Mrs B F Wake

Carnalea Residential Home

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
Carnalea Residential Home is a care home providing personal care to up to 55 people. The service provides support to older people with varying care needs including, dementia, diabetes, Parkinson's disease, epilepsy and mental health needs. At the time of our inspection there were 42 people using the service.

People's experience of using this service and what we found
The provider had ineffective systems in place to monitor people's safety and well-being. Risks were not always identified and mitigated against. Accidents and incidents were not effectively reviewed and monitored to learn lessons and minimise the risk of them happening again. Medicines were not always managed well. Systems to monitor people's medicines were not robust to pick up issues, which meant people may not receive their medicines as prescribed and required.

New staff were not always recruited safely as there were gaps in their employment history and references were not robustly followed up.

Although there appeared to be sufficient staff on shift, some people told us they had to wait when they needed assistance. The provider did not have a system for measuring people's assessed needs against the numbers of staff required to meet those needs. We have made a recommendation about staff deployment.

Systems to monitor the safety and quality of the service people received were not effective. Most audit systems were not completed and those that were, were not robust and did not identify concerns. Care plans did not provide the detail and guidance necessary to provide consistent care. Most people said staff were attentive and friendly, but some people felt they did not get the attention they needed. The provider did not have adequate management and oversight of the service.

The provider held meetings with people to hear their views and with staff to update information. The provider had not undertaken any surveys to gain feedback from people, relatives or others involved in the service.

People told us they felt safe and secure in Carnalea Residential Home. Staff understood how to protect people from abuse and knew how to raise concerns. The service was clean and safe infection control procedures were followed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 27 March 2021).

Why we inspected
We received concerns in relation to leadership and governance and staff culture. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report. 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 Carnalea Residential Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to the management of risk, medicines safety, staff recruitment and the monitoring of quality and safety at this inspection.

We have also made a recommendation in relation to staff deployment.

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

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Carnalea 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 Health and Social Care Act 2008.

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 two inspectors, and an Expert by Experience who spoke with people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Carnalea Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Carnalea Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The registered manager had recently left, and the provider was in the process of recruiting a new registered manager.

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. We sought feedback from the local authority and professionals who work with the service. We also sought feedback from the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eleven people who used the service about their experience of the care provided. We observed the care provided within the communal areas. We spoke with eight members of staff including the provider, the deputy manager, senior care workers, care workers and the chef.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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.

Assessing risk, safety monitoring and management

● Risks to people's health and safety were not always identified and mitigated sufficiently. The tools used to assess risk were not always fully completed to ensure appropriate risk assessments could be developed. Staff had completed a tool each month to assess the risk to one person's skin integrity. The tool had not been completed correctly which meant the level of risk was not accurate, placing the person at greater risk of acquiring pressure areas. The person had acquired pressure sores but did not have a specific risk assessment in place to provide staff with the appropriate guidance to prevent further damage.

● A moving and handling risk assessment tool had been completed for another person. Staff completed this each month. Relevant risk factors relating to the person's medical conditions had not been considered as the section to record these had been left blank. This meant the person may not be supported safely during transfers as individual risks had not been identified to develop a management plan. Bed rails assessments had not been completed to make sure the correct bed rails were fitted for people who required them. Associated risks had not been identified to make sure plans were in place to prevent harm.

● The risks to people based on their individual health conditions had not been taken into consideration. One person was an insulin dependent diabetic. They did not have a specific care plan or risk assessment in relation to diabetes. Staff did not have the guidance in place to make sure they supported the person to manage their diabetes and reduce the risks of associated health problems. Another person had epileptic seizures. Specific care plans or risk assessments were not in place to identify individual associated risks and how to manage them, such as from falling, or bathing.

● One person had a serious allergy and required immediate medical attention when they showed signs of an allergic reaction. A specific risk assessment had not been completed to provide clear guidance to staff, such as how to prevent a reaction and what were the individual signs to be alert to. The implications of not acting fast enough were extremely serious, putting the person's life in danger.

● The fire file with people's information, used in an emergency situation, was not up to date. Personal evacuation plans were dated January 2022 and had not been updated. Lists of people's current medicines were also dated January 2022, even though many changes had made to some peoples' prescribed medicines in that time. People were at risk of not being safely supported by staff or the emergency services during an emergency evacuation.

