Colleycare Limited

The Chadwick

Inspection report

4-10 Ware Road
Hoddesdon
EN11 9DU

Tel: 01992441624

Date of inspection visit:
20 January 2020
06 February 2020

Date of publication:
09 December 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Chadwick is a residential care home providing personal care to 58 people aged 65 and over at the time of the inspection, some of whom were living with dementia. The service can support up to 67 people. The Chadwick is a bespoke built new residential home set over three floors, with a range of communal areas, private bedrooms with en-suite and access to a local town.

People's experience of using this service and what we found
People and staff told us there were not enough staff especially during the evenings, nights and weekends to provide safe care which met people's needs in a timely way. People told us they often had to wait long periods of time to go to bed in the evenings or for staff to answer their call bells. Risk assessment tools were used by staff to establish if people were at risk of falls or at risk of developing pressure ulcers. However, actions to prevent falls or pressure ulcers developing were not always taken in an effective way. On 06 February 2020 we returned at the home to check what actions were taken by the registered manager to mitigate risk for people who were at high risk of falls. The actions taken were not effective and people continued to sustain falls and injuries as a result.

Systems and processes to safeguard people from the risk of harm were not used effectively. Staff were knowledgeable about safeguarding procedures and their responsibilities to report and record any concerns they may have had. However, when people sustained unexplained injuries, the occurrence of these were not investigated by the registered manager and were not reported to the relevant safeguarding authorities to consider how people could be safeguarded from further harm.

Evacuation procedures in case of an emergency, like fire, were not practiced with staff, although this was a required action in the fire risk assessment carried out by the provider in May 2018 and November 2019.

The laundry room presented an infection control and fire risk. There was no separation between clean and dirty laundry and there were large piles of clothing and bedding on surfaces and the floor.

The provider's governance systems were ineffectively used by the registered manager to improve people's experience about the care they received and to address concerns we reported in the previous inspection.

The registered manager carried out various audits and analysis of falls, accidents and incidents. However, they had not fully considered what actions were needed to ensure people were safe. Before the inspection we requested information from the provider and the registered manager. The data we received was conflicting and we could not rely on the accuracy of it.

On 06 February 2020 when we returned to the home we were informed by staff that there was an outbreak of infection in the home. CQC had not been notified about this outbreak.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 5 October 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not, enough improvements had been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to people waiting long periods of time for their needs to be met, lack of staffing and lack of action from the management team in the home when concerns were reported to them. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Chadwick on our website at www.cqc.org.uk.

We have identified breaches in relation to safe care and treatment, safeguarding, governance systems and duty of candour at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 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.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Chadwick

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
The Chadwick 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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last 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 spoke with 12 people, one relative, 14 staff members including the deputy and assistant managers. In addition, we spoke with the registered manager and the provider's operations manager

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records and multiple medication records. We reviewed a variety of records relating to the management of the service including audits and falls, incident, accident and wound analysis done by the registered manager.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

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 has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Staffing and recruitment; Preventing and controlling infection; Using medicines safely

