Corner House Residential Home Limited

Residential 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
Residential Care Home is a residential care home providing accommodation and personal care to five people with a range of needs, including learning and physical disabilities, mental health and sensory needs at the time of the inspection. Residential care home accommodates up to six people in an adapted building.

People's experience of using this service and what we found
We found the environment unsafe and parts of the building in need of refurbishment. This put the health and safety and well-being of people using the service at risk. Risk assessments lacked detail on how to mitigate the risks people faced. Staffing levels were insufficient to meet people's needs. Therefore, we could not be assured that people's need were always met. Recruitment practice was unsafe. This meant we could not be assured that staff employed were of good character and safe to work with people. Medicine management was unsafe. This meant we could not be assured that people received their medicines as prescribed.

There was no evidence of learning from accidents and incidents to drive changes and the provider did not identify the areas where improvements were needed to service delivery. Systems for monitoring the quality of the service were ineffective in identifying the issues found during our inspection. Audits were not routinely carried out.

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

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of key questions safe and well-led the service was not able to demonstrate how they were meeting some of the underpinning principles of right support, right care, right culture. The environment required modernising and did not enable people to have choice, control and independence. Care was not always provided in a dignified manner and people's human rights were compromised. The service lacked leadership and risk management. Leaders were not aware of their role in delivering the principles of right support, right care, right culture. We received mixed feedback from relatives about whether they felt their relative was safe living at the home. This meant we could not be confident people received appropriate care and support.

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

Rating at last inspection and update
The last rating for this service was good (published 30 December 2019)

Why we inspected
This inspection was carried out to follow up on concerns raised about safety, the quality of care, safeguarding 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 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 have found evidence that the provider needs to make improvements.

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.

We have identified breaches in relation to staff recruitment, staffing levels, medicine management and management of the service.

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 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? The service was not safe.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Residential 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.

Inspection team
This inspection was carried out by one inspector.

Service and service type
This service is a residential care home. It provides accommodation and personal care to people living at the service.

The service did not have a manager registered with the Care Quality Commission. It is a requirement of the providers registration to have a manager who would be legally responsible for running the service and for the quality and safety of the care provided.

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 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
People living at the home had complex needs, so we spoke briefly to four of the five people living at the home and two relatives about their experience of the care provided. We spoke with four staff members,

including the provider, senior support worker and two care workers. We reviewed a range of records. We reviewed medicine administration records for three people. We looked at staff files in relation to recruitment. We looked at records related to building safety, including gas safety checks and emergency lighting and health and safety audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, two care plans and associated risk assessments. We spoke with the local authority commissioning and safeguarding team. We spoke with a care worker and two relatives. We reviewed recruitment records for three staff members and documents related to the running of the service, including policies and procedures.

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 deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

- People were not always kept safe from risks to their health and wellbeing. Risks had not always been assessed and there was not always guidance to show staff how to reduce the risk of harm. For example, one person who had epilepsy and who required a hoist for transfers did not have risk assessments in place to manage these risks. A relative told us they did not feel their relative's risks had been appropriately managed in relation to their health needs.
- Risks related to people's safety in the event of a fire had not been fully assessed. Following a visit from the London fire brigade the provider was made aware of the concerns in relation to fire safety at the home. During our inspection we found people were put at risk of harm because the provider was unable to make the necessary improvements to keep people safe in the event of a fire. For example, one person who required two staff at night for transfer, was put at risk as only one staff member was on duty. The fire risk assessment sent to us and personal evacuation plans for people had not been updated.
- Medicines were not always managed safely. Care staff supporting people to take their medicines had received some training, but the provider did not have a system to check they were competent to administer medicines.
- There was lack of guidance for staff. They did not have information that described the reasons medicines had been prescribed, or any information which would alert staff to adverse reactions to keep people safe.
- Some prescribed creams were recorded but there were no clear instructions of how these prescribed creams should be applied. This meant there was a risk of incorrect administration.
- The provider did not have up to date protocols in place for medicines that were prescribed on an as and when required (PRN) basis. For example, PRN protocols for two people using the service were dated 1 August 2018 and 29 September 2018. These issues were highlighted by the senior support worker who addressed this at a staff meeting with the then manager. However, no further action had been taken to ensure these were updated. This put people at risk of not receiving their medicines when they needed it, including pain relief.
- Systems for dealing with incidents and accidents were not robust and did not show evidence of learning. Accidents and incident forms had been completed by staff, however they did not provide sufficient follow up information to reduce any further risk.

