RCH Care Homes Limited

Kesson House Care Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Kesson House Care Home is a residential care home providing personal care to 27 people living with a range of complex health needs including dementia or aged 65 and over at the time of the inspection. Kesson House Care Home accommodates up to 38 people in one adapted building.

People's experience of using this service and what we found
People received inadequate care. This had a major impact on their health, safety and well being. The provider did not have clear oversight of the service and their quality assurance process had not been robustly followed. Action taken to keep people safe had not been effective and people had suffered harm. We found significant shortfalls in people's care and support: these shortfalls had not been identified by the provider, their management team or staff.

Leadership of the service was inadequate. The provider had failed to ensure the service was appropriately managed or led. The manager was new in post and was the third manager in a year. The service had not developed a positive culture centred around people and their safety.

Important infection control guidance from the government, in relation to managing Covid-19, had not been followed and this put people at risk of contracting the disease. People were in the highest risk groups of dying from Covid-19.

Safeguarding risks had not been identified and managed to keep people as safe as possible. One person had been assaulted. Staff had not informed the local safeguarding team of incidents so they could investigate and offer support. Some people were living with dementia and had behaviours which challenged at times. Guidance had not been given to staff about how to avoid or defuse situations to ensure people were safe and their needs were met.

Risks to people had not been kept under constant review and changes in people's needs had not been identified. For example, action had not been taken when people had lost weight increasing people's risk of developing pressure ulcers and falling. We had not always been informed of serious injuries to people so we could check they had received care to keep them safe and well.

Staff had not been constantly deployed to the levels the provider had assessed were required. This had a major impact on people's safety and their health. People did not receive the care they had been assessed as needing. In addition, people frequently had to wait for their care and support, and this caused them distress. Some staff did not have the basic skills they needed to keep people safe, such as moving and handling or medicines training. The provider sent us further evidence following the inspection about action they had taken in respect of staffing, but that this did not fully mitigate the risks.

Medicines were not well managed, and people did not always receive their medicines as prescribed.

Medicines had been out of stock, others had been not been given and one person had been given to much.

Following the inspection the provider met with the commission and sent us an action plan to address the urgent issues, however this did not fully mitigate the risks.

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 26 June 2019).

Why we inspected
We undertook this targeted inspection to check on specific concerns we had about management of medicines and infection control risks, people's care and treatment, people losing weight and poor governance and leadership. The overall rating for the service has not changed following this targeted inspection and remains Good.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 risk management, protecting people from the risks of harm and abuse, medicines management, staff deployment, infection control, monitoring and improving the quality of the service and governance this inspection.

Following our inspection we used our urgent enforcement powers to vary the providers conditions of registration. This was to restrict admissions to the service. After our inspection the provider informed us they were closing the service and people were moved from the home.
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 for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Kesson House Care Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check specific concerns we had about the management of medicines and infection control risks, people's care and treatment, people losing weight and poor governance and leadership.

Inspection team
This inspection was completed by two inspectors.

Service and service type
Kesson House 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection to check if anyone had suspected or confirmed COVID 19.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including concerns from whistle blowers. We gathered feedback from the local authority safeguarding and commissioning teams. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

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

eleven members of staff including the manager, deputy manager, head of quality and care, senior care workers, care workers, a housekeeper and the chef. We reviewed a range of records. This included six people's care records and multiple medication records.

After the inspection
We continued to seek clarification from the provider . We looked at a variety of records relating to the management of the service, including policies and procedures.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns we had about people's medicines, safeguarding risks, infection control and staff deployment. We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risk of abuse and harm. During our inspection we found people had been assaulted by other people living at the service. One person had been seriously injured. No action had been taken to prevent similar incidents occurring again. This had not been reported to the local authority: Staff had failed to recognise and report safeguarding concerns to the local authority safeguarding team or the Care Quality Commission. Recommendations made by visiting health care professionals about the person's treatment following the serious injury, had not been followed. This put the person at risk of further harm and abuse.

● Although staff had received training in relation to safeguarding people this had not been effective. Staff, including the management team had not recognised that people were being abused. Some staff were not able to tell us about the signs of abuse or neglect they would report to as a safeguarding concern. Staff told us their confidence to raise concerns to the new manager had increased but there was no evidence they had done so.

The registered persons had failed to protect service users from abuse. This placed people at risk of harm. 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.

Assessing risk, safety monitoring and management

● People were not protected from the risk of harm. People's risk assessments had not been reviewed between January and May 2020. In June 2020 risk assessments had been reviewed and action planned to reduce risks. However, the actions had not been followed and people continued to be at risk. In June 2020 it was noted one person had lost a significant amount of weight and required a high calorie diet. Their care plan required staff to weigh them weekly to check the action was effective and the person had put on weight. We found the person had not been weighed each week and had lost approximately a further 7kg. They had not been referred to health care professionals and risks to their health continued.