- The provider had failed to deploy sufficient staff to meet people's needs to keep people safe. One person said, "I can do quite a lot for myself. They are lovely girls but not enough of them. [Management] will tell you they've got more than what they need but they haven't at all. I'm honest with you."
- People who relied on staff's support to have their needs met told us there were not enough staff. One person said, "I was kept waiting 30 minutes this morning, it's scary when they don't come. I don't like to use the pull cord as I worry when they don't come." Another person told us, "I rely on staff's support for everything and I need to wait all the time. I wait for half hour to be moved from the dining table, I wait for half hour to go to bed, I wait for everything. The management is not here in the evenings or over the weekend to see. They say there are enough staff."
- Staff had mixed views about staffing in the home. Some staff told us during the day it was better because the deputy and assistant manager could help, however evenings and nights there were not enough staff. One staff member said, "Staffing is bad. …….. There are times when the ground floor or 2nd floor have no staff and some people are confused. We are doing the rounds but it's hard."
- Risks to people's health and wellbeing were not sufficiently mitigated to protect people from the risk of harm. There were seventy-four falls recorded from 22 November 2019 to 05 February 2020. For example, a person had twenty-four falls between 22 November 2019 and 05 February 2020. The person had been sent to hospital four times in this period to be checked over for injuries and suffered cuts, bruises, skin tears and pain. There was no care plan in place to detail what measures staff were taking to prevent falls and mitigate the risk of injuries to this person. Staff told us they had put a sensor mat in place to alert them when the person got out of bed and the GP reviewed the person's medicines. However, none of these measures proved effective and no other actions were considered.
- Records showed that from 22 November 2019 to 20 December 2019 there were thirty-eight falls recorded. Out of these twenty-two falls occurred between 8pm and 8am when night staff were on shift. This pattern repeated from 21 December 2019 to 16 January 2020 there were twenty-six falls and twenty-two occurred between 8pm and 8am. The registered manager identified this trend through their analysis for October, November and December 2019. They recorded the majority of falls were happening at night. The only action they took was to speak with the night staff about the lighting. They had not considered the impact of staffing on the risk of people falls or the areas of the home where people fell the most. No other actions had been taken to mitigate risk for people during the night.
- The provider had failed to put guidance in place for staff about how to prevent pressure ulcers from developing. Staff had identified that some people were at high or very high risk of developing pressure ulcers. For example, one person, assessed to be at very high risk of developing pressure ulcers had no skin

care plan in place or any plans to ensure preventative measures were taken to protect them. Another person developed pressure ulcers in the home which were re-occurring. Staff referred this person to the district nurses who ordered a specialist mattress for this person to prevent further skin damage. However, other people who developed pressure ulcers had not been referred or benefitted from the same specialist mattress although they were assessed as at high risk.

● The provider had failed to put infection prevention and control procedures in place with regards to laundry. People's clothes were laundered in the home. The laundry had not been organised to ensure infection control procedures could be followed. There was a build-up of dirty laundry which was not separated from the clean laundry. This meant that there was an increased risk of cross-contamination. Staff told us the two washing machines could not keep up with the amount of washing they had to do, and this is why they had such a build-up of laundry. The overfilled room where heat was building up when the machines were working also presented a fire hazard. On the second day of the inspection staff told us the laundry had been organised, however due to an infectious outbreak in the home we could not check this.

● People's medicines were not always safely managed. We counted five people's medicines and for three the amount found in boxes did not correspond with the records kept. This meant there was a risk that people did not receive their medicines as intended by the provider.

The provider failed to ensure people were protected from the risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● In the previous inspection we found that not all safeguarding concerns were consistently investigated, reported to safeguarding authorities or followed up by the management team.

● At this inspection this continued to be an issue. For example, records showed that between December 2019 and January 2020 eight people sustained multiple bruising and skin tears. The records did not indicate if these injuries could be linked to falls or other incidents. These unexplained injuries were not investigated or reported to safeguarding authorities.

● The registered manager told us some of the people injured could have said what had happened, however this had not been recorded at the time. They also told us that they had not reported any safeguarding concerns in this period, however for some of the people they requested their GP to review their injuries.

● For people who sustained bruising and skin tears repeatedly there were no protection plans in place to try and prevent these from happening.

● Lessons learnt were not imbedded in everyday practice. There were no meetings with staff or root cause analysis carried out when things went wrong like people had falls or developed pressure ulcers to understand why this happened and how to improve practices.

The provider had failed to protect people from abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At the last inspection this key question was rated as required improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our previous inspection we found that the failure to have effective systems and processes in place to ensure the safety and quality of the service and to maintain an accurate, complete record in respect of each person was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- The previous inspection was carried out due to concerns we received related to staffing levels, monitoring of the quality of care and long delays for people to receive care.
- At this inspection we found that the provider had failed to improve staffing levels, reduce the delays in answering people's calls and monitor the quality and safety of the service being delivered.
- We requested some information about this from the registered manager prior of the inspection. The information we received was conflicting. For example, the call bell logs we received had not evidenced some of the call bells identified by the registered manager as being answered late by staff. The registered manager told us they would investigate this; however, we could not rely on the accuracy of the data we were provided with.
- The registered manager analysed falls in the home monthly. Although they identified a trend where most falls occurred during the night, they failed to take any action to mitigate the risks to people. This led to people continuing to fall and sustaining injuries.
- Care plans were not developed to effectively support staff to meet people's needs safely. For example, a person had no care plan to detail what staff had to do to keep them safe from developing pressure ulcers although they were assessed as very high risk. People at high risk of falls had no detail in their care plan of what staff were required to do to mitigate risks. Care plans had no detail of what equipment staff were using to keep people safe.
- The provider and the registered manager had failed to ensure that people at risk of dehydration were receiving sufficient amounts of fluid daily. Staff monitored fluid intake for people who were at risk of dehydration. However, there was no guidance in place to help staff understand how much each person was expected to drink daily or when staff had to report concerns that people had not drunk enough. For example, records showed that staff at times only offered between 500-600ml fluids to people over a 24-hour period. Staff told us this was probably a recording issue; however, the registered manager had not identified