We found people were put at risk of harm because the provider failed to adequately assess risk and safely administer medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff understood risks posed to people and was able to give us examples of how these were managed.

● MAR charts were up to date and did not contain any gaps in signature.

Preventing and controlling infection
● We were not always assured the service followed good infection control practice.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises and making sure infection outbreaks could be effectively prevented or managed. For example, risks related to Legionella bacteria had not been assessed by the service and there had not been any regular testing to prevent the spread of bacteria. Therefore, we were not assured the provider followed good infection control practise.
● We were not assured the provider's infection prevention and control (IPC)policy was up to date. Despite our request for a copy of the IPC policy this had not been received. This meant we were not able to assess whether the policy was in place and reflected current guidelines, such as COVID-19.

We found people were put at risk of acquiring an infection because the provider failed to follow good infection control practices. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Relatives told us they observed staff wearing PPE during their visits to see their family member. One relative commented, "Staff had on aprons, they had a marquee in the back, we had to go and have the test before entering the house. We were also provided with gloves and aprons." Another relative said, "We go through the back door, they would test you; you wear a mask. All of them [staff] always have on mask and wear gloves and aprons."
● During our inspection visit we observed staff wearing PPE, such as masks and gloves. This helped to minimise the risk of the spread of infection.
● A staff member told us, "We wear PPE all the time, as you take it off, you put on another on, we have more than enough.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was using PPE effectively and safely.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
● Prior to our inspection we received concerns about staffing levels at the home being unsafe. During our inspection we found staffing levels were not sufficient to meet people's needs. For example, we found one person who required two people for transfers and for personal care who did not always have their needs met at night.
● The staff rota reviewed for week commencing 23 August 2021 showed two staff members were on duty during the day and one staff member provided a waking night from 6.30pm to 7.30am.
● Relatives told us there was sometimes only one staff member on duty. One relative told us the service had recently arranged waking night staff, which they felt should have been provided earlier given their relative's needs. Another relative told us, "In the morning there is two/three staff, in the evening it varies, one or two. Weekends from 6pm to 7am there is one staff. I think they need more [staff]."
● Staff told us there was not always enough staff on duty to meet people's needs. A staff member told us, "We was at a point where we had a staff shortage." This staff member told us after a staff member acted up as manager, they had become very busy with paperwork. We observed the staff member was very busy and appeared rushed during our inspection visit.
● The provider told us they did not use a dependency tool to assess staffing levels. Staff knew people and

used their support plan, progress notes and monitored changes in people's needs to decide whether they required one or two staff to provide care. Despite this, staffing levels continued to be insufficient to meet people's needs.

We found people were put at risk of harm because staffing levels were not sufficient 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.

● Recruitment procedures were not safely established, and appropriate checks were not carried out prior to applicants being employed.
● Staff files contained several gaps. Application forms were incomplete, for example, employment history not always fully completed, gaps in employment were not explored and references were not always verified or from a previous employer.
● The provider did not retain interview notes to show evidence of exploring and verifying applicant's ability to do the job. This meant we were not assured that staff employed were of good character and safe to work with the people they cared for.

