Mrs Kerry Ann Davies

Carden Bank Rest Home

Inspection report

16 Belvedere Road
Burton On Trent
Staffordshire
DE13 0RQ

Tel: 01283563841
Website: www.cardenbank.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:

Carden Bank Rest Home is a residential care home that was providing personal and nursing care to 14 people aged 65 and over at the time of the inspection.

People's experience of using this service:

People had been placed at harm because medicines were not administered in a consistent and safe manner, which meant people did not have their medicines as prescribed. People were not safeguarded from abuse because staff had a poor understanding of the signs of abuse and their responsibilities to report suspected abuse. Risks to people's health and wellbeing were not consistently identified, managed or risk management plans followed to keep people safe.

There was a lack of governance and leadership in the service and the provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not identified and rectified by the provider exposing people to the risk of harm.

There were not enough staff available or effectively deployed to provide support in an unrushed way and to meet people's emotional needs. Staff had not received effective training and support to support people in an effective and safe way. Competency checks were ineffective in identifying poor practice.

The culture within the home did not promote openness and people did not always feel able to complain about their care. The provider did not have effective system in place to learn when things went wrong, this meant areas of poor practice continued.

People did not always feel cared for and there was a lack of stimulation to maintain their emotional and mental health needs.

People's nutritional needs were monitored and managed. Advance planning was in place to ensure staff were aware of people's wishes if they became unwell. People were supported to access health professionals.

Rating at last inspection:

Good (report published 22 July 2017).

Why we inspected:

This inspection was brought forward and was completed in response to information of concern we had

received from the local authority. We needed to check that people were supported safely and whether the provider was meeting the Regulations.

We found concerns during the inspection and there were breaches in regulations. We rated the key questions safe and well led as inadequate. The key questions Effective, Caring and Responsive were rated Requires Improvement. The overall rating is Inadequate.

Enforcement:

Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up:

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.

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

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.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Carden Bank Rest 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

The inspection was carried out by two inspectors.

Service and service type:

Carden Bank Rest Home is a care home that accommodates up to 14 older people who may be living with dementia. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Carden Bank Rest Home supports people in one adapted building. At the time of the inspection there were 14 people living at the service.

There was not a registered manager at the service because this was not a condition on the provider's registration. The provider managed the service and they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The inspection was unannounced.

What we did:

We used the information we held about the service to formulate our planning tool. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, safeguarding concerns, serious injuries and deaths that had occurred at the service. Before the inspection we contacted commissioners to gain their experience of working with the service.

We spoke with five people who used the service and one relative. We observed care and support in communal areas to assess how people were supported by staff. We spoke with six care staff, a volunteer and the provider.

We viewed five people's care records to confirm what we had observed and staff had told us. We looked at how medicines were stored, administered and recorded for 10 people. We also looked at documents that showed how the home was managed which included training and induction records for staff employed at the service and records that showed how the service was monitored by the provider.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely

• People were at risk because staff did not administer or record medicines safely and people did not receive their medicines as prescribed.
• Some people were prescribed 'as required' medicines. These were medicines that people only needed at certain times dependent on their condition. We found there were no protocols in place to give staff guidance on when people needed these medicines and we saw people had not received their 'as required' medicines in line with their prescriptions.
• People had not received their medicines to manage their pain or medicines required within specific time limits for conditions such as; Parkinson's disease. This meant that people were at risk of continued pain and a deterioration in their health and wellbeing.
• People were not administered their medicines in accordance with the Medicine Administration Records (MARS). For example; we saw a person was given a medicine in the morning that should have been administered at night. We found the member of staff had not administered this medicine as per the instructions on MAR. We prompted the senior staff member to contact the GP for advice about this medicine error because it had not been identified by the provider or staff that the person was at risk of harm.
• The stock held at the home did not consistently match the amounts recorded on the MARs, which showed people had not received their prescribed medicines. For example; one person had not received three of their prescribed medicines, although the staff member had signed the MAR to show this had been administered. Another person had not been administered 12 tablets, although the MAR had been signed to show this person had been administered this medicine.
• Staff were not competent in medicine administration. Competency checks of staff were completed by a volunteer who did not have up to date training to ensure they had the knowledge and skills to carry out this role.
• Due to the serious risks to people we contacted the Local Safeguarding Authority to inform them of our concerns.

Assessing risk, safety monitoring and management

• People were not consistently supported to minimise their risks. Charts to monitor people's conditions such as pressure areas had not always been completed, which placed them at risk of a deterioration in their condition.
• People were at risk of unsafe care because staff were not following safe moving and handling techniques. We observed staff assist one person to move using a hoist. The sling to lift the person was twisted and there was a risk of causing damage to this person's frail skin.
• Staff did not always ensure that call bells were available to people to enable them to call for assistance. We

saw that call bells were not always accessible to people when they were in their rooms. This meant people were at risk of not receiving support when they needed it.
• People's behaviours that may challenge were not managed and monitored. There were no behaviour charts in place for people, although their risk assessments stated that staff needed to monitor and record people's behaviours for signs of deterioration.

