Alpha Care Castlemaine Limited

Castlemaine Care Home

Inspection report

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East Sussex
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Ratings

Overall rating for this service	

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

Summary of findings

Overall summary

About the service
Castlemaine Care Home is registered to provide care, support and accommodation for up to 42 people. There were 25 people living in the service when we visited. People cared for were mainly older people who were living with dementia and with a range of care needs, including arthritis, diabetes and heart conditions. Most people needed support with their personal care, eating, drinking or mobility.

People's experience of using this service and what we found
Whilst the registered manager and provider had systems and processes to assess and manage risks to people, these had not identified some of the shortfalls we found. Some of the issues with the safety of the premises whilst known had not been recorded, actioned or a plan of essential maintenance put in place. Records for people's well-being and safety were not all up to date or accurate, for example food and fluid charts.

The premises was not maintained to a good standard. Improvements were required throughout the building, in relation to exposed hot pipes, rucked carpets and unsafe floors, which the registered manager and provider were prioritising and actioning. The cleaning of the premises needed to improve to ensure all areas of the home were clean and hygienic for people.

People received care and support from enough staff who had been appropriately recruited and trained to recognise signs of abuse or risk. However, the deployment of staff at key times needed to be reviewed to ensure peoples' mental health and well-being needs were met consistently . One person said, "I like it here." Another said, "Its home now." Most peoples' care plans and risk assessments meant peoples' safety and well-being were protected by clear guidance for staff to follow. Medicines were stored, administered and disposed of safely.

Staff had all received essential training to meet people's support and care needs. There was an induction programme to introduce new staff to the service and during this process they got to know people and their needs well. Staff told us that they felt the induction had been a good introduction to the home.

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 and update
The last rating for this service was Good (published 15 November 2019)

The overall rating for the service has changed to Requires Improvement. This is based on the findings at this

inspection.

Why we inspected
We received concerns in relation to the safety of people and staffing levels. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led relevant key question 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 Castlemaine 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 monitor the service and will take further action if needed.

We have identified breaches in relation to ensuring peoples safety and good governance.

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

Follow up
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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

Castlemaine 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. 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
The inspection team consisted of one inspector.

Service and service type
Castlemaine Care 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. Castlemaine Care 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.

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 the information we held about the service and the service provider. We looked at notifications and any safeguarding alerts we had received for this service. We sought feedback from the local authority and professionals who work with the service. Notifications are information about important events the service is required to send us by law.

The provider had completed 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.

During the inspection
We looked around the service and met with the people who lived there. We spoke with five people to understand their views and experiences of the service and we observed how staff supported people. We also 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 spoke with the registered manager, deputy manager and four further staff members.

We reviewed the care records of five people and a range of other documents. For example, medicine records, staff training records and records relating to the management of the service. We also looked at staff rotas, four staff recruitment folders and records relating to health and safety.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with three relatives and two health care professionals.

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 Good. At this inspection the rating has changed to 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
- The safety of the building was impacted by poor maintenance in certain areas and had the potential to place people at risk.
- There were exposed hot water pipes which could cause scalding to peoples' skin. One communal bathroom which was used regularly by people had exposed hot water pipes which needed immediate attention to protect people. Other exposed hot pipes were found in peoples' bedrooms. Whilst staff knew of this issue, an environmental risk assessment had not been put into place to protect people and mitigate the risks.
- Air purifiers were in communal areas. We were told these were not working, but were still plugged in. They had been used by people as rubbish bins and were very unclean. This was identified as a possible fire risk and infection control risk.
- Carpets in bedrooms that were in use, had rucked carpets that could pose as a trip hazard. Environmental risk assessments did not reflect and mitigate the potential risk to people. These issues had been identified at previous inspections and still not actioned.
- Fluid records were inconsistently recorded and were not being monitored by staff. There were three people that had been identified as risk of dehydration. The care plans for these three people stated a goal of 1500mls and records evidenced only 500mls was given. The last record of fluids taken for these people was 5.30 pm and then nothing until 9 am the following day. This meant there was no record that fluids were offered or drunk for 14 hours placing people at risk of dehydration and urinary infections.
- On reviewing people's weights, it was identified that there were people whose weight was decreasing. There was evidence that the GP had been informed, but people's nutritional risk assessment did not reflect the actions staff took to fortify food to reduce further weight loss. Food records had not identified how much people ate. On the first day of inspection, the food returned to the kitchen was high, but staff had not recorded what people had consumed or indicated a need to offer snacks later. There was a lack of oversight of people's nutritional intake and risk.
- The management of people's oral health was not consistent and poor oral health had the potential to impact negatively on peoples' overall health and eating and drinking. Many people did not have toothbrushes or toothpaste in their bedrooms or bathrooms. We also found that some people did not have denture pots for their dentures.