We found people were put at risk of harm because the provider failed to follow safe recruitment practice. This was a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● We received mixed feedback from relatives about whether people who used the service were safe. One relative told us, "I'm not totally happy. The place was small. [The provider] had [reduced] the [size] of the front room to put in a new bathroom. All residents sat in the little front room watching telly.." Another relative told us they felt their relative was safe as they had lived at the service for many years and one particular staff knew and understood their relative which provided extra reassurance.
● The provider told us, staff completed safeguarding training and were aware of the reporting procedures. This was confirmed by staff. However, training had not always been provided by the service. Staff told us they had provided certificates for training completed with a previous employer.
● Staff knew the types of abuse to report and how to whistleblow and the external authorities they could report any concerns to, including CQC, local safeguarding authority and police. However, safeguarding notifications were not submitted to the CQC.

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 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

- The management of the service had been inconsistent for some time. Staff managing the service did not always receive the support they needed to ensure they fully understood their role and responsibilities.
- The service had not had a registered manager in post since the previous manager left on 31 January 2020. The provider had been absent for over a year and had appointed someone to manage the day to day operations of the service in February 2020. However, the provider told us they were not able to oversee the work carried out by the manager, who no longer worked for the service. The provider told us this had contributed to the issues identified during our inspection.
- Records related to care and staff recruitment were not accurately maintained to ensure they were fit for purpose. Risk assessments lacked detail and staffing levels were insufficient to meet people's complex needs.
- The service had not implemented care in line with right support, right care, right culture guidance. The guidance sets out that autistic people and people living with a learning disability can expect, amongst other things, to live a meaningful everyday life, have a choice about where to live, get good care and support from health services and get access specialist health and social care support in the community.
- The provider had not made the necessary improvements needed to the environment, in order to meet people's sensory and mobility needs. For example, people's bedrooms were not personalised and contained furniture that was dated, and the home required extensive redecoration and modernisation. The stairway was narrow and unsafe. There was a staff desk in the relatively small communal lounge area. These would not be in a private home setting, therefore limited the way people could chose the way they lived their lives on a daily basis. This meant people were not able to achieve the best possible outcome.
- Systems in place to audit the service were either ineffective or not in place. We found audits were not in place to monitor the quality of records related to people using the service and staff. Medicine audits were not routinely carried out to ensure errors and gaps could be identified. Policies and procedures contained out of date information, some had not been updated since 2018, This meant staff may not be up to date with the latest practice to effectively carry out their role.

People's health, safety and well-being were at risk because systems for monitoring the service were not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had a service improvement plan produced by the local authority. This had identified the

same concerns found during our inspection and actions to be completed by the provider. With the exception made to night duty to waking night, none of the remaining actions on the list had been implemented by the provider.

●The provider told us the service had been struggling financially for some time and they were no longer able to sustain the service. At the time of our inspection the service had given the local authority notice to close the home. The provider told us they did not want to put people using the service and staff at risk.

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 told us they understood the need to be transparent when things went wrong but was not aware of the duty of candour regulation. Management were not aware of their role in reporting and submitting notifications to CQC.

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; Working in partnership with others

● We received mixed feedback from relatives about how the service was managed. A relative commented, "I think things could have been better, use to feel like crying when I left [relative] behind. There was no interactions or stimulation." Another relative who spoke positively about the care their family member received told us, they felt the environment needed to improve to accommodate all the people who used the service.

● Relatives told us they had not been asked their views about the service and did not always feel able to approach management. One relative told us, "No, nothing like that." Another said, "I wasn't [asked]." This relative also told us they didn't feel able to approach a manager who they thought ran the service as they were, "Very defensive," and thought this staff member owned the home.

● The provider told us they last obtained feedback from people and relatives in 2019. Records reviewed confirmed this. This meant people's views and experiences may not have been acted on to help shape and improve the service and culture.

● The provider understood the importance of equality and providing a service that met the needs of people using the service. However, care records were not person-centred and did not always identify people's needs around diversity, such as preferences for care and physical health needs.

● The service did not always work in partnership with health professionals. One person with behaviours that challenged the service did not have input from a behaviour specialist. This meant staff the person did not benefit from healthcare input to enable staff to better meet their needs.

● Staff told us they generally felt supported by the current management. However, this was not the case in the past. Staff told us they received support from each other.