● People who were at risk of falling and sustaining an injury did not have effective care plans in place to reduce the risk. For example, when one person was assessed as being at high risk of falling in June 2020. Guidance in their care plan had not been changed to reflect this and stated they were at low risk of falling. Guidance had not been provided to staff about how to support the person to remain as safe as possible. The person had fallen and sustained a serious injury which resulted in hospital treatment.

● Some people were at risk of developing pressure ulcers using a recognised risk assessment tool to assess people's risk. Risk assessments had not been reviewed between January and June 2020. One person had a wound documented in January, the risk assessment had not been reviewed regularly to ensure action taken to prevent further damage was effective. The management team did not know if the wound had healed. The person's care plan stated their pressure relieving mattress should be set at 70kg. We checked the mattress and found it was set at 150kg. This increased the risk of the person developing further pressure ulcers.
● Some people had behaviours which challenged and there was a risk they may harm themselves or others. However, guidance had not been provided to staff about how to support people to remain calm and reduce any anxiety. Following our inspection, the provider sent us 'behaviour which challenges care plans'. These did not identify possible triggers to behaviours which challenge so staff could support people to avoid these.

● People did not always feel safe at the service. One person told us other people entered their bedroom without their permission and they did not like this. They told us they would feel safer with a lock on their bedroom door. During our inspection we observed people going in and out of other's rooms uninvited. We observed one person in another person's bedroom. We saw this was very upsetting for the person whose room it was. They asked the person to leave their room and was verbally abused by them. During this incident no staff intervened to provide support to either person.

The registered persons had failed to assess the risks to the health and safety of service users and do all that is reasonably practicable to mitigate risks. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People's medicines were not managed safely, and this placed them at risk of harm. One person did not receive three different medicines for 10 days as they were out of stock. One of these medicines, not being taken for that length of time, placed the person at high risk of becoming unwell. Another person's medicine was also out of stock for four days. The manager was not aware the medicines were out of stock and no action had being taken to get the medicines promptly.
● Some people had not received their medicines as prescribed. One person had not been given their medicine as they were often asleep at the time they were prescribed. One medicine not given supported the person to remain calm and reduce their anxiety. There was a risk this may lead to an increase in behaviours that challenge. This had not been discussed with the person's GP to ensure medicines were prescribed at a time which best suited them. One person was prescribed a medicine once each day. On four occasions in a five day period the person had received double the prescribed dose.
● Records of people's medicines were not fully completed. For example, three people's medicines administration records had not been signed to confirmed they had received the medicine. The stocks of the medicines showed the medicines had been administered.

The registered persons had failed to manage medicines in a proper and safe way. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● There were insufficient staff to meet people's needs. This had a major impact on people's health, safety and well being. The provider told us they had a process to consider people's needs when deciding how many staff were required each day. However, they were unable to show us any document to demonstrate what this process was. They had assessed five care staff were required each day. However, staff had not

been deployed to the levels the provider had assessed were required and fell far short of the provider's assessed levels. Rotas from 1 May 2020 to 22 July 2020 showed that out of the 31 days in May 2020, there were 2 occasion where 5 staff were on duty. On all other days there were a maximum of 3 or 4 staff. In June 2020 there were 4 days where 5 staff were on duty, and up to the date of this inspection there had been 6 out of 22 days where there had been 5 staff. These staffing levels meant people's assessed needs would not be met and placed them at risk of harm.

● People did not always receive the support they needed when they wanted it. We observed people calling out for help but there were no staff available to respond. For example, one person was calling out for assistant to got to the toilet. Staff did not respond, and the person had a continence accident, which distressed them.

● Staff deployment during the day was not managed. We observed two staff sitting in the lounge completing records, with two people who were asleep, while other people were calling for assistance in other areas of the service. Staff breaks were not planned to make sure there were always two staff available to support people, for example to move from one place to another. We observed two care staff on a break at the same time leaving 1 staff member on the floor.

● Not all staff had completed the provider's mandatory training and there was a risk they did not have the skills to keep people safe. For example, nine staff had not completed refresher infection control training. We observed one of these staff preparing food for people without wearing a mask or visor in line with current guidance to reduce the risk of Covid-19.

The registered persons had failed to consistently deploy sufficient staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider sent us further evidence following the inspection about action they had taken in respect of staffing, but that this did not fully mitigate the risks.

