Minster Care Management Limited

Rydal Care Home

Inspection report

Rydal Road
Darlington
County Durham
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Tel: 01325369329

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03 August 2020
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26 August 2020

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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
Rydal Care Home is a nursing care home registered to provide accommodation for up to 60 people. The home is split into four units. Two of the units specialise in providing care to people living with dementia and the third was not in use. At the time of this inspection 46 people were living at the service.

People's experience of using this service and what we found
Risks which affected people's health, safety and wellbeing were not always documented. This meant that staff did not always have adequate information to manage and mitigate risks to people. Accidents and incidents had not been thoroughly recorded and action had not been taken to reduce risks.

Staff did not have access to adequate supplies of personal protective equipment (PPE). The service did not have enough infection prevention and control measures in place. Government guidance in relation to COVID-19 was not followed.

Prior to starting our inspection there had not been enough staff on duty to keep people safe. Staff had been unable to appropriately assist people to attend to their personal care. Just before and whilst we were inspecting the provider increased staffing numbers to the previous safe levels.

Whistle-blowers had made us aware a large number of staff had left the service prior to the inspection. The information the manager supplied about this was incorrect and we found more staff had left to what we had been told. The high staff turnover combined with the need to rapidly increase staffing levels to a safe number meant shifts at times had 90% of agency staff covering them. Permanent staff told us they hoped this situation was resolved quickly as it was stressful supporting high numbers of agency staff on a shift, who were not familiar with the needs of people who used the service.

The manager in post had failed to follow safe recruitment practices. Staff had not been trained to undertake their roles or in key areas such as falls prevention.

The manager had not ensured action was taken to ensure electrical works and repair faults on doors were carried out in a timely manner. We raised this with the provider's nominated individual, and they confirmed the repairs would be carried out immediately.

Safeguarding concerns had not been reported by staff and management. The manager who had been in post was not clear of their role and responsibility in relation to safeguarding.

Quality assurance processes were in place to monitor the quality and safety of the service, but these did not identify serious concerns we found and contradicted practice we observed. There was a clear lack of provider oversight and they had not ensured effective and competent management was in place.

Most staff members we spoke with raised concerns about the management of the service.

We did observe people appeared comfortable and happy with staff interaction with them.

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

Rating at last inspection
The last rating for this service was good (report published 20 February 2019.)

Why we inspected
We received information of concern from whistle-blowers and healthcare professionals about the new manager cutting staffing levels, which were leading to people being unsafe. Relatives raised concerns around people sustaining injuries, a lack of personal care and there not being enough staff. As a result, we carried out 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 substantial 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 Rydal Care Home 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 the safety of people and the risk of harm. We also identified breaches in relation to the management and monitoring of the service, recruitment, premises and staff training at this inspection.

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

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 continue to monitor information we receive about the service and we will continue to work with partner agencies. We will also request a specific action plan to understand what the provider will do immediately to ensure the service is safe. We will work alongside the provider and the local authority to

closely monitor the service. We will return to visit in line with 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?

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.

Rydal 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
The inspection team consisted of an inspection manager and three inspectors.

Service and service type
Rydal Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 solely legally responsible for how the service is run and for the quality and safety of the care provided. The manager who was in post left the service as we concluded the inspection.

Notice of inspection
We gave notice of the inspection on the day we visited due to current COVID-19 restrictions.

What we did before the inspection
We attended multiple safeguarding meetings held by the local safeguarding team and the local authority serious provider concerns meeting.

We reviewed information we had received about the service since the last inspection. We spoke with local safeguarding authority team members and service commissioners. We requested and reviewed documents we obtained from the home the week prior to the inspection. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people, eight relatives, the manager, clinical lead, residential lead, two nurses, CHAP (a healthcare assistant practitioner), three senior care workers, 10 care staff members, four agency staff both on inspection and after the inspection during telephone interviews.

We reviewed, eight care plans, Medicine Administration Records (MARS), four staff files and a variety of records relating to the quality of the service.

During staff telephone interviews, the inspectors received information raising concerns about the delivery of the regulated activity. These concerns were about the care of specific individuals and we have shared them with the local safeguarding authority for action and investigation where appropriate.

After the inspection
We requested further information from the area manager, quality and compliance director and nominated individual for the provider.

We shared the concerns we found with the local safeguarding team and various commissioning authorities of those people where we identified as being the highest risk.

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.

Assessing risk, safety monitoring and management
- Risks to people had not been appropriately managed.
- We found effective measures had not been put in place to manage the risk of falls and resultant injuries.
- Where risk assessments were in place these lacked detail and had not been routinely reviewed or updated. For example, one person did not have a risk assessment in place for the times they left the home without staff being aware, being unaccompanied and not being road safe.

The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had failed to ensure the home was well-maintained. In December 2019 the electrical installation report found significant remedial work was needed. This work had not been completed. Some of the fire exit doors were readily opened by people who used the service, and these had not been repaired.

The provider failed to maintain standards of the premises and equipment. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
- The manager had failed to recruit staff in line with legal requirements and the provider's procedures. The latest five employees' application forms did not provide information about their employment history, which meant references could not be validated. References had not been requested for all new staff and some were from staff who had also been recently recruited.