The provider had failed to assess and mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we were sent risk assessments for the exposed pipes and a time frame to box in the pipes. We were also sent a new fluid and food monitoring chart which would enable staff to monitor the records more effectively.

● The service used a computerised system for care plans and risk assessments and this was used to record individual risks to people such as skin integrity, continence and mobility. Whilst all care plans and risk assessments had recently been reviewed, there was evidence that they had not been regularly reviewed over the past six months. This included monitoring peoples' mobility.
● Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. People's ability to evacuate the building in the event of a fire had been considered and each person had a personal emergency evacuation plan (PEEP).
● Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

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 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. The registered manager was currently updating the DoLS and ensuring that all were current and valid. We viewed three which were current and valid.
● The registered manager had made DoLS applications to the local authority when necessary and kept them under review until a response had been received. There had been a delay of transferring DoLS authorisations into the care plans and risk assessments, this was currently being undertaken by the management team and was nearly completed.
● Staff had received training in the principles of the MCA and understood their role and responsibility in upholding those principles.
● People were asked for their consent and were involved in day to day choices and decisions.
●There was a file detailing all the DoLS authorisation requests submitted and their status. The documentation supported that each DoLS application was decision specific for that person, for example, regarding restricted practices such as locked doors, and sensor mats. We saw that the conditions of the authorised DoLS had been met. For example, each person's care plan reflected how the decision had been made and what actions staff needed to take for that condition to be met.

Staffing and recruitment
● Staffing levels were adequate to meet people's needs. During the day, there was one senior and three care staff supporting 25 people, there was also an activity person who worked as part of the team Staff said, "It's not always easy as some people like to walk and we can't always monitor as closely as we need to," "We have some people who like to stay in their room at the moment and so it takes us away from the lounge," and "It's ok, but hard work, I think we need more staff so we aren't rushing people." These comments were

shared with the provider.
● The short observational framework tool for inspections (SOFI) identified times there was little positive interaction between staff and people, specifically between 10:30am and 12:30pm. Engagement was brief and resulted in people getting up to seek out staff and being directed away as staff were busy assisting other people. One resident said, "I am lucky, I have my books and can go out, otherwise I would be bored in the mornings."

The deployment of staff at key times needs to be reviewed to ensure their mental health and well-being needs were met consistently.

● On discussion with the registered manager, we were told that the staffing levels had been decreased in the month of April 2022 due to reduced numbers of people living in the home. This is being closely monitored by the management team to ensure that it does not have a negative effect on people's health and well-being. Falls and incidents had decreased in March 2022 and the monthly analysis of falls and incidents will be used to determine future safe staffing levels.

● New staff were safely recruited. All staff files included key documents such as an application form, interview notes, full employment history, at least two references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or adults. This ensured only suitable people worked at the service.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The overall cleanliness of the home needed to be improved to ensure that people lived in a clean and hygienic environment, walls and door frames had dirty marks on, dust was seen on radiator covers and window sills and an unused shower facility in a well used communal toilet was dirty. There was also some furniture whose outer layer was broken and therefore a cross contamination risk as it could not be cleaned. this included arm chairs and tables.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● We were somewhat 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.

We have also signposted the provider to resources to develop their approach.

The provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely
● Arrangements had been made to ensure the proper and safe use of medicines. Medicines were stored, administered and disposed of safely. Medicines were ordered in a timely way.
● All staff who administered medicines had the relevant training and competency checks that ensured medicines were handled safely. We observed staff administering medicines safely to people ensuring that

they were offered the medicines, given time to take them in the way that they preferred and signed for once they were taken.

● Protocols for 'as required' (PRN) medicines such as pain relief medicines were available and described the circumstances and symptoms when the person needed this medicine.