Preventing and controlling infection

● Effective infection prevention and control processes were not in operation at the service. Shortly before our arrival we asked the manager if anyone at the service had symptoms of Covid-19. We were told no one was suspected of having the virus. However, one person was showing signs and had been tested for Covid-19 the day before. National guidance was not being followed and the person was not isolated. We observed the person's bedroom door was open and staff did not change their PPE before entering and leaving the person's room. We observed staff not always wear disposable gloves when assisting people. This significantly increased the risk of infection being transferred from one person to another.

● The provider had not completed risk assessments for staff who were not able to follow government guidance about wearing face coverings. We observed one staff member working without a face covering. The risk to people and other staff had not been assessed and action had not been taken to ensure everyone was safe.

● Areas had been set up throughout the service for staff to put on and take off their personal protective clothing (PPE). None of these areas had stocks of face masks, important to reduce the risk of Covid-19 spreading. During the inspection the manager put supplies of face masks in these areas. Staff were not wearing visors when supporting one person with suspected Covid-19, this did not follow current government guidance.

● Staff's competence to manage infection control risk associated with Covid-19 had not been assessed. The manager had shared information with staff but no action had been taken to ensure staff read it and applied the guidance to their practice. We observed one staff member was not wearing their mask correctly while in people's company. Some staff told us they had not had any training in relation to Covid-19. One staff

member said, 'I was off sick but on my return I was told what PPE I should wear. This wasn't formal though it was just from other staff.'

The registered persons had failed to ensure effective infection prevention and control processes were in operation to keep service users safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check a specific concern we had about inconsistent leadership and poor oversight of the service.
Continuous learning and improving care
● Inadequate monitoring of risks to people living at the service had caused people to suffer harm and be at risk of continued harm. People were not protected from the risk of poor quality care because an effective system was not in operation to assess and improve the quality of the service. The provider's operational procedures and quality governance framework had not been completed as the provider required. For example, they required monthly accident and incident analysis. We asked to see these, the head of quality and care told us they had not been completed. There was a risk that patterns of accidents and incidents would not be identified, and care not planned to support people to remains as safe as possible.
● The provider's quality assurance process required daily, weekly and monthly checks of medicines management. We asked to see these, but the provider did not share this information with us. We found shortfalls in the management of medicines at the service.
● The providers home development plan dated 17 July 2020 states training should be at 95% by the 3 July 2020. However, this had not been achieved. For example, only 71% of staff had completed infection control training, despite there being a global covid-19 pandemic. One staff member who had been working at the service for over six months had only completed 20% of the required training.
● The home development plan also stated, 'All care plans have been reviewed, and contain appropriate levels of information to support residents needs'. However, we found this was not the case. One person's care plan reviewed on 25 June 2020 did not provide staff with information and guidance about how to care for the person's catheter.

The registered persons had failed to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had not developed a culture of openness and transparency within the organisation. The provider's mission and values stated, 'We strongly believe in the importance of honesty as the starting point of everything we do. You can rely on us to be open, honest and transparent in all of our interactions… with external regulators.' During and after the inspection we asked the provider to share important information with us, such as records of accidents and incidents between January and June 2020. We did not receive this information. ● People and staff were not involved in the service. They had not been asked for their views of

the service so the provider could ensure the service met their needs. The manager told us it was their intention to meet residents but had not put any plans in place. It is important people are supported to be involved in the service, especially during exceptional circumstances such as Covid-19 restrictions.

● Before the inspection we received concerns about the service from whistle blowers. Whistle blowers are staff who are protected by law from unfair treatment after raising concerns and can choose to remain anonymous. During the inspection we spoke with the provider's head of quality and care about the concerns we had received. They told us they knew who had blown the whistle and would be talking to them about their conduct.

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

● The provider had not ensured there was effective management and leadership at the service. There had been three managers at the service in a year. The manager was new to the organisation and the service. They had completed the provider's induction and were receiving 'buddy' support from the manager of another service once per week. The provider described them to us as 'A rabbit in the headlights on a steep learning curve'.

● The management team lacked oversight of the service. For example, the manager told us they had instructed staff to isolate one person with symptoms of Covid-19. They had not put a risk assessment and plan in place to guide staff. They were unaware that the person had left their room and had not acted to ensure people's safety.

● People's personal information was not held securely. We observed records of people's care were accessible to others on a cupboard in the lounge. Other confidential records were stored in an unlocked cupboard. We told the manager who arranged for the records to be locked away.

The registered persons had failed to maintain service user's records securely. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service. This is so we can check appropriate action had been taken. The provider had not notified us of a serious injury one person had sustained at the service.

The registered persons had not informed us about serious injuries to service users. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Following the inspection the provider met with the commission and sent us an action plan to address the urgent issues, however this did not fully mitigate the risks.