Mrs Christine Lyte

Caythorpe Residential Home

Inspection report

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Caythorpe
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Caythorpe Residential Home is a residential care home providing personal care to up to 14 people aged 65 and over. At the time of the inspection the service was supporting 12 people, some of whom were living with dementia.

People's experience of using this service and what we found.
People were not supported to reduce their risk of exposure to infection. The provider had failed to assess and mitigate risks in relation to infection control. People were not supported by staff who had knowledge of changes in government guidance around the spread of infection.

People were not always supported to have maximum choice and control of their lives. Staff did not always support them in their best interests; the policies and systems in the service did not always support this practice.

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

Rating at last inspection.
The last rating for this service was good (published 3 July 2018).

Why we inspected
The inspection was prompted in part due to concerns received about residents safety and infection control. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only. We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

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 changed from Good to Requires Improvement. This is based on the findings at this inspection.
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 Caythorpe Residential Home on 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 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 people's safe care and treatment and the governance of the service at this inspection.

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 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 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Caythorpe Residential 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 an Inspector and an Assistant Inspector. On the day of inspection there was a representative from the local authority at the service.

Service and service type
Caythorpe Residential 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
This inspection was unannounced, after a preparatory telephone check had been made to ensure we were following the recommended PPE guidance for the home.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We also sought feedback from the local authority and professionals who work with the service. 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.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with the registered manager.

We reviewed a range of records. This included four people's care records. We looked at four staff files in relation to recruitment and staff supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke to two relatives and two staff members.

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

Assessing risk, safety monitoring and management

- Risk assessments contained guidance for staff to follow however, these were not consistently reviewed and updated. For example, one person's risk assessment did not include known risk and support which would ensure they could eat all meals safely. The service had not sought support from relevant health professionals to support this person. We did not find evidence people had come to harm, this was because staff had good knowledge of people needs and had worked at the home for a long time which reduced the risk of this person receiving an incorrect diet.
- Recent improvements to the external door closing mechanisms were found to be effective. The registered manager was also planning to install an external secure gate to improve safety to the access roadway. This would ensure greater safety for people, visitors and staff, as there was now a busy building site next door, which posed a hazard. Within a week of the inspection we received notification that this gate had been fitted.
- We identified two internal environmental risks for people. We found not all radiator covers were securely fixed to the wall, and fireguards did not extend to cover the whole fireplace surround. This meant there were exposed hearths which would be dangerous to people if they tripped and fell.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding systems and processes were in place to keep people safe.
- People told us they felt safe in their home. One person told us "it's perfect here, the food is lovely; I feel safe and I love living here".

Staffing and recruitment

- Staffing and recruitment processes were found to be robust.
- Staff did not always follow relevant guidance in relation to working in health and social care settings. We noted one member of staff was working at two different locations. This is inadvisable during the current Covid-19 pandemic and could place residents at risk. We raised this with the registered manager as a concern.

Using medicines safely

- We found suitable arrangements were in place to safely order, administer and dispose of people's medicines in line with national guidelines.
- Medicines were stored safely and only staff who had been trained in the safe administration of medicines had access to people's medicines.

Preventing and controlling infection

- We found that current guidance for the control of infection including the wearing of Personal protective Equipment (PPE), was not being followed.
- We saw several staff not wearing masks when we entered the premises, and during the inspection. Some people living in the home questioned why we were wearing masks.
- There was no designated "donning and doffing" area for staff which did not encourage the safe use of PPE.
- After the inspection staff told us they didn't think they had to wear masks when there was no Covid-19 in the home, or if they had had a negative test. Relatives also commented on the fact staff did not wear masks all the time.
- We were concerned that the provider may not be able to effectively manage if there was an infection outbreak due to the design of the home making it difficult to effectively isolate people. We discussed this with the Registered Manager.
- We also found that the latest guidance regarding cleaning solutions was not being followed and sent the Registered Manager this guidance immediately after the inspection

This was a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 good. At this inspection this key question has now deteriorated to requires improvement.

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

- The registered manager understood their regulatory responsibilities. They had improved their skills to fulfil our regulatory requirements. For example, they ensured they promptly notified us of relevant incidents using appropriate formats.
- We identified not all risks were identified and swiftly addressed, particularly with environmental issues. We raised these when we found them with the registered manager, who took actions after the inspection to address these.
- It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had clearly displayed this in the home.

Learning lessons when things go wrong

- The management team did not always take prompt action to accept and act on feedback to minimize risk to people. For example, risk assessments were not adequate to protect people from avoidable harm
- When people living at the home had left unsupervised and been found in precarious, hazardous situation such as on the nearby building site or on the main road, immediate action had not been taken to better secure the premises or update the risk assessments. This showed a lack of oversight and willingness to learn from mistakes by the Registered Manager.
- We found that systems, records and audits for Infection Prevention and Control had not been updated in line with recent guidance. This also showed poor Governance by the Registered Manager.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- Some staff reported they hadn't received training in several key areas, infection control, safeguarding, tissue viability and fire safety. The registered manager assured us training programmes were ongoing.

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

● People told us "they felt safe", and the "staff are all lovely", "we can ask (the staff) for anything and if they can they will."
● Relatives told us they received questionnaires and in summary they commented "It is a small home and it is very homely, it's not like one of these massive homes, every room is individual."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives, people and staff all told us the manager was very approachable and relatives told us they were getting telephone updates when they couldn't visit, which they appreciated.
● Staff told us they felt respected, valued and supported. They could make suggestions, and these were heard and acted on.

Working in partnership with others
● We found the home worked in partnership with other agencies to enable people to receive 'joined-up' care. This had been particularly useful with the increasing electronic communication the local doctors practice were using.
●Whilst we were there the home also took delivery of a "WyZan" box, which is designed to facilitate electronic transmission of people' clinical condition straight to the GP practice. This will improve access to healthcare.