B and E Thorpe-Smith

Adelaide House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Adelaide House Residential Care Home is a residential home providing accommodation and personal care for up to 23 people, some of whom are living with dementia or a cognitive impairment. The service was providing support to 18 people at the time of our inspection visit.

People's experience of using this service and what we found
The provider's audits were either not effective or had not been carried out which meant shortfalls in service provision had not been identified. This included shortfalls in fire risk management, health and safety and medicines management.

Improvements were needed to maintain oversight of staff training and practice and to provide staff with formal opportunities to discuss their role and responsibilities.

The provider had failed to demonstrate learning had been taken from previous inspection visits to improve risk management and governance processes. There was no effective system to audit adverse incidents that occurred in the home.

There were enough staff on duty to meet people's needs. Staff understood their responsibility to keep people safe and report any concerns to managers.

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.

People's changing needs were responded to promptly by staff and other healthcare professionals were contacted when needed. Staff understood people's nutritional risks and knew those people with nutritional risks who needed to be encouraged to eat and drink more.

Rating at last inspection and update
The last rating for this service was requires improvement (published 14 June 2019) and there were two breaches of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

At our last inspection of this service breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance in the home.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe, Effective and Well-led.

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.

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. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Adelaide House Residential Care Home 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 will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified two breaches of the regulations in relation to the safety of people's care and the management of the service.

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

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Adelaide House Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. 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 three inspectors. Two inspectors visited the home. The other inspector contacted relatives by telephone to gather feedback on their experiences of the home.

Service and service type
Adelaide House Residential Care Home is a care home. 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.

The service had two managers registered with the Care Quality Commission. The registered managers 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
Our inspection was announced. We gave the service 60 minutes notice of our visit because the service was inspected during the coronavirus pandemic and we wanted to be sure we were informed of the home's coronavirus risk assessment for visiting healthcare professionals before we entered the building.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection and any recurrent

themes of concerns. We sought feedback from the local authority and commissioners who work with the service. We also contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information helps support our inspections. 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 carried out observations to assess people's experiences of the care provided. We spoke with a registered manager and four staff including care, catering and maintenance staff.

We reviewed two people's care records and seven people's medicines records. We looked at a sample of records relating to the management of the service including health and safety checks, accident and incident records and policies and procedures. We repeatedly asked for samples of completed audits and checks throughout the visit, however we were provided with minimal evidence.

After the inspection
We spoke with four people's relatives via the telephone. We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was an increased risk that people could be harmed.

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

At our last inspection, the provider had failed to robustly manage risks relating to the health safety and welfare of people and there had been a failure to learn from previous inspection visits. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and there was a continuing breach of regulation 12.

● At our last inspection we found issues relating to the management of fire risks. At this inspection we identified similar concerns.
● Bedroom doors were required to be fitted with mechanisms which meant they would close automatically in the event of a fire to hold back smoke and keep people safe. We found some fire doors did not close properly when the mechanisms were released. Some bedrooms did not have the correct floor plate to safely hold the fire door in place.
● A fire zone plan displayed by the fire alarm panel was inconsistent with the fire zone plan within the provider's own fire risk assessment. A zone plan is a layout of a building highlighting the areas of fire detection zones.
The main purpose of a zone plan is to be able to immediately identify, as well as using the fire panel, where any potential fire may have occurred and to help evacuations in an emergency situation and to direct emergency services.
● Personal emergency evacuation plans did not reflect the equipment required to support people to evacuate safely in an emergency situation. This meant staff and emergency services would not have accurate information as to the exact location of a fire or what specific support people needed to evacuate safely.
● In some high-risk fire areas, items were being stored inappropriately.
● After the inspection visit, we shared our urgent concerns with the provider and asked them to tell us, what improvements they would implement without delay to help minimise the potential fire risks within the home. We also shared our concerns with the fire authority.
● Equipment was not always used safely. Despite signs reminding staff to fold the chairlift seat away when it was not being used, we saw numerous occasions when the seat was not folded away. This presented as a trip hazard to people using the stairs.
● At our last two inspections the provider was unable to show us any recorded audits of incidents or accidents, and we did not see any evidence these had been used to identify patterns or trends across the service. At this inspection we found there was still no effective system to audit adverse incidents that

