Wellington Healthcare (Arden) Ltd

Carders Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Carders Court is a care home providing nursing and personal care to 149 people aged 65 and over at the time of the inspection. The service can support up to 150 people. The care home comprises of five separate units each supporting up to 30 people and a separate office block with kitchen and laundry. One unit provides nursing care, two units provide residential care and two units provide support for people living with dementia. One unit with dementia also has a separate area where people are discharged from hospital to be assessed before returning home.

People's experience of using this service and what we found.
People and relatives we spoke with were generally positive about the service and felt they were well cared for. However, outcomes for people varied considerably across the home and we found one unit in particular was experiencing significant pressures.

Medication was not being managed safely and we identified several concerns that required improvement. We identified health and safety risks and risks in relation to people's pressure care, nutrition and hydration need and choking risks. We observed a lack of monitoring of people's health care needs, around epilepsy and diabetes.

Care plans did not always reflect people's needs and there were concerns around the capacity of the current call bell system. Staffing levels were not always sufficient and we observed people calling out for help.

Complaints had not been managed effectively and there had been a distinct lack of managerial oversight at the service. The new manager had not been in post long, but had started to address concerns and responded proactively to our feedback.

People and their relatives told us the staff were caring and very kind. We observed pleasant interactions between staff and residents and feedback we received about unit managers was relatively positive.

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 requires improvement (published 17 September 2019) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations. We also found three further breaches of regulation.

Why we inspected

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 the service can respond to COVID-19 and other infection outbreaks effectively.

We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about people's care needs. A decision was made for us to inspect and examine those risks.

We inspected and found there were concerns with people's care needs, complaints and the management of the service so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, responsive and well-led.

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 previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

We have found evidence the provider needs to make improvements. Many of the concerns we identified related to the dementia unit that also supported people who had been discharged from hospital. The provider took action to mitigate the risks we found on inspection. They sent us an action plan immediately after the inspection. We met with the provider and the local authority to discuss the concerns identified. Following on from this meeting, a further meeting took place with the provider, the manager and the deputy manager. The provider agreed to voluntarily cease admissions to the discharge to assess unit. This has been effective and has reduced the risks considerably.

Please see the safe, responsive 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Carders Court 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines, risk management, staffing, complaints and governance at this inspection. We also made a recommendation about care plans.

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

Follow up
We have met with the provider prior to this report being published to discuss how they will make changes to ensure they improve their rating to at least good. The provider has already submitted an action plan. 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 always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below

Carders Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 team consisted of two Inspectors, a nurse specialist, a pharmacist and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type.
Carders Court 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.

At the time of the inspection the service did not have a manager registered with the Care Quality Commission. There was a home manager who had recently transferred from another area and intended to register with the CQC. A registered manager and the provider 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. 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 reviewed all the information we held about the service including statutory notifications the service has sent and feedback we had received. We contacted the local authority and Healthwatch for additional information and feedback. 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 all of this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service about their experience of the care provided. We spoke with 19 members of staff including the manager, deputy manager, unit managers, human resource manager, care workers, laundry staff and the chef. The Expert by Experience made telephone calls following the site visit and spoke with 18 relatives.

We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at five 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
Following inspection we spoke with a further three relatives. We continued to seek clarification from the provider to validate evidence found.

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.

Using medicines safely
At our last inspection the provider had failed to ensure the administration of medicines was safe. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12

• We found a number of concerns about the management and administration of medicines. For example, there were issues around the administration, storage and recording of controlled drugs; medicines were stored at too high a temperature; and medicines were not always provided in a timely way.
• Protocols for when people required 'as needed' medicines, were not always clear, and sometimes the information about when medicines were required was contradictory
• People who were prescribed creams did not always have information detailed on how or where these should be applied, and people's thickening products were shared between residents.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure medicines were effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we found areas that required improvement, we acknowledge that some concerns were exacerbated by external pressures affecting the dementia/discharge to assess unit. We have raised these directly with the local authority.

