Althea Healthcare Properties Limited

Colne House

Inspection report

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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
Colne House is a residential care home providing personal care and accommodation for up to 38 older people, some of whom may have mental health needs and or may be living with dementia. At the time of our inspection 25 people were living in the service.

Colne House is an adapted building, consisting of three floors with a separate annex.

People's experience of using this service and what we found
Systems and processes in place were not effective enough to review and assess the quality of service provision. This meant the previously demonstrated good standard in well-led had not been maintained. In safe, shortfalls identified in risk management and infection control, meant it remained as requires improvement.

Risks to people had not been fully assessed and action. Improvements were needed to minimise the risk of people experiencing anxiety due to other people living with dementia entering their bedrooms by mistake. Staff monitored people's temperature and oxygen levels as early indicators of infection and deterioration in health. However, staff had not been given effective training and guidance in the use of pulse oximeters and when to seek medical advice.

We found improvements were needed in the provider's oversight and monitoring of the service to ensure staff feel valued through good communication.
Staff wore personal protective equipment (PPE) to keep people safe and reduce the risks of cross infection. However, we found shortfalls where staff were not always following safe practice, including hand hygiene, enhanced cleaning and management of risks.

The service continues to follow safe recruitment procedures to ensure only suitable staff were employed to work at the service. A relative described staff as being, "So loving and caring."

Relatives provided examples of the good relationships they had built up with staff, who kept them updated on any incidents or health issues and systems. They praised the dedication of the new registered manager and staff during the pandemic, sending thank you notes to the service, one referring to staff as the 'Kingsley Heroes.'

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 20 June 2019). At this inspection we found the rating had changed to requires improvement.

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about staffing, monitoring people's oxygen levels, supporting people living with dementia and infection control. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with oversight of the service to check the systems they had in place were effective to support people in a clean and safe environment. So, we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Colne House 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 have identified breaches of regulation in relation to infection control, risk management and good governance at this inspection.

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.

Colne House

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
This inspection was carried out by one inspector.

Service and service type
Colne House 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 a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We carried out an unannounced inspection on the 26 January 2021, and completed inspection activity on the 18 February 2021, when we gave feedback.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We reviewed information we had received from members of the public and whistle-blowers. We used all of this information to plan our inspection.

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 met and observed staff supporting two people living in the service. We were shown around the environment and spoke with five members of staff including the registered manager, senior support worker, domestic and catering staff.

We reviewed a range of records. This included multiple medication records, daily cleaning schedules, care handover sheets, temperature and oxygen readings, staff rosters, staff recruitment and induction file.

Following the site visit, we continued to seek clarification from the provider to validate evidence found. A variety of records relating to the management of the service, including policies and procedures, complaints log, monthly accident and incident analysis, feedback from relatives; surveys and thank you emails. We contacted two professionals, three relatives and two staff to enable them to share their views and experience of the service.

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 requires improvement. At this inspection this key question remained the same. 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.

Preventing and controlling infection

- We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. There was no clear monitoring and guidance on the use of single use and reusable face visors. Where staff wore long sleeve tops, and /or jewellery on their wrist and hands, this meant they could not follow good hand hygiene.
- We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. The provider had not robustly assessed the risks associated with staff working for other care providers and the impact of domestic staff covering care duties, as well as maintaining a clean environment, including enhanced cleaning. Where staff had unblocked a drain in the shower room, the smelly residue had not been cleaned away, prior to a person using the shower. Staff were not always around to support people living with dementia to social distance and not enter other people's bedrooms.

Systems were either not in place or robust enough to ensure good oversight and management of infection control. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was admitting people safely to the service, accessing testing for people using the service and staff, and their infection prevention and control policy was up to date.
- Relatives said prior to the pandemic, and also during window / conservatory visits, they had always found the service looking clean.

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

- Management and staff did not always respond quickly enough to concerns. The impact of people living with dementia entering other people's bedrooms, had not been effectively risk assessed to ensure people's safety and wellbeing. One relative told us, "Always been a problem." They gave examples where a person had entered their family member's bedroom at night, moved and took items, confusing the bedroom as being their own. Another described their distress whilst talking to their family member over the telephone, to hear another person had entered the bedroom uninvited, "Stop standing over me and get out of my room.'' Staff were not aware until they called the service and asked them to intervene.
- Relatives told us when they had mentioned this to staff, they felt the emphasis was on their family members to alert staff. One relative felt staff hadn't taken into account the person's capacity themselves to call for staff, or be anxious as they, "Wouldn't want to be a trouble." Staff had suggested locking the bedroom when they left it, but they were not able to do this independently.

● We observed as a person living with dementia was occupying themselves opening other people's bedroom doors. When staff were present, they gently guided the person back to their own bedroom. However, within a short time they were back out, walking around the corridor, opening bedroom doors again.
● There was a lack of technology in use to alert staff, if a person had entered someone else's bedroom by mistake. The registered manager said they had tried sensor mats, but they hadn't worked. During feedback they said they would take action to research available technology and best practice to support people's needs.
● Training records showed not all staff had completed 'refresher' training in fire safety, health and safety, moving and handling to keep their skills updated. The new registered manager was aware and would be prioritising this as staff returned to work following isolation.
● Checks were in place to ensure fire detection systems were in safe working order. However, in the event of a fire, information given to the fire service on arrival was out of date. It had not been updated since September 2020 and did not reflect the current occupancy. Information on bedroom doors was incorrect and could cause confusion when trying to locate people and evacuate areas. The registered manager provided reassurance they had acted on our concerns during feedback and ensure it was kept updated.
● Staff used a pulse oximeter to monitor people's oxygen levels. There was no formal training or written guidance, such as risk assessments, for staff on using the equipment effectively and safely and when to seek medical advice. Although the registered manager took action straight away and found current guidance to ensure staff knew when to seek advice this had not been independently identified as a risk.

