Tendercare Home Limited

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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
Tendercare Home Ltd is a residential care home providing personal care and accommodation for up to 43 older people some of whom may live with Dementia. The service was supporting 30 people at the time of the inspection.

People's experience of using this service and what we found
People were not supported in a safe way. People were not protected from potential harm and abuse. Abuse or improper treatment was not always reported and investigated. Medicines were not managed safely.

The provider's systems failed to identify that care and support was not provided in a safe way. Audits did not identify concerns with risks to people, safeguarding, medicines, and care plans.

Staff concerns were not always acted on. Staff practice was not effectively monitored, and new staff did not receive the training they needed for their role.

The provider did take immediate action when information of concern was shared with them to protect people from further harm.

Rating at last inspection. The last rating for this service was Good (published 14 March 2020).

Why we inspected
We received whistle blowing concerns in relation to safeguarding, medicines management, moving and handling, and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We received further whistle blowing concerns on the 17 November 2020 which were also reviewed as part of this inspection process.
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 inadequate. This is based on the findings 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 coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well Led sections of this full report. The provider took immediate action to mitigate the risks of people receiving unsafe care.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tendercare Home Ltd 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 safe care and treatment, safeguarding, staffing, and governance. Please see the action we have told the provider to take at the end of this report.

Follow up
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.

Special Measures:
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.

Tendercare Home 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.

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 site visit was carried out by two inspectors.

Service and service type
Tendercare Home Ltd 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.

Inspection activity started on 10 November and ended on 24 November 2020. We visited the service on 10 November 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority 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. We used all of this information to plan our inspection.

During the inspection-
We spoke with 10 people who used the service and four relatives about their experience of the care provided. We spoke with 12 staff, the provider and an interim manager from another of the providers services.

We reviewed a range of documents and records including the care records for seven people, five medicine records, two staff files and training records. We also looked at records that related to the management and quality assurance of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training information, care plans and quality assurance records. We spoke with one healthcare professional the safeguarding social worker.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes were not operated effectively to prevent abuse of people living at the home.
- An investigation was undertaken by both the provider and the local authority in response to the whistle blowing concerns CQC and the local authority had received. The outcome of this was the concerns were substantiated, and specific staff were found to have verbally abused certain people in the home.
- Two staff we spoke with told us they had raised their concerns with the registered manager, but procedures had not been followed and these concerns had not been acted upon and reported to the safeguarding team at the local authority.
- The investigation undertaken also concluded a staff member had used an inappropriate physical intervention when a person displayed distressed behaviour.
- The training matrix provided to us showed 25 of the 35 staff had completed Safeguarding training. This demonstrated staff had received training on the procedures to follow if they had concerns about the safety of people. However, although some concerns had been shared with the registered manager, staff did not escalate their concerns to external agencies until 05 November 2020. This meant, despite receiving training, staff did not have a clear understanding regarding the importance of raising safeguarding concerns appropriately in order to keep people safe

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Once the concerns were shared with the provider, they took immediate action to safeguard people. Disciplinary action has been taken in response to the concerns and outcomes from the investigations undertaken.
- The provider advised us all staff would be undertaking further safeguarding training and ongoing competency assessments would be undertaken. This would help ensure staff were confident and competent to follow the safeguarding procedures in place.

Assessing risk, safety monitoring and management; Using medicines safely

- The registered manager failed to mitigate known risks to people. This meant they failed to ensure care and treatment was being provided in a safe way putting people at risk of poor and unsafe care.
- CQC received concerns that staff were using unsafe moving and handling practices when supporting people with their mobility. These concerns were investigated by the provider and the local authority. They confirmed the registered manager and staff were using unsafe moving and handling techniques when supporting people.

● Two staff we spoke with also confirmed unsafe moving and handling techniques were being used within the home. Staff told us they were unaware these techniques were unsafe until they received further training after action had been taken in response to the concerns. This meant people had been at risk of harm from incorrect moving and handling and this had not been identified due to a lack of oversight.
● We reviewed the systems in place to monitor incidents and accidents in the home. We found although falls had been recorded for people, there was no evidence to support what actions had been considered to prevent the risk of further falls for those people that had fallen. There was no evidence to support patterns and trends had been considered as an analysis of the falls had not been undertaken.
● We reviewed the care of a person with sore skin. We found the care plan and risk assessment did not provide staff with detailed information on how to support this person and the frequency required to provide pressure relief to prevent further deterioration of their skin. Records showed the person was receiving support from healthcare professionals. Their daily notes recorded pressure relief was being provided on a two-hourly basis by staff. Feedback from a healthcare professional we spoke with advised pressure relief was recommended at two hourly intervals. When we reviewed the records for October 2020 of the pressure relief provided, we found on 63 occasions pressure relief was provided less frequently than the two hourly intervals.
● We reviewed the medicines for five people. The electronic records confirmed medicines had been administered to people as prescribed. However, we found discrepancies for two people when we counted the balances of medicines in stock. These were not accurate with what medicines had been administered and signed for. This meant we could not be assured people had received the medicines when they needed them.
● We found some people were prescribed transdermal patches which were applied to their skin. For one person there was no records in place to indicate the location each patch had been applied. The manufacture instructions state it is important to change the skin site every week, making sure at least three weeks pass before you reuse the same site. The lack of records of where previous patches had been applied, meant we could not be assured the manufacturer instructions were being adhered to.