● Regular safety measures around fire safety were not always carried out or recorded to reduce risk. A fire risk assessment had been completed in January 2022 with actions to complete to ensure fire safety. Actions remained outstanding. There was no clear plan in place to identify what action still needed to be taken and when they would be completed by. The provider confirmed after the inspection all outstanding action had been taken. Weekly fire alarm tests were completed sporadically, not weekly, with regular gaps of 3 and 4

weeks between tests. Fire drills were completed, however, only staff names were recorded with no evidence of what went well and what needed improving for staff learning.

Learning lessons when things go wrong

● Accidents and incidents such as falls were not sufficiently assessed to provide guidance to staff to prevent further incidents.

● One person, who had epileptic seizures, had 9 falls. There had been no monitoring or analysis to identify cause and if epilepsy had been a feature and an increased risk.

● One person's care plan stated they could be verbally and physically abusive to staff. There was no further information or guidance for staff how to support and proactively manage these incidents to promote safety and security. Incidents had not been recorded or analysed to develop a care plan, risk assessment or management plan.

Using medicines safely

● Medicines were not always managed safely. There were some inconsistencies in the amount of stock in place and the amount recorded on the medicines administration record (MAR). The record for one person's prescribed painkillers documented more tablets were in stock than there actually were when the tablets were counted. This meant the person may not have been given their pain relief when a staff member had signed to say they had been given. Another person was prescribed pain relief, 1 – 2 tablets 'as and when required' (PRN). Staff did not record whether the person had taken 1 or 2 tablets on the MAR so it was not possible to check if the numbers of medicines left in stock balanced with the numbers of tablets given.

● People's medicines care plans did not describe any special instructions for particular medicines. For example, people who were taking medicines to treat Parkinson's disease. Some of these medicines are time controlled so must be given at specific times to support the efficacy of the medicine, helping to control symptoms. People may not be able to remain as healthy and independent as possible if their medicines are not given correctly.

● Skin patches prescribed for pain relief were not placed on different sites of the skin as advised by the pharmaceutical information label. Some people's records did not show where the patch had been sited so staff could determine the safest area to place the next patch. This meant people who were prescribed pain patches were at risk of skin irritation.

● Some people who were prescribed PRN medicines did not have guidance in place to make sure their medicines were administered safely. For example, how many tablets can be taken safely in a 24-hour period and what the medicines were prescribed for. This placed people at risk of not receiving their medicines safely.

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

Staffing and recruitment

● There were some shortfalls in safe recruitment practices. Three out of the 4 staff recruitment files we looked at showed gaps in staff employment histories, or missing dates of previous employments. Staff references were not verified as having been written by the person intended. It was not clear if referees were previous employers or not or when the staff member had been previously employed, as dates of employment had not been given on the references. Although the deputy manager said one staff member's DBS had been received by the staff member, the provider had not seen it yet. The member of staff had started in their role without assurance their DBS was clear. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer.

The information helps employers make safer recruitment decisions.

The registered person failed to ensure staff were recruited safely. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Some people told us staff were always available when they were needed, but others said they often had to wait when they needed help. The comments we received included, "I do feel there are times when it's not easy to find a carer, as they are so busy. I wanted the toilet but no one was about, so I wet myself, though I do have pads as well"; "While there are staff around, it can take time for them to come to you in your room"; "They generally answer my buzzer in reasonable time" and "Most of the time someone is around to help me."
● The provider used a tool to assess people's dependency needs, to determine if they had high, medium or low needs. However, the individual assessment outcomes were not used to fulfil the purpose of calculating how many staff were needed on shift to meet people's individual needs. This meant when people's needs changed, requiring more staff on duty, the provider could not evidence this had been taken into account and staffing levels reviewed. Staff told us they thought there were enough staff on duty each shift and agency staff were used if there was a shortfall due to staff absence.

We recommend the provider seek advice and guidance in how to ensure the safe deployment of staff based on people's needs.

Systems and processes to safeguard people from the risk of abuse
● There were systems and processes in place to support people from the risk of abuse. Staff received training in safeguarding, and staff we spoke with had a good understanding of the types of abuse, and how and where to escalate concerns.
● People felt they were safe at Carnalea Residential Home. Comments included, "Yes the carers are really good, and they are always there when I need them. It gives me confidence that I am safe and well looked after"; "Everyone looks after me well and so I feel safe. Everything I need is here" and "The people here are nice, kind and patient and all of that makes me feel safe and secure. No one has ever been unkind or hurt me."
● The provider understood their responsibilities to report concerns to the local safeguarding authority. When concerns had been raised, they worked with the local authority by providing information requested, supporting investigations.