Assessing risk, safety monitoring and management
● Risks had not always been assessed appropriately and there was a lack of risk assessments around people who were at risk of choking. We found conflicting information in people's plans around their nutritional needs and a lack of dietary and fluid intake monitoring. There was a lack of records of pressure care relief for some individuals and one person's seizure sensor alarm had a part missing. We also identified a number of health and safety issues, for example, a fire exit was blocked.
● We identified a broken call bell and raised concerns about the effectiveness of the capacity of the current call bell system. We had received a complaint prior to inspection relating to missed calls resulting in anxiety and distress. We have been reassured a new call bell system was in place on one of the units and that plans

were in place for this new system to be rolled out across the site.
● We raised all these issues with the manager during the inspection and identified all these issues related specifically to people on the dementia/discharge to assess unit. Following on from inspection an immediate action plan was sent to us outlining how these issues were being addressed.
● Prior to the inspection we had received concerns that people had not been referred to dieticians and chiropodists. The manager acknowledged this had been an issue in the past and we saw evidence this was no longer the case.

The provider had failed to ensure that systems were in place and robust enough to effectively manage and mitigate risk and ensure people received the safe care they needed. We found no evidence that people had been significantly harmed, however, this placed people at risk of harm. This was a further breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There had been an over reliance on agency staff at the service. However, the provider had taken on a project worker to specifically manage recruitment and monitor the use of agency staff. Although levels were still high, the levels had been reducing as they had started to recruit their own staff.
● Staff on the dementia/discharge to assess unit told us they did not feel that staffing levels were safe and were concerned they were not providing the level of care they felt they wanted to. Some relatives confirmed this and told us that some days there was no nurse on duty. We observed that staff were struggling to manage and observed people shouting out for assistance. There was only one member of staff on the discharge to assess unit and this meant that when people required 2-1 support, staff were taken off the dementia unit.
● Staff did not always feel competent with the current training received. Some staff felt they could be better equipped to support people if they had training specific to the needs of the people on their units, such as behavioural techniques, dementia.
● Some staff working on other units told us they felt staffing levels had been cut and they did not feel they had the time to care. We discussed this feedback with the manager and nominated individual and they agreed to look at dependency levels throughout all the home to ensure there were enough staff.

The provider had failed to ensure appropriate staffing levels were in place to meet people's needs in a timely way. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We looked at five recruitment files and saw that appropriate checks had been undertaken to ensure staff had been recruited safely.

Systems and processes to safeguard people from the risk of abuse
● Staff had received training in safeguarding people from abuse. They told us they had recently changed to a new training system and this was much better. Staff had a good understanding of safeguarding and whistleblowing procedures and felt confident raising concerns. Some staff felt that although they raised concerns previously, they had not always been taken into account. However, they told us this had improved since the change in management.
● Most people and their relatives told us they felt people were safe and well looked after. People told us, "It's good here, the manager is very good," and "I feel safe, the staff are very kind." One relative told us, "Yes [name] is OK. She is safe and seems happy and I have no complaints."

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- 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 accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong

- The new manager discussed the importance of communication and listening to residents, relatives and staff. He was open and transparent and aware that a breakdown in communication had contributed to many concerns within the service. Although he was relatively new in post, we saw evidence of changes taking place and improved communication.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

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 people's needs were not always met.

Improving care quality in response to complaints or concerns
● Complaints were not managed effectively.
● Prior to the inspection we received concerns that people's complaints were not being responded to. The themes of the concerns related to loss of belongings, lack of referrals to chiropody and dietician, poor communication, lack of care and poor management. Some relatives had even contacted head office, but had not received any response. People we spoke with, told us they felt, 'Fobbed off and ignored.'
● Although the service had a complaints policy, it was not user friendly and was only given to people if they requested a copy of it.The policy stated that 'every written complaint is acknowledged within 5 working days.' We saw numerous complaints from relatives that had not received a response and one that had been unresolved for over a year. The service was not following their own policies and procedures in relation to managing complaints.

The provider had failed to ensure that people's concerns and complaints were responded to appropriately. This was a breach of regulation 16 (Receiving and Acting on Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager had responded by writing back to all the relatives that had complained and had apologised for the fact that they had not been listened to and treated with compassion.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● Care plans were variable across the home. Some care records did not reflect people's needs effectively and others were very detailed. We found care plans on some units did not contain life histories and advanced care plans.

We recommend the provider ensures that care plans reflect people's individual care needs.

