Broadoak Group of Care Homes

Cockington House

Inspection report

38 Cockington Road
Nottingham
Nottinghamshire
NG8 4BZ

Tel: 01159288013

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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

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Cockington House is a residential care home providing personal care to up to 6 people living with a learning disability. Accommodation is provided over 2 floors. A communal lounge with a dining room, and kitchen are based on the ground floor. At the time of our inspection there were 4 people using the service.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care:
Care was not always person-centred. Staffing levels were not always adequate to ensure people received the right care. Staff ensured they respected people's dignity, privacy and human rights. People were supported by caring staff.

Right Culture:
Governance systems were not effective, and the provider lacked an oversight of the service. Concerns had been raised but were not always investigated and action had not been taken to improve the service. People, staff and relatives had not been asked to provide feedback about their views. There was a new management team in place, who promoted a positive culture and led by example.

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 30 November 2017).

Why we inspected
We received concerns in relation to a closed culture and restrictive practice being used. Concerns were shared about restraint being used by untrained staff, People's health care needs not being appropriately met and staffing levels which were not safe. Also, we heard about concerns of the management of incidents 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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cockington House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and governance at this inspection.

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

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 safe findings below.

Cockington House

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 Health and Social Care Act 2008.

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 was carried out by 2 inspectors.

Service and service type
Cockington House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cockington House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The provider had appointed a new manager. They had not started yet but we were told they will be putting an application in to be registered with the CQC. From 17 July 2023 an interim manager and area manager were appointed and were managing the home. For the purpose of this report, where interim manager and area manager have shared responsibility for areas of work, they are referred to as the management team.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We observed people and their interactions with staff and each other throughout the inspection visit. We spoke with 3 people, 3 relatives/representatives and 2 health and social care professionals to gain their views. We also spoke with 7 members of staff including the interim manager, area manager and 5 care staff. We reviewed a range of records, this included 3 care plans, 4 medicine records and 4 staff files in relation to recruitment. We reviewed a range of records relating to the management and oversight of the service, staffing, risk assessments, health and safety records. After the inspection we continued to receive and review health and safety records, information relating to training, and a range of policies and procedures.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Systems and processes to safeguard people from the risk of abuse

- Action had not always been taken when relatives or staff members had raised concerns to previous management regarding staff conduct towards people. A relative told us, "(For a) few years I have been concerned, and I did raise the concerns regarding [staff member] and [staff member] and [the management] did not do anything."
- Staff had completed safeguarding training, but it was not always effective. One staff member told us, "I have had safeguarding training online, I felt I learnt enough." Staff had recognised safeguarding incidents and reported them to the previous management. However, when no action was taken, staff did not ensure they reported the incidents to external agencies, such as the local authority safeguarding team. This meant staff did not follow their safeguarding training.
- Records did not always evidence that all safeguarding allegations had been recorded, investigated, and monitored. However, the new management team had put effective systems and processes in place to ensure people were protected from harm and abuse.
- The management team had held a staff meeting to discuss safeguarding concerns to ensure staff were aware of concerns raised and the changes they had made to protect people.

Assessing risk, safety monitoring and management

- Environmental safety checks had not always been completed. The fire risk assessment was completed by a staff member who had not received appropriate training and did not identify risks and concerns we identified at this inspection.
- We found weekly fire alarm testing and an asbestos report had not been completed. The legionella risk assessment had been completed, but the concern identified of ensuring the tank water temperature needed to be over 60 degrees was not actioned. We told the provider they must take action.
- Since our visit the management team told us they had booked external contractors to complete a fire risk assessment and an asbestos assessment. We were told weekly fire alarm checks would be completed and the water tank temperature would be checked and within the required range.
- Staff had not always followed people's behaviour care plan when people showed signs of distress or agitation. For example, we observed 1 person was distressed, the management team supported them and used distraction techniques and the person felt better. However, when a different staff member started to support the person, they did not follow the agreed strategies and the person became distressed again.
- The management team had reviewed and updated people's care records and risk assessments. This meant staff had update to date information and guidance on how to support people safely.
- People's care plans ensured the strategies to be used by staff were the least restrictive. Management told

us, "We updated the staff to ensure they are aware no-one living here requires the use of physical restraint. We have updated the care plans and told staff to use distraction strategies. Staff have completed restraint training, but this is to keep staff safe and only use the techniques to protect themselves."

Learning lessons when things go wrong
● The service did not have a culture of learning lessons when things went wrong. This meant measures were not put into place to reduce the re-occurrence of incidents.
● When incidents had been investigated there was no system or process to share lessons learnt with the staff team.
● The management team did take action and put things into place following areas of concerns highlighted by the local authorities last inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment
● Staffing at Cockington House has improved with the new management team in place. One staff member told us "We used to only have two staff on most weekends." But improvements have been made, and another staff member told us, "The staffing levels are now a lot better, and people are getting more one-to-one and two-to-one support. People are getting better care and the situation with the staffing is much better." Another staff member told us, "Now a lot better staffing there is 4/5 staff on each shift 7 days a week. People are able to do more activities and we can take them out more. Night shift is covered, and we have 2."
● The management team had used staff from other services and recruited new staff. Staff had been recruited and inducted safely.
● People's care records contained a clear one-page profile with essential information and dos and don'ts to ensure that new or temporary staff could see quickly how best to support people.

Using medicines safely
● People were supported by staff who followed systems and processes to administer, record and store medicines safely.
● Staff had completed medicines training. The management team checked staff competency to ensure staff were competent to support people with their medicines safely.
● A medicines audit had been completed by the management team and action was taken when discrepancies were identified.