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

● Once these concerns where shared with the provider they took immediate action to address the concerns. Disciplinary action has been taken in response to the concerns and outcomes from the investigations undertaken.
● The provider has arranged for an external trainer to provide training to staff in moving and handling to ensure staff support people safely. The provider confirmed competency assessments will be undertaken on a regular basis to ensure staff continue to follow safe practices.
● The provider arranged for a full pharmacy audit of the medicines systems following our inspection visit.

Staffing and recruitment
● People were not supported by skilled and competent staff.
● Staff told us, and records confirmed, newly employed staff had not received training essential to support people safely". For example, one staff member told us, "I have not received training in Fire safety, safeguarding or moving and handling and I have been here several months now." Another staff member said, "I didn't receive an induction when I first started, I haven't done Fire safety and only recently completed moving and handling and found out I was doing it all wrong." This meant that staff did not have the correct knowledge required to support people safely.
● We asked how the practices of the existing staff were monitored. The provider sent us records of staff competency in relation to medicines. No other competency assessments could be located to demonstrate

the ongoing monitoring of staff practices to ensure safe procedures were being followed.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People we spoke with told us they were supported by enough staff to meet their needs. One person said, "When I need help the staff come and help me."
● Records confirmed the required recruitment checks had been completed before staff commenced working in the service.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were somewhat assured that the provider was meeting shielding and social distancing rules. Where possible people were encouraged to socially distance and chairs had been reorganised for this reason.

● We were somewhat assured that the provider was admitting people safely to the service. People were encouraged to isolate following their admission. However people that lived with dementia needed support and direction to help them understand the reasons for this and to remain in their rooms.

● 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
● As recorded above incidents, and accidents had been recorded but there was no clear analysis to identify themes and prevent future occurrences.
● The provider acknowledged and advised there were many lessons to learn following the concerns that had been shared, investigated and proven. The provider advised us an action plan was being developed to address all areas, and to mitigate the risks of these events occurring in the future.

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 Good. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The registered manager had not provided effective leadership and direction to staff. The registered manager was using and allowing staff to use unsafe moving and handling techniques and did not challenge poor practice. People were therefore exposed to risk.
- Systems and processes were not established and operating effectively to investigate abuse or improper treatment. Safeguarding incidents had not been alerted to the relevant authorities or investigated appropriately. As a result, people were exposed to the risk of immediate and ongoing harm.
- Effective systems were not in place to mitigate risks to people. Incidents and accidents were not analysed to mitigate further risks for people. Pressure area care was not monitored to ensure people received the care they needed to reduce further risks of harm.
- The registered manager gave incorrect guidance to a staff member in relation to how tablets that had been found on the floor were to be disposed of.
- Robust audits were not in place to monitor the medicines systems in place. Although audits were completed these did not demonstrate whether people's stock balances were checked and accurate. The audits were brief in detail and did not pick up the issues we found on this inspection.
- There were ineffective systems in place to ensure staff were able to raise concerns. Although some staff raised concerns with the registered manager, they told us they did not feel confident in approaching the provider as other staff discouraged this. Staff did not feel confident in raising concerns with external agencies.

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

- The provider took immediate action to address the concerns shared and disciplinary action was followed against the registered manager who then resigned from her position. The registered manager has now deregistered with CQC. A new manager has been recruited and will commence their role in the home following recruitment checks.
- Following our inspection process the provider sent to us evidence of information they had requested from the registered manager in relation to the management of the home. No information was provided to indicate any concerns within the home. The provider was unable to visit the service due to COVID19

restrictions.
● Staff we spoke with after the inspection visit told us things had improved at the home, and the staff morale was "getting better". A staff member said, "Action has been taken and the atmosphere is much better now, and people are receiving the care they need and deserve."

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 provider took immediate action when the concerns were shared with them. They have contacted relevant relatives to discuss the concerns and the action that has been taken. The provider investigated the concerns and what had gone wrong in the home. Staff discussions were arranged to give everyone the opportunity to speak up about any issues or concerns they may have. This showed they understood their responsibilities in relation to duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Not all people were involved in the concerns that were raised. Other people we spoke with told us they liked living at the home, and the staff did involve them in their daily lives.
● People did receive support from external healthcare professionals where needed to meet their healthcare needs.
● The provider engaged and worked alongside the local authority to investigate the concerns that were shared and continues to do so to make improvements.
● The interim management team and provider have engaged with the local authority during the Covid-19 pandemic.

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 People did not receive their medicines as prescribed and did not receive support in a safe way.

The enforcement action we took:

NOP to impose positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to prevent abuse of people living at the home.

The enforcement action we took:

NOP to impose positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not robust enough to demonstrate safety was effectively managed.

The enforcement action we took:

NOP to impose positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by suitably qualified, competent, and skilled staff.

The enforcement action we took:

NOP to impose positive conditions.