet got any action plans in place for learning from incidents, but they planned to create a new incident form. We reviewed a previous incident and looked at how it had been reviewed. We found the review had not identified any lessons learnt or identified actions to reduce recurrence.

Care and treatment had not always been provided in a safe way for people. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People and staff told us they thought there needed to be more staff. We observed staff had to leave a person they were assisting with their meal to go and do another personal care task. Staff told us they did not have time to write up care records as they went along. We found two people who were reliant on staff for their personal care waiting for staff to assist them. We saw no activities were arranged for people and interactions between staff and people were mainly focused on tasks that were required. There was not always enough staff to assist people and staff did not have time to meaningfully interact with people.
●Care staff on the day of the inspection were also cooking meals, providing drinks and snacks, doing laundry and when available, answering the phone to outside callers. The manager and trainee deputy manager were present on the inspection but were not seen providing care. We observed the phone not being answered as there were not always staff available to answer the phone. The local authority provided feedback to us prior to the inspection that it was difficult to get in touch with the home on the phone. We asked to see the staffing calculations the provider used to assess how many staff were required to meet people's needs. This did not include details of people's needs. The hours of care provided by care staff had been compromised by the other tasks they had to complete, and staffing had not been planned in relation to meet people's needs.
●Staff were not always present to monitor people's safety and reduce risks. An incident report detailed an

altercation between two people and had resulted in injury. The incident report stated: 'Due to two staff members assisting another resident in the shower, another staff member answering a buzzer and assisting with personal care, and myself administering medication and answering a phone call from a residents relative the start and cause of the altercation was unwitnessed.' Insufficient staff were deployed to ensure people's safety was monitored and risks reduced. There had been insufficient staff deployed to ensure people's safety.

●The manager was not able to show us the overview of staff training and demonstrate all staff had up to date training in areas of care relevant to people's needs. One staff member told us they had been hit and bitten by people however they told us they had had no training in managing behaviours that challenged. Staff had not always been equipped with the skills and knowledge needed to meet people's needs, and the provider was not able to demonstrate staff had the skills, knowledge and competence to meet people's needs.

Sufficient staff were not always deployed to meet people's needs and the provider could not demonstrate staff had sufficient training, skills and competence in people's areas of care. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff knowledge of safeguarding was mixed. The provider had a safeguarding and whistle-blowing policy in place, however not all staff knew where to find these. The manager was unable to provide evidence staff safeguarding training was up to date as they could not access the training system to monitor this.

● Staff recruitment records were in place, however no DBS check was recorded for one member of staff. This meant the provider had not completed all the required checks to ensure this member of staff was suitable to work with people using the service.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Not all staff promoted people's dignity and privacy. Staff left a toilet door wide open in a communal area and commenced changing a person's continence pad, exposing their bottom. Inspectors intervened to protect this person's privacy and dignity. We observed staff did not close a bedroom door when assisting a person with personal care and staff opened toilet doors when people were using the facilities. Staff did not promote people's privacy and dignity.

Ensuring people are well treated and supported; respecting equality and diversity

- One person told us they wanted a reading light, but this was not available; they told us they had to have the hall light on instead. Their bedroom wall and ceiling had signs of water damage that had not been re-decorated.
- We observed one member of staff appeared impatient with a person when they had difficulty mobilising. They did not use gentle open-handed techniques when assisting the person's legs to move, instead they gripped their leg.
- Some staff chatted to some people as they worked, however most interactions occurred when people needed care.

Supporting people to express their views and be involved in making decisions about their care

- We observed staff put clothing protectors on people for mealtimes without asking them if this is what they would like to have.
- Care plans were personalised however it was not clear how these had been reviewed with people to ensure they remained up to date. The manager told us there was no system currently in place to ensure people were involved in their care plans. They told us this was something they would like to improve.

People were not treated with dignity and respect. This is a breach of regulation 10 (Dignity and respect) 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 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.

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 operate effective management systems to mitigate risk. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

● The new manager told us they had been in post for five weeks. The previous registered manager had left but had not yet cancelled their registration with the CQC. The provider had not submitted the required statutory notification to report an absence of a registered manager. Providers are required to display the latest CQC rating at the location; this was not displayed.
● The provider was not compliant with their own 'good governance' policy. This was because a number of audits for the quality and safety of the service had not been completed in line with this policy. We found a number of risks as detailed in the safe section of this report in areas such as infection prevention and control, health and safety and safety and security of the environment. This placed people at risk of harm as risks had not been identified and action had not be taken to improve the service.
● We found numerous medicines management shortfalls as detailed in the safe section of this report. The provider was not following their own 'management of medications' policy to ensure medicines were managed safely.
● The manager had no oversight of staff training as they were not able to access the provider's staff training account.
● Staff did not write people's care records in a contemporaneous manner. Care staff wrote records on behalf of other care staff where they had not directly been involved in providing care. We found care plans contained contradictory information and were not always up to date and accurate.

Continuous learning and improving care; Working in partnership with others; 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;
● There was no effective system in place to review accidents and incidents. The manager told us a system to review accidents and incidents was not in place and they relied on verbal reports from staff. They were not

able to show us a written record of a fall a person had sustained. They told us there was no analysis completed on accidents or incidents. This meant systems to help inform continuous learning and improve care and safety had not been effectively operated.

Systems and processes designed to assess, monitor and improve the quality and safety of services and reduce risks had not been operated effectively. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw the provider worked with the local authority and visiting health professionals.
● We spoke with the nominated individual and one of the directors following our inspection and they told us they would take action to make the required improvements.
● The provider had a complaints policy in place which supported the provider's duty of candour to be open and honest with people and families when things went wrong.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There had been a recent staff meeting where the manager had discussed the standard of care expected. Systems to help improve communication and staff feedback had been implemented, such as a staff communication book and handover sheets.
● The manager told us they understood the service needed to improve and they had made a start, however they were clear that they would need time and resources for the improvements to be implemented. These improvements included actions to ensure people were involved in the service and that people received good outcomes.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably skilled staff deployed to meet people's needs safely. (1)(2)(a)

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 Risks to service users were not always assessed and mitigated; premises and equipment was not always safe and used in the intended way; medicines were not managed safely; risks associated with infections were not reduced. (1)(2)(a)(b)(d)(e)(g)(h)

The enforcement action we took:

We issued a Warning Notice for the provider to become compliant with Regulation 12 (Safe care and treatment)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to assess, monitor and improve the quality and safety of services, and assess, monitor and mitigate risks to the health, safety and welfare of services users were not operated effectively. Care records were not accurate, complete to contemporaneous. (1)(2)(a)(b)(c)

The enforcement action we took:

We issued a Warning Notice for the provider to become compliant with Regulation 17 (Good governance)