Systems were not in place to identify and ensure risks to people were identified, acted on, mitigated and learned from. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse;
● The service had safeguarding policies and procedures in place. Staff told us they always put the person first and were aware of the internal and external agencies to report any concerns.
● Relatives told us staff kept them updated on any incidents or health issues. One relative said staff, "Will always ring me and let me know if [family member] has had a fall."
● A relative told us they felt their family member was safe and, "Looked after well." This reflected feedback the service had received directly from people's relatives.

Staffing and recruitment
● One relative told us during the COVID-19 outbreak there had been, "Real staff shortages…they never use agency," in the main home. Feedback from staff showed staffing levels fluctuated. Although agency staff cover was used for the annex, this cover had not been provided in the main home to cover absences.
● On the day we visited, a staff member said the staffing levels on the care side were, "Brilliant today, a senior and four support workers, yesterday just two cleaners [trained in care] and two support workers." This conflicted with records, which showed an additional support worker had been in, covering as senior.
● The domestic staff were able to provide care. Staff told us it ensured people's physical needs were being met but impacted on the time they could spend providing social and emotional support.
● Following feedback, the registered manager who had just returned to work, provided reassurance they were acting on the feedback, and ensuring staffing levels were being maintained.
● The service continued to follow safe recruitment procedures to ensure only suitable staff were employed to work at the service.

Using medicines safely

● Systems were in place to ensure people received their medicines as prescribed. A staff member designated to administer medicines, said they had received training and felt they were competent to support people with their medicines safely.

● The registered manager showed us how the electronic monitoring system was used, which supported them to take action quickly if there were any issues. It alerted management if a person declined their medicines, or if it had been given too early or late. The system also alerted staff when medicines needed to be reordered, which reduced the risk of medicines not being available.

● As part of monitoring staff were following safe practice, the registered manager carried out 'spot' checks, to ensure the amount of stock listed on the electronic system, matched the actual amount held. Any differences, which could indicate a person had not been given their medicine as prescribed, would be investigated and appropriate action taken.

● Where people were receiving end of life care, anticipatory medicines had been prescribed in case they were needed. This enabled community nurses to have quick access to relieve any pain, and symptoms such as nausea and anxiety to keep the person comfortable.

● The service had a system in place to guide staff on when to administer 'as and when required' medicines, referred to as PRN, to support people's individual needs. We found three people had missing PRN forms. The registered manager told us they were aware, and would be putting them in place, and reviewing all the PRN forms to ensure they were more, "Person centred."

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

- Quality monitoring systems were not always effective as they had failed to identify some of the issues we found in relation to infection prevention control, communication and risk management.
- One relative told us they did not feel listened to until they escalated concerns to the provider, rather than to the senior staff in the home.
- Another relative felt in the, "Last month or so communication has been poor…used to get regular updates, emails, newsletters." They were aware the deputy post was vacant and felt the provider could have communicated better on the management arrangements whilst the registered manager had a temporary leave of absence. It was not until they contacted the service they were told the manager was not at work.
- The provider's oversight during a COVID-19 outbreak was not effective enough to ensure management and staff at the service were being listened to and given effective support in identifying, managing and mitigating potential risks.
- In the absence of the registered manager, requests for more staff, had been declined. Staff said it left them feeling unsupported and unappreciated at a difficult time where they were all pulling together to keep people safe. The registered manager told us how staff had also shared these concerns with them on their return.

Management systems were not robust enough to demonstrate effective quality monitoring or to recognise, identify and mitigate risks to people. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since our last inspection in 2019, a new manager had been appointed, who was registered with the Commission in January 2021. Having previously worked in the service as deputy manager.
- Relatives praised the dedication of the registered manager and a senior support worker when they had moved into the service to support staff at the start of the COVID-19 outbreak. One relative said it showed how, "Very dedicated," they were.

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; Continuous learning and improving care

● Following our feedback to the service, the provider's director of compliance had been in contact to update on changes they have made in their organisational structure to ensure good oversight support and improved communication.
● The registered manager was open during the inspection and our feedback session. They confirmed what actions they had been taking to support staff to share their views through meetings.
● All the staff we spoke with, demonstrated their commitment to putting people first, by supporting each other during a difficult period. One support worker described the, "Amazing," domestic staff who stepped in to assist them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● All of the nine people's relatives who had completed survey feedback in September 2020, were positive about the quality of care their family members received. Comments included, 'there is nothing to improve,' 'the staff are committed and caring,' and, 'my [family member] is extremely happy here.'
● A relative felt the contact they had with the service was, "Extremely supportive…I phone a fair amount… do have a good relationship with the home, staff are so loving and kind."
● During the pandemic the service had been working in partnership with external health and social care agencies to keep people safe and support their individual care needs. This included community and specialist nurses, GPs, Public Health England, and Clinical Commission Group infection control leads.

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 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to identify and ensure risks to people were identified, acted on, mitigated and learned from. The provider did not have robust infection control systems in place to assess and prevent the risk of infection spreading. Regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality monitoring and communication systems in place were not robust enough to identify risk and drive improvements. Regulation 17 HSCA RA Regulations 2014 Good governance