Swillbrook Limited

Coote Lane Residential Home

Inspection report

Coote Lane
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Preston
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Tel: 01772312152

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Coote Lane Residential Care Home is a residential care home providing accommodation and personal care for up to 24 people aged 65 and over. There were 17 people living at the service at the time of the inspection. Some of the people lived with dementia and required support with their physical needs.

People's experience of using this service and what we found
People told us they felt safe and staff were kind and caring. However, our observations showed that people did not always receive safe care and treatment. Staff had not reported safeguarding concerns to safeguarding authorities including repeated and unexplained injuries. People's safety had been compromised due to the lack of adequate falls reductions measures being put in place. Risks to people were not always reviewed to identify ways to reduce repeat occurrences. People were at risk of harm from equipment and premises that were not inspected and maintained regularly. Risks of the spread of infections were not managed appropriately. People were offered their medicines in a safe manner however; improvements were required to the safe storage of medicines and record keeping.

People were not supported to have maximum choice and control of their lives and staff did not 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. People told us staff sought their preferences, however, people's ability to make decisions and to consent to care and treatment had not been assessed. The registered provider had not followed national guidance and best practice to support the effective delivery of care. People were not always supported by staff who had the right competences, induction and supervision to meet their needs. Staff supported people to have access to health professionals and specialist support. People were not offered a variety of choice on their daily meals.

The governance and quality checks in the home did not promote the delivery of safe care and treatment. The registered provider had not established good governance in line with best practice to improve the care delivered and to ensure compliance with regulations. There were no established policies to promote the effective delivery of care. The registered provider had not established robust oversight to support staff on the running of the service and compliance with regulations and to monitor people's experiences.

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 the service under the previous provider was Good, published on 2 November 2018. This is the first inspection of the service under this new provider.

Why we inspected
We received concerns in relation to the management of falls and safeguarding concerns. As a result, we undertook a focused inspection to review the key questions of safe, effective 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.

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 keeping people safe from preventable harm such as repeated falls, risk of fire, responding to changes in people's needs, the safe maintenance of equipment and premises, seeking consent and poor governance at this inspection. 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? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Coote Lane Residential 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
Two inspectors carried out the inspection.

Service and service type
Coote Lane Residential 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 had no manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including information from the provider about important events that had taken place at the service, which they are required to send us. We sought feedback from the local authority. 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
We spoke with four people who lived at the home about their experiences of the care provided. We spoke with three members of staff including the acting manager, a senior carer, maintenance man who was also working in the kitchen on the day of the inspection. We also spoke to the director who is the nominated individual for the service. We reviewed a range of records. This included six people's care records, multiple medication records, one staff recruitment record and we looked at a variety of records relating to the management of the service. We spoke to one visiting professional.

After the inspection
We continued to seek clarification from the manager and the nominated individual to validate evidence found. We looked at training data and quality assurance records and sought feedback from health and social care professionals.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- People were not protected from the risk of harm because there were poor arrangements for assessing, reviewing and monitoring risks associated with repeated falls. Whilst staff sought medical attention following falls, we found a significant number of incidents where people had experienced repeated falls and head injuries. However, risk assessments had not been reviewed to established ways to reduce the falls or to consider whether the service continued to be suitable to manage the risks.
- There were no robust arrangements to monitor risks associated with nutrition and choking. Referrals were made to external professionals for specialist guidance. People's weights were recorded to track people's weight and the risk of unintentional weight loss.However, staff were not always aware of people's nutritional needs including those who lived with diabetes and the specific diet they required.
- The provider had not protected people from the risks associated with fire. Firefighting equipment such as fire extinguishers and emergency lighting had not been inspected and serviced in line with manufacturers guidance to ensure they would work as expected in the event of a fire. In addition, the fire risk assessment had not been reviewed to ensure identified actions to reduce the spread of fire had been carried out. We shared our concerns with the local fire and rescue service.
- The provider had not carried out health and safety maintenance checks on the premises and the equipment used to deliver care in line with national guidance and manufacturer's recommendations. This included, the boiler and the passenger lift. In addition, equipment used to lift and transfer people such as hoists, standing aids, profiling beds and a bath lift had not been serviced as recommended. Staff could not be assured the equipment they were using were safe.
- The floors and carpets in one part of the home were worn and in need of repair to prevent the risks of trips and falls. The provider informed us they had plans to carry out repairs and had been delayed by the pandemic. However, a majority of the maintenance and inspections had been overdue before the pandemic started.
- People were not adequately protected against the risk of infection. While staff were observed wearing personal protective equipment (PPE) and the home was visibly clean, there were no regular infection prevention audits carried out since August 2019. People's bedrooms did not have handwashing facilities such as soap and hand towels. The provider had not followed national Covid-19 guidance and establish protocols in a number of areas. These included, having Covid-19 guidance for staff, welfare monitoring checks, cleaning protocols, and new admissions protocols. While there were no known positive cases of Covid-19 at the time of our inspection, the practices in the home exposed people to risk. We referred the home to the local Public Health authority and the provider took immediate action to address some of these concerns.