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 supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● 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.

Visiting in care homes

People were able to have visitors when they chose. People told us their loved ones could visit regularly.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- The provider was not able to evidence regular monitoring to ensure the quality and safety of the service. No audits had been undertaken to check people's care plans had the information needed to enable good and safe care. We found concerns with the assessment of individual risk. Care plans did not provide the level of detail needed to ensure people received the care they needed. The provider was not aware risk assessment tools were not completed correctly to identify people's individual levels of risk.
- Medicines audits had been completed monthly by the deputy manager, however, when the deputy manager was on leave, no audit was carried out that month, a contingency plan was not in place. The medicines audits did not identify issues or areas to improve. We found concerns around medicines management that had not been identified through the providers monitoring. People may not have received their medicines as prescribed as a result.
- Although staff had completed mandatory training on-line, they had not undertaken training to make sure they understood people's specific needs such as serious health conditions. Staff had not received training in relation to epilepsy, diabetes or Parkinson's disease, even though people with these conditions were living at the service. One staff member had not received practical moving and handling training to test if they understood the basics of moving people safely, and they had started their employment in May 2022. These shortfalls in staff training had not been picked up by the provider.
- Accidents and incidents had not been monitored to learn lessons and make improvements to reduce risk where needed. There was no oversight of accidents and incidents by the provider. Incidents such as when people had episodes of anxiety or accidents such as falls had not been monitored by the provider. This meant themes, or ways to prevent future occurrences had not been explored.

The registered person failed to operate a robust quality assurance process to ensure any shortfalls were addressed. The registered person failed to maintain accurate and complete records in relation to the service and people's care. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- It is a condition of the provider's registration they have a registered manager in place. Although a registered manager was not in place at the time of this inspection, the provider had taken reasonable steps to recruit a new manager. A new manager was due to start in post the week after the inspection. The provider assured us the new manager would apply to register with CQC once they had settled in their new role.

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

● People's assessments did not always provide the information needed to support the development of a robust care plan. Some people's care plans did not provide an accurate record of their care needs for staff to follow. Care plans did not provide the level of individual detail needed to be sure people received the person-centred care they needed.

● Most people said staff knew them well, one person said, "It surprises me with all these residents, that I get such personal treatment. A carer said to me, 'You're wearing the wrong glasses: you need your brown ones.' She went and got them. I find that quite endearing." However, not everyone thought this, and another person said, "I don't feel a closeness to staff: they don't seem that friendly".

● The signs around the service were not always dementia friendly so may not support people living with dementia find their way around. Doors did not always have people's names, to support people to find their room. We did not find evidence that this had been a choice that people had made. One person told us they did not have a number on their door and would like one, "There's no number on my door, which I think I should have."

● Staff spoke well of the provider. They said the provider had high standards and knew people living at Carnalea Residential Home well. One member of staff said, "The provider knows everyone very well and wants the best for them – wants them to maintain their independence and makes sure staff are doing that for as long as possible."

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 duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. We found that the provider had been open and honest, and understood their responsibility to comply with the duty of candour.

● When incidents occurred, people's loved ones were kept informed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider supported people to engage in the service by holding meetings with people. One person told us, "We've had residents' meetings and chatted generally about things." Surveys had not been used to gain feedback from people, their relatives or others involved in the service.

● The provider held staff meetings regularly. Staff said they felt able to raise concerns or ideas during staff meetings. Staff said they would also speak to the provider if they had a concern they wished to raise outside of the meetings.

Working in partnership with others

● People were referred to health care professionals and the service had close working relationships.

● The deputy manager told us they joined other providers in the local area including local health centre staff on a regular basis. They found the meetings very useful, keeping up to date with local networks and changes.

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 The registered person failed to assess the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. The registered person failed to manage medicines safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person failed to operate a robust quality assurance process to ensure any shortfalls were addressed. The registered person failed to maintain accurate and complete records in relation to the service and people's care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person failed to ensure staff were recruited safely.