Navigation Care Limited

Rushall Care Home

Inspection report

204 Lichfield Road
Walsall
West Midlands
WS4 1SA

Tel: 01922635328
Website: www.navigationcare.co.uk

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08 December 2020
09 December 2020
22 December 2020

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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

About the service
Rushall Care Home is a residential care home providing personal and nursing care to 35 people aged 65 and over, at the time of the inspection some of whom were living with Dementia. The service can support up to 39 people.

The home is set over three floors with access to all floors through a lift. There are communal areas on each floor for people to access.

People's experience of using this service and what we found
Whilst many aspects of medicine management were safe, we determined that further improvement was needed in some areas.

People had not received a service that was consistently well led. Whilst there were systems to monitor the quality and safety of the service, we found these needed further improvement. There was a new manager at the service who had identified these improvements were needed. Further time was needed to enable the planned improvements to be put into practice.

People were supported by staff who were knowledgeable about how to recognise and escalate safeguarding concerns. Staff were recruited safely and there were systems in place to determine safe staffing levels.

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 01 December 2018)

Why we inspected
We received concerns in relation to the management of pressure care and infection control practice. 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 requires improvement. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement.

You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

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?

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 well-Led findings below.

Rushall 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.

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 site visit was carried out on 08 December 2020 by one inspector and a nurse. The nurse had specialist knowledge of the needs of the people living at the home.
An assistant inspector carried out phone calls to relatives on 09 December 2020.
Inspection activity started on 08 December 2020 and finished on 22 December 2020 due to continued analysis of the evidence sent to us.

Service and service type
Rushall Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not currently have a manager registered with the Care Quality Commission. The manager has stated their intentions to apply to be the registered manager at the service. The service did have a provider who was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We informed the service of the inspection shortly before entering the building because of the risks associated with COVID19. This meant that we could discuss how to ensure everyone remained safe during

the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We reviewed what our intelligence about the service was telling us. We sought feedback from the local authority. All of this information was used to help us plan our inspection.

During the inspection-
We spoke with six members of staff including the manager, deputy manager, one nurse, care workers and the activities coordinator.
We reviewed a range of records. This included ten care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. We observed care practice being provided due to the need to conform to social distancing requirements.

After the inspection –
We spoke with seven relatives to seek their views of the service. We continued to review care plans, quality assurance records and policies. We continued to seek clarification from the manager to validate evidence found.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

Using medicines safely

- Whilst most medication was given safely, we found issues with two areas of medication management that needed improving.
- One type of medication we reviewed required a medicinal patch to be placed on a different area of the body to prevent skin irritation. We found there was no record of this patch rotation since September 2020. In addition, one of the records for one person indicated that patch rotation hadn't occurred. We raised this with the manager who has taken action to put a system in place to record the rotation of patches for people following our inspection.
- Another medication we reviewed was being given covertly (hidden) as needed. There had been no written authorisation sought from the GP regarding this. We were shown evidence that this has now been actioned and the correct authorisation is now in place following our inspection.

Systems and processes to safeguard people from the risk of abuse

- People were supported by staff who understood how to recognise safeguarding concerns and the appropriate action to take should these occur. One staff member told us, "The first thing is to keep these [people] safe."
- The manager had made appropriate referrals to the safeguarding teams where required. Learning took place following any safeguarding concerns to reduce the chance of a similar event occurring again.
- Relatives told us they felt their family member was safe living at the home.
- We observed one person requesting support. We saw that staff were able to respond to the persons request and provide reassurance. In another example we saw staff supporting people with their meals. People appeared relaxed and comfortable with the staff supporting them.

Assessing risk, safety monitoring and management

- Checks were carried out to ensure equipment was safe for people to use.
- Staff we spoke with were aware of the risks associated with peoples care and how to support them safely.
- One relative we spoke with described action the service took to ensure their family members medical condition was managed safely. This involved different members of the staff teams such as the kitchen staff and nurses at the home.
- Prior to the inspection we had received concerns about the management of pressure areas. The service had been receiving support from external healthcare professionals to review people's existing pressure areas. We saw that there was documentation and monitoring in place around those people who had pressure areas.