occurred in the home.
● Individual risks to people were mostly identified and care plans guided staff as to the actions they needed to take to help them manage and mitigate risk. However, a continued lack of risk assessment tools in some people's care plans meant it was not clear how the level of risk had been assessed.
● Some known risks had not been assessed. There was no diabetes risk management plan for one person. Not all staff had received training in diabetes care and there was no guidance to alert staff to the signs of any changes in blood sugar levels or what action to take in such circumstances.

This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

Using medicines safely
● At our last inspection we found medicines were not consistently managed safely. At this inspection, we found improvements in the management of medicines were still required.
● Overall, records showed people received their medicines as prescribed and medicine administration records (MAR) had been completed correctly.
● However, protocols to guide staff when administering 'as required' medicines to support people's emotional and mental health were still not in place.
● People receiving medicines in a patch, had their patch applied at the required intervals, but there were still no charts to record the application site and removal of patches. Charts provide a safeguard to ensure the application sites are rotated to prevent people's skin becoming irritated or that medicines are absorbed at an unsafe rate.
● Body maps to inform staff where prescribed creams and ointments should be applied had not been completed.
● Handwritten amendments to MARs had not been signed by the staff member or countersigned by a second staff member to confirm their accuracy. This did not accord with NICE guidelines for managing medicines in care homes.
● Medicines were stored securely and safely.

Preventing and controlling infection
● The provider had systems in place to prevent visitors from catching and spreading infections and to meet shielding and social distancing rules.
● However, staff did not consistently follow current guidance when using personal protective equipment (PPE) such as gloves, masks and aprons. Whilst PPE was available within the home, we observed numerous occasions when care staff were wearing their masks under their nose or chin in communal areas.
● The provider promoted safety through the layout and hygiene practices of the home and people were admitted safely to the service.
● The provider was accessing testing for people using the service and staff.

Staffing and recruitment
● There were enough staff on duty to ensure people's needs were met safely.
● Since our last inspection the registered manager had improved their recruitment processes to ensure staff were safe to work with people.

Systems and processes to safeguard people from the risk of abuse
● Staff were knowledgeable about safeguarding and could explain the processes to follow if they had concerns.
● Any potential allegations of abuse had been reported to the local authority and CQC.

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.

At the last rating inspection, this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff told us they had regular training opportunities, but this was not always evidenced by the records maintained. During our inspection visit we saw issues around infection control practices, fire safety and safe medicines practice.
- The provider's systems to review and monitor staff practice and to ensure staff with delegated responsibilities had the understanding and competence to carry out those responsibilities effectively were not sufficiently robust.
- Whilst staff felt able to speak with the registered managers at any time, they had not been provided with formal opportunities to discuss their work and identify any further support or training needs. One staff member told us they had not had any formal supervision meetings in the last 18 months.

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

- The registered manager worked with trusted assessors and social workers to ensure any admissions from hospital or the community could be supported safely.

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

- Staff understood people's individual dietary needs and knew which people needed to be encouraged to eat and drink more because of their nutritional risks.
- The lunch time meal was well-presented and people were happy with the food offered. Staff were vigilant in prompting people to eat more and discretely offered assistance when a need was identified.
- Where people had lost a small amount of weight, this was being monitored and referrals were made to other healthcare professionals where this persisted.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People were able to access health professionals and medical treatment when needed.
- Staff explained how they monitored people's changing health conditions, and when required contacted other health professionals such as occupational therapist, the GP and 111.

Ensuring consent to care and treatment in line with law and guidance, assessing people's needs and choices; delivering care in line with standards, guidance and the law

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 when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). 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 reviewed people's capacity to make decisions and where people had restrictions, these were reviewed to ensure they remained relevant, without unnecessarily restricting a person's freedom.
- Staff recognised giving people choice was important. One staff member said, "If I do something it is because it is my choice and I want things to be the residents' choice."
- Care plans recorded information about powers of attorney and important relationships in people's lives so those people could be included in care planning.