The above evidence shows a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

• People were not protected from the risk of abuse because staff did not have the knowledge and skills to ensure people were safeguarded from harm. Staff were unable to clearly explain scenarios that may be identified as abuse.
• There was not a clear structure in place to ensure staff understood who was responsible for referring concerns to the local safeguarding authority.
• Staff had started to complete body maps where bruises had been identified. Where these were unexplained staff had not reported these directly to the provider or senior member of staff. For example; one person's body map stated that they had scalds on their leg and arm but there had been no investigation into how this had happened and this had not been referred to the local authority.
• The provider did not have a system in place to monitor body maps, which meant investigations had not been completed and referrals had not been submitted to the local safeguarding authority.

The above evidence shows a breach of Regulation 13 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

• There were not enough staff available to consistently meet people's physical and emotional needs. Most people had their physical needs met, such as being assisted with personal care. However, we saw one person waited for a period of three hours before being supported to use the toilet. The inspector had to speak with the provider to ensure this person was supported to use the toilet.
• People told us staff did not have time to chat with them and we saw staff were rushed and did not have time to interact with people in a meaningful way. One person said, "I am bored. It would be lovely to be able to chat with staff but they don't have time. They are always rushing about".
• The provider did not have a staffing tool in place to ensure there were enough staff available to meet people's physical and emotional needs. This meant there was not a system to regularly review and update staffing levels against people's changing needs.

The above evidence shows a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had followed safe recruitment procedures to ensure staff were of a suitable character to provide support to people.

Preventing and controlling infection

• Improvements were needed to ensure that cross infection was minimised. People were supported to move in shared wheelchairs, which we saw were unclean. Other equipment to move people such as a rotunda and

hoist were also unclean. People who needed to be moved using a hoist had been provided with their own slings. However, staff told us they shared the slings to move people. This put people at risk of cross infection. The environment was clean and there were no mal odours present at the inspection.
Staff wore gloves and aprons when they supported people in line with infection control procedures.

Learning lessons when things go wrong

• The provider had started to implement some changes from feedback received from professionals. However, they did not have effective systems in place to proactively identify concerns and learn lessons when things went wrong.

Requires Improvement

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

RI: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations were not met.

Staff support: induction, training, skills and experience

• Staff did not have the sufficient skills and knowledge to support people effectively. Although staff had received training this had not been effective. Staff were not competent in the handling of medicines, assisting people to move and recognising and reporting safeguarding which had placed people at risk of harm.
• The provider did not have an effective system to ensure staff were competent and understood the training provided.

The above evidence shows an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

• People's needs had been assessed prior to using the service. However, information gained had not consistently been used to ensure care plans had sufficient information for staff to follow.
• Care plans contained details of people's religious needs and how the service needed to support people to maintain this part of their lives. However, improvements were needed to ensure other areas of the protected characteristics of the Equality Act 2010 were also gained from people to enable personalised support in all areas of their care.
• Improvements were being made to the care plans at the time of the inspection. These had not been fully completed or imbedded into the service. We will assess this at our next inspection.

Staff working with other agencies to provide consistent, effective, timely care

• Improvements were needed to ensure people received consistent care. Staff told us they had a brief verbal handover at the start of their shift. There was no record of the handover for staff to refer to and there was a risk that important information about people would not be passed over to the next members of staff on duty.

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

• The service had been adapted to meet people's needs. There was equipment available to ensure people were safe when moving around the service.

• There were signs in the building to aid people's orientation so they could access their bedrooms and toilets independently.
• Some improvements were needed to ensure there was a regular maintenance/decoration plan in place where areas had become worn or damaged.

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 that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• Mental capacity assessments had been completed. However, improvements were needed to ensure people's mental capacity assessments related to specific decisions that needed to be made.
• 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 had the appropriate legal authority and were being met.
• . The provider had referred people for DoLS where they considered a restriction was in place and were awaiting assessments to be completed.

Supporting people to live healthier lives, access healthcare services and support

• People told us they had access to health professionals when they were unwell. One person said, "I have seen a doctor when I have felt unwell."
• Records showed that people had been visited by G. P's, district nurses, dieticians and the falls team to ensure people's health needs were monitored.
• Advice provided by healthcare professionals was followed by staff which ensured people were supported effectively to maintain their health and wellbeing.

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

• People told us they enjoyed the food. One person said, "The food is good, we can choose something else if we don't like what is on offer".
• People's nutritional risks were managed and monitored. Staff had followed advice when people's food needed preparing in a specific way to protect them from the risk of choking.
• Where people were at risk of malnutrition we saw that food monitoring charts were completed. We saw people had access to drinks throughout the day to ensure they were well hydrated.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity

• People were not always treated in a way that made them feel cared for. People told us that they often felt bored and staff didn't have time to spend with them. One person said, "I have mental health issues and I'm not sure staff understand me. It would be nice to be able to spend time chatting so they understand me." Another person said, "I am enjoying my chat with you as staff do not have time. I understand they are busy but would love to chat like this. It would make me feel better about things."
• We saw staff were busy and did not have time to spend with people. People spent long periods of time with no interactions from staff to provide stimulation to support their emotional wellbeing.