this and was not monitoring to ensure the records were accurate and that people had sufficient fluid intake. On the day of the inspection, at 1pm, one person only had 100ml and another 95ml recorded. This had not been raised as a concern by staff. This was not effective monitoring of people's fluid intake and the lack of action taken meant that people were not protected from the risk of dehydration.

● The registered manager had not assessed the fluctuating staffing numbers against their evacuation process in case of an emergency. There were no fire drills carried out with reduced staff numbers when staff were not present on each floor in the building. Practicing evacuation was a required action in the fire risk assessment carried out by the provider in May 2018 and November 2019. This meant there was a risk of a delay in evacuating people in case of an emergency.

● Staff did not feel listened to. They told us they did not feel listened to when they reported their concerns to the management in the home. One staff member told us, "There is no point to report that we haven't got enough staff. We are told to try and cover shifts, or we work short. We are told we are enough staff to the numbers of residents but it's not true."

● The provider had failed to use a 'lessons learned' process to improve the quality and the safety of their services. We have identified similar concerns in our inspections of the provider's other services in relation to a lack of risk management and pressure care management for people identified at high risk. This demonstrated that there was a lack of learning across the organisation and a failure by the provider to develop effective strategies to help ensure people received safe care.

Inadequate systems and processes to assess, monitor and improve the service meant that lessons failed to be learnt. The provider had failed to reduce or remove risks where possible and this had a negative impact on people. This was a continuous breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When events occurred in the service that required notifying to CQC or the local authority these were not always completed promptly. Staff told us on 06 February 2020 when we returned to the service that there was an infectious outbreak in the home. The registered manager reported to Public Health England, however they failed to notify CQC or the Local Authority.

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

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 registered manager had not been responsive to issues and concerns. They had failed to be open, honest, and apologise to people when things went wrong.

● Duty of Candour sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. There was no evidence in people's care records or in discussions with staff or management to demonstrate where this had occurred. Staff recorded that they informed relatives when people had falls or there was a change in their needs, however the registered manager had not followed Duty of Candour.

This was a breach of regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 [Regulated activities] Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics

- The lack of effective leadership did not promote a positive and person-centred culture in the home.
- Staff's morale was low, and staff told us they did not feel listened to by the management. One staff member said, "A lot of staff are leaving because it's just a lot of pressure and we are not listened to."
- People told us they reported their concerns to the management team in the home, but they were not listened to. One person said, "Yes, I would raise any concerns. I don't always feel that I am listened to." Another person said, "[Management] don't listen. I am complaining that there are not enough staff and the laundry service is appalling, but nothing is done about it."
- Staff's attitude at times did not promote a person-centred, caring culture. One person told us, "Staff told me a few times, 'There are other people here you know, you're just going to have to wait.' I don't think this is nice at all."

Working in partnership with others

- The service worked in partnership with people's GP and the district nurse team when 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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Care Quality Commission of notifiable incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered manager had not been responsive to issues and concerns. They had failed to be open, honest, and apologise to people when things went wrong.

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 The provider failed to ensure people were protected from the risk of harm.

The enforcement action we took:

We issued an urgent notice of decision to restrict admissions into the home until improvements are made and people receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Inadequate systems and processes to assess, monitor and improve the service meant that lessons failed to be learnt. The provider had failed to reduce or remove risks where possible and this had a negative impact on people.

The enforcement action we took:

NOP