There was a failure to assess the risks to the health and safety of service users. There was also a failure to

ensure premises and equipment were properly maintained, including maintaining standards of hygiene appropriate for the purposes for which they were being used. These were breaches of Regulation 12 (Safe care and treatment) and Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Staff did not understand their responsibilities to protect people from avoidable harm or abuse. They failed to report incidents of repeated injuries, falls during moving and handling procedures and unexplained injuries to the local safeguarding authority. These are now subject to a whole service safeguarding investigation by the local authority.

● The provider had not established protocols for facilitating staff to review and learn from incidents and near misses and enable them to improve practices and reduce repeated incidents such as falls. There was a lack of scrutiny and oversight on accidents and incidents in the home.

There was a failure to report safeguarding concerns to authorities. This was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Improvements were required to the medicine's management practices in the home. Topical creams were not stored safely to prevent misuse. We found one person had paraffin based topical creams that had not been prescribed them which could expose them to the risk of fire. People's medical records did not always accurately reflect when they had an allergy to a specific medicine.

● The provider and their staff failed to ensure sufficient equipment and/or medical devices that are necessary to meet people's needs were available at all times. Staff had failed to order catheters for one person despite being prompted to do so by a health care professional.

We found evidence that people's welfare had not been significantly affected by unsafe medicines administration practices, however, systems were either not in place or robust enough to support safe medicines management. 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

●The provider ensured there were enough staff who had been safely recruited to support people with their assessed needs. We observed, staff responded to people's requests for support promptly. However, one person told us this was not always the case and at times they had to wait for long periods to get assistance from staff.

● The provider followed safe recruitment procedures to make sure staff were of a suitable character to work in a care setting.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs, and choices were not effectively assessed and reviewed. The provider had not assessed people's changing needs. This included the lack of assessments when people had been discharged from hospital with increased needs and when people had experienced falls.
- The provider did not have arrangements in place to facilitate the delivery of care and treatment in line with legislation, standards and evidence-based guidance, including the Health and Safety Executive, National Institute for Health and Care Excellence (NICE) and other expert professional bodies, to achieve effective outcomes. This included areas such as Covid-19 guidance, care planning, falls prevention and review of care needs.

Ensuring consent to care and treatment in line with law and guidance
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 Act requires 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

- The provider and staff did not consistently work within the principles of the MCA. People's capacity to make decisions was not assessed or recorded. There were no mental capacity assessments or best interest decisions for the use of equipment such as bedrails where this was required to maintain people's safety. In addition, there was no evidence to show how deprivation of liberties had been considered to ensure restrictions on people were lawful.
- We observed staff speaking with people and gaining their consent before providing support or assistance. However, we noted consent was not recorded in the records we reviewed. This included consent to photography and storage of medicines.

There was a failure to ensure care and treatment was provided with the consent of the relevant person. This

was a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People had been referred to various specialists including dieticians and mental health professionals. However, there was a lack of consistent approach in monitoring people's changing needs and staff were not always aware of the changes they needed to monitor and how to identify concerns with specific needs such as medical attachments.

● People were not adequately supported with their oral health needs and mouth care. We found toothbrushes that were dry and stored away with no indication that they had been regularly used. Daily records and oral care records did not show staff were regularly considering and supporting people with their mouth care.

● We identified people whose needs could not be safely met in this home and shared our concerns with other health professionals who took immediate action to assess and facilitate transfer to more suitable placements.

Staff support: induction, training, skills and experience

● Staff were not adequately supported with induction into their roles, responsibilities and regular supervision. Staff were not always provided with induction at the beginning of their employment. This also included when they were appointed to take leadership roles.

● Staff had not received supervision or appraisals from either the provider or the manager to support them in their roles.