Staffing and recruitment

● There were systems in place to ensure staff were recruited safely. This included obtaining a Disclosure and Barring Service check (DBS) to ensure staff recruited were suitable to work at the service.

● We saw there were sufficient staffing levels to support people living at the service. Staff told us, "We work as a team and help each other."

● There were tools available to determine safe staffing levels at the service. The manager informed us that these were reviewed when people's needs changed.

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 meeting shielding and social distancing rules.

● 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 accessing testing for people using the service and staff.

● 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.

Learning lessons when things go wrong

● There were systems in place to review incidents and accidents on an individual basis to reduce the chance of a similar incident occurring again.

● Analysis of trends in incidents and accidents across the home occurred to determine whether any further action could be taken to mitigate risks to people.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems to monitor medicine management had not identified the concerns we found at the inspection.
- Systems had not identified the requirement for more specific detail in people's Covid 19 risk assessments.
- Systems in place had not identified that peoples care records needed further information. For example, we found further instruction was needed around how to support people to mobilise safely. In another example, we found further detail was needed around how to support a person with their constipation.
- Monitoring systems had not identified that an incident report had not been completed relating to a skin tear.
- There was an electronic system in place to record people's daily care. Prior to the manager starting at the home this had not been used consistently. Whilst work had been carried out to improve staff recordings on this, further improvement was needed to ensure peoples daily care needs had been consistently documented. This would enable improved monitoring and escalation to other care professionals when people's needs changed.
- The providers oversight had not identified the concerns at the service and whilst there were monitoring systems in place these needed to become more robust to ensure the quality and safety of the service could be monitored more effectively.

We found no evidence that people had been harmed however, the systems in place to monitor and improve the quality of the service were not robust. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There has not being a registered manager at the service since August 2020. The current manager started working at the service in August 2020 and has stated their intentions to apply to become the registered manager.
- The new manager had identified a number of areas that needed improving at the service. They informed us about work that had taken place to review and improve a number of the systems at the service but needed further time to ensure these planned improvements could be implemented.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives we spoke with were complimentary of the staff team that supported their family member. One relative told us, "Can't speak highly enough of the staff at Rushall." Another relative told us, "The staff have been brilliant."
● Staff we spoke with knew people well. They were able to inform us of people's preferences for care and what was important to them.

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 understood their responsibility to notify us of specific events that had occurred at the service.
● The manager was open about the further improvements that were needed at the service.
● Following the inspection, we received some concerns about the conduct of some members of the staff team. We have asked the manager and provider to respond to these concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us they felt supported in their roles and that they were able to make suggestions for improvements. One staff member told us, "If I have any problems or concerns, I can talk to him [the manager] and he will listen." Another staff member told us, "[Name of manager] supports us more and I feel I can go to him with problems and he will listen."
● The service had adapted communication between relatives and people living at the home due to visiting restrictions being in place. Relatives told us they felt involved in their family members care. This was particularly important as relatives had not been able to visit the home consistently due to Covid 19 restrictions.
● A number of people living at the home were being cared for in bed. There had been consideration of how to seek these peoples views and questionnaires had been completed due to these people not being able to attend meetings.
● During the initial restrictions imposed by Covid 19 a number of people isolated in their bedroom. Work had been carried out, alongside professionals to encourage these people to integrate back into home life following the restrictions been eased.
● The manager had introduced daily meetings with key staff working in the home to enable communication about any changes to occur. This enabled better communication between different staff teams and enabled staff to keep up to date with peoples changing needs.

Working in partnership with others
● The manager informed us that when they started working at the service all of people's healthcare needs had been reviewed. This had been in conjunction with specialist healthcare professionals such as occupational therapy and speech and language therapists.
● There was continued support available from the local authority and healthcare professionals such as tissue viability nurses and also included weekly GP rounds. This partnership working enabled people to receive the healthcare they needed.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were effective and robust systems in place to monitor the quality and safety of the service. Regulation 17 (1)(2)(a)(b)(c).