● The service had moved to an electronic care planning system and not all staff felt confident with this. Some staff felt the up to date information on their hand-held devices was a godsend and they could easily access information they needed. Other staff felt that it was too task orientated and they could not access all records.
● We raised this as an issue with the manager and he reassured us he would ensure they would appoint champions across the service to support all staff and ensure all information would be uploaded to the system.
● People we spoke with told us they were involved in their care and support plans and we could see these

were reviewed regularly

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

● People were supported to maintain relationships with families during the pandemic. Staff told us they kept in touch through phone calls, emails and video calls. The service had invested in visitor pods with audio, to enable people to see and speak with their family members. We spoke with one visiting relative who was receiving a visit and told us she was very happy with the measures the service had put in.

● Activities were taking place on some units. We observed people playing dominoes, snakes and ladders and people told us they enjoyed having their nails painted. However, on other units there was a lack of stimulation. We raised this an issue with the manager who advised the activity coordinator on one unit had been off sick and due to COVID-19 restrictions they did not want to move staff around.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The manager was aware of the accessible information standard. We observed communication plans were in place for people and we saw evidence that strategies were in place for staff to follow. For example, one record we looked at stated, '[Name] to be given time to answer, staff to speak slow and clear so she has time to take in information and respond.'

End of life care and support

● The home worked in conjunction with the local hospice. People were nursed at end of life and treated with dignity and compassion. Staff we spoke with understood the need for compassion and empathy and it was evident staff were caring individuals.

● There was a section in each care plan to record peoples end of life wishes. Although some were not completed, those we did see were detailed and documented plans for keeping people comfortable and dignified.

Requires Improvement

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 remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- There had been a lack of oversight of the overall management of the service and this had led to the concerns identified in this inspection. The previous manager had been absent from the service for extended periods of time and communication had been extremely poor at the service.
- Some staff told us they had tried to raise issues with their managers but felt their concerns were not always taken seriously. Relatives who had complained agreed. One person told us, "The carers are good but it's the management who are not addressing issues."
- Systems in place for the oversight and monitoring of the service were not sufficiently robust. We found shortfalls around medicines management, governance, complaints, risk management and staffing at the service.

The provider had failed to ensure systems for governance and management oversight were robust and effective. This 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.

- The new manager was responsive to our feedback and acted promptly to mitigate the identified risks. Staff and relatives told us he had been supportive and had listened to their concerns. Several staff we spoke with told us the new manager had been responsive when they had raised issues. Staff generally spoke highly of the unit managers.
- The provider had submitted statutory notifications to the CQC as required. Statutory notifications are certain changes, events and incidents that the Registered providers must notify us about that affect their service or the people who use it.
- The rating from the last comprehensive inspection was displayed in the office and on the website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There had been lots of changes at the service since the new provider had taken over. Some relatives told us they would have appreciated more information about the service, particularly for those moving in during the pandemic.
- There was a daily call for managers and staff to discuss important updates relating to the residents. The new manager also ensured daily manager walk rounds took place, to identify any issues.

● Although we have identified concerns, we also observed positive interactions between staff and people who use the service and saw evidence people received person centred care.
● People and relatives generally spoke highly of the service. They told us the staff were caring and understood the needs of their loved ones.

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
● Although we were aware of some instances where the previous management had not always been open and transparent with people, most relatives we spoke with told us that communication was good and they had been kept updated when incidents and accidents had occurred.
● The new manager was keen to improve communication at the service and move forward and engage with people and their families.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Staff told us supervisions had not been routinely taking place under the previous management, but these had recommenced over the past couple of months. We saw evidence of recent supervisions and competency checks taking place and staff told us they had regular team meetings.
● People and relatives we spoke with had not received any feedback forms or surveys to share their views on the service. We discussed this with the new manager who advised he had recently sent letters out to families asking for their feedback on the service, but response rates were minimal.
● Staff we spoke with told us they did not feel listened to previously. However, with the recent changes to management, staff felt this had started to improve and changes were taking place.
● The management team had good relationships with the local authority and were keen to work in partnership with other agencies and professionals visiting the service. One visiting professional we spoke with was very complimentary about the staff at the home and felt that people were well cared for.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not ensure that systems were robust enough to ensure medicines were managed safely. The provider had failed to ensure that systems were robust enough to effectively manage risks and ensure people were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The provider had failed to ensure that people's concerns and complaints were responded to appropriately and in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure that systems for governance and oversight were effective to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

The provider had failed to ensure appropriate staffing levels were in place to meet people's needs effectively.