Four Seasons Homes No.4 Limited

# The Maltings Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
The Maltings Care Home is a residential care home providing personal care to 39 people aged 65 and over at the time of the inspection. The service can support up to 43 people, some of whom may be living with dementia. The service is split into upper and lower floors, each with its own communal areas.

People's experience of using this service and what we found
People did not always receive care and support which was safe and which met their needs. Medicines were not well managed and there was a lack of effective monitoring by the provider which meant errors with medicines and unsafe practice was not identified. People did not always receive their prescribed medicines.

Safe systems were not in place regarding the risk and spread of infection, including COVID-19. Staff were not wearing PPE in accordance with government guidance and cleaning procedures were not robust. Oversight of cleaning was poor and some areas were not as clean as they should be.

Some risks were poorly managed including those relating to blood thinning medicines, choking, pressure care and people not drinking enough. Records were incomplete and some risks had not been fully considered and action taken to reduce them. Fire risks had not been fully assessed and mitigated. We required the provider to address specific issues related to this and they have done so. Staff knowledge and understanding of fire procedures was not good.

Staff recruitment procedures were not robust which meant people who used the service were not fully protected. Staffing levels were mostly in accordance with the provider's own assessment of what is safe but staff told us there were not enough to meet people's needs. The provider is in the process of reviewing staffing levels. The service was using a lot of different agency staff and systems to ensure they have all the information they need to carry out their roles safely were not robust.

Governance and oversight of the service was not effective and did not protect people. Audit systems did not identify the concerns we found and records throughout the service were incomplete, contradictory and confusing for staff. Where things had gone wrong, investigations into what happened and how to learn lessons for the future were not robust or timely. One significant incident had not been reported appropriately to CQC.

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 4 December 2019.)
At that inspection we identified a breach of regulation 12 (Safe care and treatment). At this inspection we found that the provider had not made sufficient improvement and the service was still in breach of this

regulation.

Why we inspected
The inspection was prompted in part by concerns we received relating to poor management of a person's fall. Our investigation of this led us to have concerns about multiple areas of the service including records, medicines management and risk management including risks associated with Covid-19. As a result, we undertook a focused inspection to review the key questions of Safe and Well-Led.

We reviewed the information we held about the service and considered the fact that this inspection was taking place during a time of global pandemic. No other major areas of concern were identified in the other key questions. We therefore did not inspect them. We used ratings from the previous comprehensive inspection for those key questions to calculate the overall rating at this inspection.

The overall rating for this service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe 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 report. During the inspection we had concerns for the safety of people in the home and wrote to the provider. The provider took immediate steps to address the concerns and continues to work with us to improve provision at the home.

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 The Maltings Care Home on our website at www.cqc.org.uk.

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

At this inspection, we have identified breaches of regulation in relation to safe care and treatment, recruitment, governance and notifying CQC of reportable events.

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

Follow up
The overall rating for this service is 'Inadequate' and the service 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 well-led?**

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

# The Maltings 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.

This was a focused inspection looking at the key questions of Safe and Well-Led. As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was carried out by four inspectors, three of whom carried out a site visit on 19 August. The lead inspector led the inspection remotely.

Service and service type
The Maltings Care Home 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 service had a manager registered with the Care Quality Commission. This means that they 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
We announced our inspection the day before the site visit. We did this due to the current COVID-19 pandemic. The short notice period gave the registered manager time to discuss any safety concerns and enabled them to begin gathering some information for us in preparation for our visit.

What we did before the inspection
We reviewed the information we had received from the service since the last inspection, including notifications the service is required to send us by law. We also reviewed the information the service sent us

in response to an enquiry where a person had sustained an injury following a fall. We spoke with staff from the local authority quality monitoring and safeguarding teams.

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
Due to the COVID-19 pandemic the time spent onsite by inspectors was reduced. This was done to help manage any associated risks. Further inspection activity, such as reviewing of records and speaking to staff and relatives took place remotely. The inspection activity took place between 19 and 25 August 2020.

During the inspection process we spoke with one person who used the service, three relatives, seven staff, including two senior care staff and one agency staff. We also spoke with the chef, the registered manager and the regional manager.

We carried out observations throughout the inspection.

We reviewed a range of records relating to the safety and quality of the service. This included two recruitment records, one agency recruitment record, rotas for the last six weeks, seven care plans, including care plans for people receiving respite care and medication records for seven people.

After the inspection
We asked for the service to address some urgent concerns about fire safety. They took prompt action to do this. We have alerted the fire officer of our findings with regard to fire safety. We contacted the service for further documentation which they provided. We have continued to work closely with colleagues from the local authority quality monitoring team.

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; learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made the required improvements and remains in breach of this regulation.