● Staff had completed online training in a number of areas, but there was a lack of competence checks in areas such as moving and handling, first aid and medicines management. The provider could not be assured that staff had achieved the right levels of competences following completion of e-learning.

There was a failure to ensure that all staff had received appropriate support and training to enable them to carry out the duties. This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People gave us mixed responses regarding the food choices they were provided with. Comments from people included, "The food is alright, I just don't like big portions." However, another person told us, "There is only one choice to choose from, I know I can ask for something else but I tend not to bother so I end up eating what they give me." The manager told us they were aware of this issue and had planned to address this before our inspection.

● People's weight and nutritional intake was monitored. Referrals were made to healthcare professionals and ongoing risks of unintentional weight loss were monitored.

Adapting service, design, decoration to meet people's needs

● As described in the question 'Is this service safe?', the homes' design, maintenance and decorations were not adequately maintained to meet people's needs. This included the lack of adequate numbers of accessible call bells in the communal areas to allow people to summon for help. One person told us; "I like sitting in the lounge with others but I am avoiding it because I don't like the idea of sitting there shouting for staff to help me to get to the toilet, you have to shout them and it's embarrassing."

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

This is the first inspection for this newly registered service. This key question has been rated 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 provider, managers and staff were not clear about their roles. There was no registered manager employed and an acting manager had been appointed. However, there had been a lack of clear direction and understanding of quality in the home. Staff had not been provided with robust leadership and oversight on the day to day running of the home by the provider. Instances of poor practices had not always been identified or challenged which resulted in the deterioration of the standards of care provided.
- The provider's quality assurance systems were inadequate. Although there was a system for reporting to the nominated individual, governance systems were not fit for purpose. There were no organisational policies and procedures to provide staff with operational guidance and direction. The provider had failed to effectively implement robust systems to support the continuous monitoring and improvement of people's experiences and the care and provided.
- The provider had failed to address shortfalls and areas of non-compliance with regulations in a timely fashion to ensure prompt action was taken. Where audits had been carried out, the findings were not used to improve the safety and quality of care.
- Systems for learning from incidents and near misses had not been implemented which meant staff could not demonstrate whether they had reviewed what could be learned from incidents and events to reduce re-occurrences. This led to repeated themes of falls and injuries to people in the home.

There had been a failure to assess, monitor and improve the quality, safety and welfare of service users and others who may be at risk. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider's governance arrangements and the culture in the home did not promote the provision of high-quality, person-centred care and transparency. Systems for supporting staff including inductions, supervision and appraisals were not implemented to support the delivery of safe care.
- The provider had not submitted statutory notifications to the Care Quality Commission and a significant number of concerns and safeguarding concerns had not been shared with the local authority. In addition, information provided by the home's management with us during the Emergency Support Framework assessment of the service was found to be inaccurate and we observed not to be in place during the inspection visit. This meant that we could not undertake our regulatory function effectively.

This was a potential breach of regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009.

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

- The manager told us they encouraged feedback from people to improve the home and had planned a meeting. The provider informed us they had carried out a meeting to inform people of changes in management. However, we found no evidence of any other meetings with people or their relatives from August 2019 when the provider took charge of the home. This included people and staff surveys to show how the provider had engaged with people and staff.
- The provider had not established policies and procedures to ensure peoples equality characteristics of disability in respect of dementia care were being considered and supported in line with the law and their needs.
- The manager had developed close links and good working relationships with a variety of external professionals.

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 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to seek people's consent to care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way for service users and failure to assess the risks to the health and safety of service users of receiving the care or treatment; including doing all that is reasonably practicable to mitigate any such risks; There was a failure to ensure that the premises used by the service provider were safe to use for their intended purpose.; Failure to ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; Failure to ensure equipment or medicines are supplied in sufficient quantities to ensure the safety of service users and to meet their needs; Failure in assessing the risk of, and preventing, detecting and controlling the spread of, infections.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to safeguard people from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure premises and equipment were properly maintained, including maintain standards of hygiene appropriate for the purposes for which they were being used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not robust and there was lack of robust oversight on the regulated activity. The registered provider had failed to assess, monitor and improve the quality and safety of the services provided. The provider failed to establish systems and processes enable them to identify where quality and/or safety was being compromised and to respond appropriately and without delay.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure staff were suitably qualified and competent to make sure that they can meet people's care and treatment needs.