The provider failed to ensure suitably qualified, competent, skilled and experienced staff were employed. This is a breach of Regulation 19, (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not ensured staff had adequate knowledge of the service and risks to individual's health and wellbeing. For instance, new staff working as a CHAP had not received training for this role. Some people had difficulties eating but staff had not receive dysphasia training. The provider could not demonstrate catering staff had received the required food safety training.

The provider failed to ensure suitably qualified, competent, skilled and experienced staff worked at the service. This is a breach of Regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

● Prior to the inspection there had not been enough staff on duty to keep people safe. Staffing levels had been raised when CQC and the local authority commissioners raised concerns about people's safety.
● Over the course of six weeks a third of the staff working at the home had left. Subsequently when staffing levels were increased there were not enough permanent plans to cover then. This led to agency staff covering up to 90% of the covering shifts, which permanent staff told us was stressful.

Systems and processes to safeguard people from the risk of abuse
● The provider did not always keep people safe from the risk of abuse.
● Staff members concerns about alleged abuse had not always been fully investigated or alerted to the local authority safeguarding team.
● The provider had policies and procedures to deal with allegations of abuse and staff had completed safeguarding training, but a culture had developed where safeguarding concerns were not raised.
●. Staff had not ensured they worked in ways that kept people safe and were not overly restrictive. People who lacked capacity, had left the home via fire doors with faulty locks. Staff brought them back safely. Staff had not obtained deprivation of liberty safeguards for these people, fixed the doors, put measures in place to reduce the risks or reported these as safeguarding concerns.

The provider failed to ensure systems and processes were in place to keep people safe from the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control
● People were not protected from the risk of infection.
● During the height of the pandemic the manager had assured the CQC, the local authority and infection control nursing team in telephone discussions about how they were managing the risk of Covid-19, that they had appropriate supplies and were following government guidance relating to COVID-19 practice.
● At inspection however, we found the provider had failed to implement and follow COVID-19 guidance to reduce the risk of infection. For example, we saw insufficient supplies of Personal Protective Equipment for staff, staff were not following basic hand hygiene procedures and social distancing was not being followed.
● Infection control audits were in place. However, these had not identified the poor practice we observed and the lack of PPE we found.

The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Systems and processes were not in place to ensure lessons could be learnt when things went wrong.
● Accidents and incidents had not been fully recorded or investigated by management.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines had been administered safely. At the last inspection there were no issues raised around the

administration of medicines. During the inspection we found staff continued to administer medicines in line with expected practices.

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; Continuous learning and improving care

- The manager did not ensure quality performance, risk and regulatory requirements were met.
- Quality assurance processes were in place and were carried out, but they were not effective. The systems either failed to identify issues or if identified did not enable staff to rectify them. The lack of systems and processes in place to identify concerns or shortfalls within the service placed people at increased risk. For example, the shortage of staff and lack of training relating to falls prevention contributed to the increase in falls people were sustaining.
- Investigations and auditing of incidents and accidents were not always robust, fully completed or managed appropriately to mitigate future risks to people.
- The provider failed to ensure there was effective and competent management arrangements in place. They had a lack of oversight of how the service was being run. They did not have adequate monitoring systems to identify significant shortfalls within the service.

The provider failed to ensure systems and processes were in place to assess, monitor and improve 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

- A person-centred culture was not promoted. Some staff told us they felt unable to raise concerns as they felt their confidentiality would not be upheld.
- Staff did not feel supported within their roles. They had not been provided with enough training to ensure they had the skills and knowledge they needed. They expressed concerns over the lack of management within the service.
- There was not consistent leadership for the staff team. At the start of the COVID-19 pandemic, the manager was not in post and left the role when we were completing the inspection.

The provider failed to ensure staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This is a breach of Regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 manager had not been responsive to issues and concerns. They had failed to be open, honest, and apologise to people when things went wrong.

● The manager failed to report concerns in relation to COVID-19 to the local authority in a timely manner to enable appropriate, additional support to be provided.

The provider failed to seek and act on feedback provided or concerns raised. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The service had not engaged with partners. Professionals visiting the service and relatives expressed concerns over the care and support people were receiving.

● The service had been offered support throughout the COVID-19 pandemic from the CQC, the local authority and infection and prevention control nurses. All partners were led to believe from the manager there were no issues with the service understanding and following guidance and having the appropriate supplies such as PPE.

● The manager introduced care plans and risk assessments, which only contained basic information. This meant people's views and preferences about how they wanted their care to be given were not always taken into consideration.

● The manager did not listen to concerns raised by staff and others when reviewing the service. This led to their approach being inflexible and the continuation of practices, such as reducing staffing levels despite being made aware this was unsafe.

The provider failed to ensure the care and treatment was appropriate, met people's need and reflected people's preferences. This was a breach of Regulation 9, (person-centred care), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the care and treatment was provided in a safe way . Regulation 12(!)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes were in place to protect people from the risk of abuse. Regulation 13(1) and (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises properly maintained. Regulation 15(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure persons employed for the purposes of carrying on a regulated activity were of good character, had the

qualifications, competence, skills and experience which are necessary for the work to be performed by them, and could properly perform tasks which are intrinsic to the work for which they are employed.

Regulation 19(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have systems or processes in place and operated effectively to ensure compliance with the requirements. Regulation 17(1)

The enforcement action we took:

We issued a warning notice.