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

- The provider was in the process of making improvements to the environment to ensure they could meet people's needs. For example, one person's en-suite had been changed into a wet room to enable them to maintain their independence when showering.
- At our last inspection we saw the carpet in the corridors was heavily patterned which made it difficult for people to differentiate between the flat surface and the steps. The registered manager told us the carpet was in the process of being replaced.
- Whilst there was some signage in communal areas, there was still limited use of aids on bedroom doors, such as photographs or memory boxes, to help people find their own room more easily.

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 Requires Improvement. At this inspection this key question has remained the same. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

At our last inspection, the provider's systems and processes to manage and monitor the quality and safety of the service were not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and there was a continuing breach of regulation 17.

● At our last inspection in May 2019, the service was rated requires improvement overall for the second consecutive time, and therefore at this inspection we expected significant improvements would have been made and the provider to be compliant with all regulations. However, we found repeated breaches of the same two regulations.
● The provider had failed to ensure action was taken to address the regulatory breaches and concerns we identified at the last inspection to ensure people received high quality, safe care.
● At our last inspection we found there were limited formal systems in place to audit the safety of the service in areas such as infection control, health and safety and incidents and accidents. This continued to be an issue at this inspection.
● Audits were either not effective or had not been carried out which meant shortfalls in service provision had not been identified. For example, medicines audits only consisted of stock checks and had not identified the concerns in safe medicines practice we identified. Fire checks were inadequate to ensure fire risks were effectively managed.
● One person needed occasional support when transferring. Whilst staff understood how to do this safely and what equipment to use, this had not been recorded in the person's care plan. This lack of information had not been identified because audits of care plans had not been completed.
● The provider had failed to maintain oversight of staff training and practice. There was no central record to ensure staff completed training in a timely way and staff had not been given opportunities to discuss their training needs or to receive formal feedback on their practice.
● There were limited provider audits to ensure checks were driving improvements.

We found no evidence that people had been harmed however, the provider had failed to make improvements to the service and comply with regulations. Service oversight and governance systems were ineffective. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our urgent response to the provider with our findings, they took action to make improvements. The provider told us they were committed to making those improvements.

● A new manager had become registered with us 11 months before our inspection visit to support the long-standing registered manager. The new registered manager told us they were responsible for the day to day management of the service with the long-standing registered manager maintaining regular oversight.
● Staff spoke positively about the registered managers. One staff member said, "If I had a problem I could always go to [Names of registered managers]. You can always pick up the phone if they are not here."
● Despite our immediate concerns, we found staff knew people well and people received person centred care. Relatives were happy with the care their family members received. Comments included: "I have been very impressed with the staff I have met and how caring and sunny their disposition is in the face of the pandemic", "I think they're doing a really good job" and, "[Name] is happy. The staff are caring. It (the home) is homely and nurturing."
● The provider had met the legal requirements to display the services latest CQC ratings in the home and to tell us about notifiable incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● At the time of our inspection visit formal processes to capture the views of people and relatives such as regular meetings and quality assurance questionnaires were not being undertaken.
● However, the new registered manager spoke with people on a daily basis to check they were happy with the care provided and the chef gathered people's verbal feedback to inform any changes to menus.
● Relatives said they had confidence in managers and staff who they described as approachable. One relative told us, "I feel I can discuss anything with staff. They are outright in telling me what [Name] needs." Another relative told us how the new manager informed them of what was happening in the home and described them as, "Absolutely brilliant."

Working in partnership with others
● The provider worked with other health and social care professionals. This further supported people to access relevant health and social care services and improved links with commissioners and Infection control teams who provided support throughout the pandemic.

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 had failed to assess the risks to the health and safety of service users and do all that was reasonably practicable to mitigate any such risks.

The enforcement action we took:

We issued a Warning Notice against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes to manage and monitor the quality and safety of the service were not effective.

The enforcement action we took:

We issued a Warning Notice against this provider.