Supporting people to express their views and be involved in making decisions about their care

• People told us they had choices in the way their care was provided. One person said, "I am very independent and I choose everything really. The staff listen to me and respect what I want." Another person told us they could get up and go to bed when they wanted. We saw staff gave people choices, asked questions and waited for people to respond with their answers.
• Staff understood people's individual methods of communication and support plans were in place which gave staff guidance on the most effective way of communicating with people to help them express their views

Respecting and promoting people's privacy, dignity and independence

• People told us that recent improvements had been made to ensure their privacy was respected. The provider had been using CCTV in the home and was advised by a health and social care professional to gain the consent from people to use this technology, which can be invasive. One person said, "I didn't want the CCTV so when I was asked I spoke my mind. They [provider] has listened as they no longer use it and I feel better that I am not being watched."
• People told us they could spend time in their private rooms when they wished to spend time alone and staff respected their wishes.
• People were supported with personal care in the privacy of their own rooms or bathrooms to ensure their privacy was upheld.
• Personal information was stored in locked cupboards to protect people's confidentiality.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI: People's needs were not always met. Regulations were not met.

Improving care quality in response to complaints or concerns

• People did not always feel able to complain. One person told us, "I feel by making a complaint it goes against me and there is bad atmosphere from staff towards me". This meant there was not an open culture for people to raise concerns.
• Complaints were not consistently managed. There was a complaints log, which showed two complaints that had been investigated. People told us they had made complaints about the service. However, these had not always been recorded as a complaint by the provider. This meant there was no evidence to show how the investigations into people's concerns had been managed to bring around improvements at the service.

The above evidence shows a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

• People told us there were bored and there was not enough for them to do at the service. One person told us how they enjoyed reading but they had not had any new books for some time. Another person told us they enjoyed going out in the community but this had been stopped recently.
• Staff told us they were expected to provide activities. However, we saw this was not always possible as they were supporting people with their personal care needs and people spent long periods of time with very little stimulation to maintain their emotional wellbeing.
• People and their relatives had been involved in the planning of their care and people's preferences had been gained. Staff understood people's preferences and explained how people liked their care to be provided. However, reviews of people's care had not always taken place after their needs had changed to ensure care records were up to date.

End of life care and support

• There was no one receiving end of life care at the time of the inspection.
• Information was available with regards to people's wishes if they became unwell, which included DNACPR's. DNACPR is a document issued and signed by a doctor, which informs the medical team not to attempt cardiopulmonary resuscitation (CPR).

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; Engaging and involving people using the service

• The culture of the service did not always promote openness. People did not always feel listened to when they raised concerns at the service and told us they felt this had an impact on the way staff treated them. People's complaints were not used to learn and make improvements to people's care.
• Feedback had not been gained from people who use the service to inform service delivery.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• There was a lack of effective governance systems in place to monitor the service and mitigate risks to people. For example; medicine audits were not carried out to identify poor practice. In response to the local authority feedback the provider had implemented a system for staff to record incidents and bruising. However, this system had not been progressed to contain an oversight of the concerns and the actions taken to safeguard people from further harm.
• There was not a clear leadership and management structure in place. Staff did not have a good understanding of their responsibilities to report poor care and inappropriate staff were providing advice and leadership.
• The system in place to check staff knowledge and skills was ineffective in identifying and rectifying poor care. Staff had received guidance and competency assessments by a volunteer who did not have up to date skills and knowledge to carry this out. This had led to a deterioration in staff practice and staff had not been held to account for poor performance.
• Records were not always accurate and had not been updated to reflect a change in people's needs. For example; one person told us they walked downstairs with the support of staff. Staff knew this information but the records did not contain these details and the possible risks associated with the person mobilising downstairs.
• The provider had not notified us of a death that had occurred at the service since our last inspection, which is a requirement by law.

Working in partnership with others; Continuous learning and improving care

• The provider did not have an effective system in place to continually learn and make improvements to the care people received. Staff meetings had not been held regularly to update staff of learning and

improvements required.
• Before the inspection social care professionals had identified concerns with people's care and action had not always been taken to ensure advice was acted on in a swift manner to keep people safe.
• The provider had been made aware of areas of risk by the local authority and had not implemented a clear action plan to mitigate the risks to people.
•The service has been in Large Scale Enquiry by the Local Authority. However, the provider had not worked successfully with partner agencies to improve the quality and safety of care. We found that people were exposed to the risk of harm due to the continued shortfalls we found at the inspection.

The above evidence shows a breach of Regulation 17 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	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not consistently managed and people did not always feel able to raise complaints at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff available to consistently meet people's physical and emotional needs.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks and medicines were not managed to keep them safe from harm.

The enforcement action we took:

We served an urgent notice of decision to impose conditions on the provider's registration.

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 People were not safeguarded from the risk of abuse.

The enforcement action we took:

We served an urgent notice of decision to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective governance systems in place to ensure that risks to people were monitored and mitigated. There was a lack of clear leadership at the service and the culture of the service did not promote openness. People had received poor care as a result of this.

The enforcement action we took:

We served an urgent notice of decision to impose conditions on the provider's registration.