- Risks relating to fire safety were not well monitored and mitigated. We found that a fire door was partially blocked and an additional electronic keypad lock placed on it which would have slowed down any evacuation in the event of a fire. The provider took prompt action to remove both these hazards following our inspection.
- Staff received fire safety training but they were not all clear about actions to take in the event of a fire and who would assume responsibility for which tasks. This was of particular concern as some shifts were being led by senior staff from an agency who would be even less familiar with the layout and protocols of the service.
- Some risks had been assessed in care plans but not all. For example, people who take blood thinning medicines are at a heightened risk of bleeding should they fall. There were no specific risk assessments or care plans relating to this and records showed gaps in observation charts for these people in the period following a fall. The lack of clear processes placed people at risk.
- There was contradictory information in one person's plan about how to manage their risk of choking. It was not clear how much thickener should be added to their food and drink to make it safe for them to have. Where people were identified as at risk of losing too much weight, their weights were not always appropriately monitored.
- Where people were at risk of not drinking enough, fluid charts were not effective in monitoring their intake as they contained gaps and very low fluid intakes were recorded but no action taken. Two people had recently had hospital admissions for dehydration and urosepsis. Both of their fluid charts showed very low fluid levels.
- Poor processes and practice may have placed people at an increased risk of developing a pressure area. We reviewed recent audits and noted that since 3 August 2020 five people had been identified as developing pressure areas. People's change of position was recorded in different places and records were very poor. We could not be fully assured that people were receiving all the pressure care they needed. One person with a pressure ulcer needed to be helped to stand up for 5 minutes every two hours and repositioned every two hours over a 24 hour period. This was not happening and records documented them being in the same position in a chair during the day and in bed at night for hours at a time.

The service had failed to do all that is reasonably practicable to assess and mitigate risk. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

●Staff were not adhering to government guidance regarding the use of personal protective equipment (PPE). We saw staff providing care and support with no masks on, including helping people to eat their meals and preparing food. PPE was not used appropriately by staff administering medicines to people. Only 73% of staff had a record of infection control training, some of which had been delivered before the global pandemic. The registered manager told us that additional specific COVID-19 training had not been provided to staff but was part of their e learning and was discussed at handover. They did not check the knowledge and understanding of agency staff.

●PPE was stored in one area downstairs with additional supplies upstairs in trollies. Staff told us that sometimes they have to come downstairs to source more supplies. This lack of zoning of the service meant the additional staff movement increased the risk of the spread of infection.

●There were no temperature checks for the inspection team or for other healthcare professionals when they arrived at the service and inspectors were not asked if they felt well before commencing the inspection. The registered manager told us they have introduced this since the inspection.

●Records relating to cleaning rotas were not completed and audits of cleaning practice were not routinely being completed. The most recent cleaning audit had been completed on 4 August 2020. Some areas of the service were not clean, including the treatment room and medicines trolley which was not routinely cleaned in between medicines administration rounds. This placed people at an increased risk of infection.

●Staff were not clear about the latest COVID-19 working practices, including times people would need to isolate to make sure they were free from infection. They were also not clear about where to go for current information.

●The service's infection prevention and control policy did not reflect the most up to date government guidance.

The lack of clear information and ineffective monitoring had led to poor infection control practice which placed people at increased risk. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●When we began to investigate the incident where a person fell and injured themselves requiring hospital treatment, we found that safe processes were not in place for their admission back into the service. Key information about their condition and the treatment and investigations they had received in hospital was not formally documented. Staff were also unclear if they had had a test for Covid-19 and failed to isolate them which may have placed others at increased risk. Records showed that they were not appropriately monitored after their return. The Registered Manager put some new processes in place following this incident and we were able to determine that records are now improved.

Using medicines safely

●People did not always receive their medicines as prescribed. Some medicines, including pain relieving medicines, were recorded as being out of stock. The service was not always effective in sourcing these medicines quickly for people. For example, two people went without their morphine patches – one for 36 hours and one for five days. This meant there was a risk of people's pain not being controlled.

●Records relating to one person's antibiotics indicated that several doses had not been given and staff could offer no explanation. Another person had not received a medicine on multiple occasions as they were recorded as being asleep. The medicine was consistently recorded as being offered at 6am and not offered

again later in the day. We have asked the provider to investigate all of these issues.
●Audit systems, designed to check that staff had given people their medicines correctly, were not effective. The registered manager had introduced a daily morphine patch check but staff were unclear of its purpose and were doing it weekly in some cases.
●Staff received training to administer medicines but this did not cover the administration of morphine patches in detail. Staff had their competency to administer medicines checked but not agency staff. We observed an agency staff member giving medicines. They were not confident and were not wearing their PPE correctly.
●Stock control systems for medicines were poor and did not provide assurances that people were receiving their medicines as prescribed. One balance of tablets showed the amounts increasing at times rather than decreasing and we found another person had a record of 520mls of liquid medicine being administered but only 250mls being received into the service.

The service had failed to ensure proper and safe management of medicines. 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

●Recruitment processes were not sufficiently robust and did not fully protect people. Suitable references and full employment histories were not in place in the records we saw. Where staff had convictions on the Disclosure and Barring Service check these had not all been risk assessed by the service to make sure people were suitable to work in this care setting.