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

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.

Visiting in care homes
The service supported visits in line with current guidance.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was not always a positive culture and people did not always receive person-centred care to enable them to achieve good outcomes. Records showed people did not participate in doing things they enjoyed. For example, a person had asked to go to bingo, but no action was taken to follow this up. The interim manager told us, "I am aware. I am inducting the new staff to ensure they are aware of people's support needs and once they are aware of how to manage risks, people will be supported to go out more and regularly."
- The provider had not taken appropriate action to ensure the service had always been adequately staffed. Records, staff, and relative feedback showed people had consistently not received their one-to-one or two-to-one support to enable them to have person- centred support. This meant people could not access the community and had not always participated in meaningful activities. A relative told us, "They are not doing things, before the home had a 7-seater vehicle and they use to go out. Now they just doing puzzles at home all the time and nothing for [person] to do."
- Concerns regarding staff culture had been raised and the provider failed to ensure appropriate action had been taken. We were told, "For years we have raised concerns to the management, and they have had staff names and what has been happening and [the provider] hadn't taken any action."
- The provider did not have an effective system or process in place to ensure managers and staff were always clear about their roles, had an understanding of quality performance and had managed identified risks.
- There was lack of provider oversight and poor governance systems. This meant people were not always kept safe and did not identify people had not received good quality care and support. Accident and incidents were logged but there was no monitoring in place to ensure lessons were learnt and measures were put into place to prevent similar issues arising again.
- Management audits were ineffective because they had not identified concerns, risks, and actions. For example, health and safety audit had been completed but environmental checks that had not been completed as required were not identified.
- Quality assurance arrangements were not in place. Relatives and staff told us they had not been asked to complete any feedback records or attend any meetings to obtain their feedback in relation to the quality of the service. Relative told us, "I've not been asked for a long time, they use to send them [quality questionnaires] years ago." And, "We use to have meetings, but that stopped when [name] became the manager."

The provider had failed to ensure the service's governance system were effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

● The current management team identified concerns regarding the culture within the service and spent time with staff and people discussing staff behaviours and values. They told us, "We found the home had been managed by staff and not the manager. We have addressed this and working with the staff to ensure the people who live here get the care and support they deserve and ensure staff are supported."
● We observed good interactions with staff and people. For example, during lunch staff spoke to people kindly and respectfully. People were given choices with what they would like to eat and drink.
● There was no registered manager in post at the time of the inspection. Two managers from other services were managing the service for 3 weeks and were aware of their role and had an understanding of managing risks and quality performance.
●The management team had plans of developing and implementing an effective governance system. They told us "We found there was no processes, so we have started to use the systems we have [at care home] because they work well. We are also developing a clear process for when the new manager starts to ensure things are done when they need to be, like supervisions, resident meetings, care plan audits and then we will be checking they have been done".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, continuous learning and improving care, 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 did not have a system or process for people, staff, relatives, and visitors to be involved in developing the service. No engagement was made to involve people in obtaining their feedback to improve and develop the service. For example, the providers policy was to have resident meetings monthly. We were told by the management team, "Resident meetings should have been happening but had not been completed. We have completed one since we have been managing."
● People, staff and relatives had made informal feedback. However, there was no record of the informal feedback, and no action was taken. This meant the provider failed to improve the service and use the information for continuous learning.
● The provider had not ensured there was a culture of continuous learning and improving care. For example, Staff were not given an opportunity to have supervisions and staff team meetings were not held. Supervisions and staff meetings provide staff members with an opportunity to reflect and learn from their practice, check competence, identify training needs and discuss concerns.
● Relatives were not happy with the lack of consultation and communication. Relatives told us, "(We have) not really been made aware of the changes within the home. [Staff member] said to me, do you know the manager has left. Didn't know [name] wasn't the area manager. [Person] does not like the change and feeling it and they have not told them."
● The provider failed to ensure all safeguarding allegations were investigated appropriately. For example, when people, staff or relative verbally raised concerns, these had not been recorded or investigated.
● People were not given the opportunity to speak up because the provider did not have systems or processes to ensure people could raise concerns or feedback. When relatives raised concerns on behalf of people, no action was taken to investigate the concerns. A relative told us, "When I've had concerns and raised them, I was made to feel [person] was making them up and it use to make me doubt myself. I didn't have leg to stand on because made me feel I needed hard evidence."
● Incident records did not show the provider had ensured acts on the duty of candour was followed.

The provider's quality assurance systems and processes were not always effective and had not enabled them 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

● The management team was committed to making improvements and delivering good care. Where issues were identified during the inspection the management team responded to these concerns.
● Staff felt they could now raise concerns and the new management team would listen and respond. Staff comments were, "[name] is really good and a good manager, very approachable and listens." "I can with [name] and I would say they are very approachable, and you can go to them, and it's dealt with." "Yea I would raise concern, yes especially now with the new manager. I haven't personal raised anything. They have come to me and asked questions and asked for my feedback."

Working in partnership with others
● The provider had not worked with health professionals to ensure people had their annual health checks. For example, people had not been for a dental check-up and there was no information to show when the last time they had a check-up.
● The management team were keen to work with health care professionals to improve the care they provided. They told us, "We are working on the action plan following the local authority visit and want to make the changes. We have found concerns and took action to ensure people are receiving care and support they deserve."

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 17 HSCA RA Regulations 2014 Good governance Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.