Recruitment processes did not fully protect people. This was a breach of regulation 19 (Fit and proper staff) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff and relatives raised concerns with us about staffing levels. Many felt that levels did not enable staff to provide the best quality care and two people described the approach as being like a 'conveyor belt.' One staff member said, "There are a lot of [people who need two care staff to move them using the hoist]. This takes time and takes people off the floor…Weekends are very difficult. There's no time for people- especially [people who are] end of life. It's hard."
●Other staff commented on the high agency usage putting an additional strain on the staff team. One relative commented,"[There's] not a good skill mix – younger ones without experience."
●The staffing at the service was assessed using a dependency tool and was reviewed weekly. Rotas broadly showed staffing levels were provided in accordance with this assessment. However, several staff commented that people's needs had increased a lot in recent weeks and months and this had not been taken into account fully. Given the comments we received we asked the provider to review this tool and reassess people's needs in terms of staffing hours required. They have told us they are about to introduce a new dependency tool which would be a more accurate assessment of staffing needs.

Systems and processes to safeguard people from the risk of abuse
●Staff received training in safeguarding people from abuse or the risk of abuse. We saw that 80% of staff had complete this training. However, not all staff were able to explain the processes they would follow.
●The registered manager confirmed that they made appropriate referrals to the local authority safeguarding team and we saw records to confirm this. However, one relative told us that their family member had had problems with another person who used the service coming into their room frequently. They said the person did the same thing to others. The only solution offered was to close the person's door which they found

isolating. We also found an incident record about a person entering another person's bedroom. We were not fully assured that all actions had been taken to reduce the likelihood of repeat occurences.

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; Continuous learning and improving care

- Staff were aware of some of the basic requirements of their role but some key knowledge was not understood. Training was not fully embedded. This was of particular concern with regard to fire safety and the wearing of PPE as staff were not aware of their individual responsibilities to keep people safe.
- Senior staff charged with auditing and checking responsibilities did not always do this effectively and did not act on their findings. For example, the daily check of morphine patches which the registered manager had devised was not taking place. A senior staff member told us they thought this was a weekly check to be done 24 hours after the patch was put on, even though the record was called a 'daily' check.
- During a recent period of annual leave whilst the registered manager was away, the staff member in charge at the time displayed a lack of knowledge and understanding of their role. They were unable to respond to our requests for key information about an incident where a person had sustained an injury.
- We found that part of the reason staff were not always clear about people's current needs may have been due to the poor recording systems that were in place. The paper records were onerous and, if fully completed, took considerable staff time. Often they were not fully completed and information, including dates and times was missing. Information was recorded in different places which led to confusion. Some staff told us that information we requested was stored in the manager's office. Staff could not identify key information quickly which placed people at potential risk.
- Oversight from senior staff at the service, the registered manager and from regional staff at Four Seasons was not effective. Audits, schedules and analysis of incidents were in place but did not ensure safe practice and did not follow up on issues promptly. Audits did not identify patterns and trends and did not reduce risk or drive improvement. Audits of fluid and repositioning charts, cleaning and medicines were poor. This placed people at risk.
- CQC acknowledges that this period is one of global pandemic and that this has brought huge increased stress and disruption to services. However, basic care needs were not being met for some people and there was significant risk. Lessons were not truly learned and action taken to reduce risk. Analysis of incidents was not detailed, and the record often stated 'lessons learned and communicated to staff' but similar issues occurred again.
- Oversight from more senior staff at Four Seasons was not effective. Staff did not cross the threshold of the service for a period of three months during the height of the pandemic.During this time regional staff were relying on poor records and testimony of the registered manager to establish the safety and quality of the service. This level of oversight did not protect people from unsafe care.
- On the day of our inspection we asked Four Seasons to investigate some serious concerns with the unsafe

management of medicines. This investigation by senior staff had still not taken place a week later which meant that poor records and unsafe practices could have continued to place people at risk. The service was in breach of regulation 12 (Safe care and treatment) at the last inspection and there has been a repeated breach of this regulation at this inspection. This gives us serious concern about the safety of this service.

The quality and safety of the service had not been effectively assessed and monitored to mitigate risks. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had failed to notify CQC of events that are required to be reported. An incident where a person sustained an injury requiring hospital treatment and leading to a period of prolonged pain was not notified to us.

This is a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

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

●Some staff were positive about the registered manager and the support they received but morale within the staff team was low and the culture quite divided. Not all staff felt able and comfortable to raise issues as they thought things would not change. Staff had become task focussed, with many citing the current staffing levels as the main issue.

●Two relatives commented on how stretched the staff are and how stressed they appeared and commented that communication from the service had deteriorated. This had increased their anxiety about their family member, especially during the times they were unable to physically see them.

Working in partnership with others

●Other stakeholders had not been aware of issues at the service but the registered manager assured us that they would now be working closely with key partners. The local authority quality monitoring team have not had recent involvement with the service but are intending to do so following this inspection.

●The registered manager told us that relationships with the local GP surgery and district nursing teams were good. In spite of this assurance we remained concerned about the time it took to source some medicines for people. Closer partnership working was needed to ensure these delays are not repeated.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The registered manager understood their responsibilities regarding duty of candour and records showed that relatives had been informed appropriately when incidents occurred.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider failed to notify the Care Quality Commission of a relevant incident. Regulation 18 (1) (a) (iii). |