● Medication audits were being completed on a daily, weekly and monthly basis. The increase of audits was due to a recent (March 2022) external audit identifying issues with the management of medicines. The deputy manager who was also the medicine lead reviewed and analysed the findings of the audits to ensure they took action that may be required to safeguard people.

Learning lessons when things go wrong

● Accidents and incidents were documented and recorded. Any serious incidents resulting in harm to people were escalated to other organisations such as the Local Authority and CQC.

● Staff took appropriate action following accidents and incidents that ensured people's safety with restricting their mobility. For example, one person had an unwitnessed fall in their bedroom. Staff looked at the circumstances and ensured that risks such as footwear and trip hazards were explored. A sensor mat had been placed in their room which meant staff could support the person safely, whilst not restricting them from walking independently.

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

At our last inspection, we asked the provider to make improvements to the systems for auditing the quality of the services provided. This included peoples care records, environmental audits and responsive care planning.

- At this inspection systems and processes to assess, monitor and improve the quality and safety of the service provided had declined and therefore potentially placed people at risk from an unsafe environment and unsafe care. There were shortfalls in people's care documentation, accidents and incidents had not been cross referenced in to care plans in a timely way This meant that staff were not pro-actively reducing risk and accident and incident overviews and analysis had not been consistently completed. Following an external consultants' audit in March 2022, some of these areas had been identified and systems had been put in place, such as an accident and incident tracker. Care plans had been reviewed in March 2022 and accidents and incidents were now being analysed and actions taken.
- There were some areas of maintenance that had the potential to cause harm/injury to people and whilst known by the provider and registered manager had not been prioritised for action or risk assessed. For example, some flooring in corridors and bedrooms were found to be sinking when walked on, staff were unsure if this was due to the disintegration of the wood/hardboard floor. This had been identified but not acted on.
- Carpets in bedrooms that were in use, had rucked carpets that could pose as a trip hazard. Environmental audits did not reflect the potential risk to people or any action recorded to reduce risk.
- Fluid charts for people identified as at risk from dehydration were not completed competently, there was no monitoring if they had reached the fluid target set and no follow up recorded. Some fluid charts had gaps of up to 14 hours where drinks were not offered or given. Some people only reached a quarter of the target set in 24 hours. There was no action recorded or evidence that staff were aware of the risk of dehydration.
- Whilst people were weighed, weight loss was not always reflected in the weight loss tool or plan of care as to what actions staff were taking to mitigate the risk of further weight loss.
- There were continued shortfalls found in the standard of cleanliness in some areas of the home, particularly in communal bathrooms and corridors. The décor in some areas was tatty and in need of attention.

● There had been a quality assurance survey sent to people, staff, professionals and relatives to gain their views in January 2022, however there was no record of actions taken to address some issues or reassure people that their comments had been taken forward, for example environmental issues.

The provider had failed to assess, monitor and improve the service. The provider had failed to assess, monitor and mitigate risks to people and to act on feedback. The provider had failed to maintain accurate, complete and contemporaneous records. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Following the inspection, we received action plans from the provider regarding the maintenance of the premises with proposed completion dates. We have also been sent a plan of how they were to address record keeping regarding fluid monitoring.

● Staff felt supported and told us they received support and guidance when needed. One staff member said, "The deputy is really good, and is always helpful and supportive."
● Staff told us they were involved with regular staff meetings where they could discuss training or any ideas to improve care. They felt that this had been helpful especially as they had

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff spoke of how they promoted a positive culture in the service. We were told they maintained a regular and positive contact with people and relatives. One relative told us, "The staff are very good, It's been a long journey but staff are all kind and very cheerful which makes it easier."
● People, relatives and visiting professionals were positive about the registered manager and the management of the service. One relative said, "Seem efficient." Another said, "I was kept informed of changes during the pandemic, they did a good job." A visiting professional said, "The deputy manager is knowledgeable about the residents and the medicines, we are asked for advice when needed."
● Staff were confident with management arrangements They talked of training and how they felt supported in performing their role.
● The management structure allowed an open-door policy, the manager's office was in the reception area and so the manager was visible to visitors, people and staff. The registered manager told us, "I like to open the door to visitors and get to know them." about lack of surveys.

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 provider understood duty of candour, working openly and honestly with people when things went wrong. The registered manager was aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The service had notified us of all significant events which had occurred in line with their legal obligations. One health professional told us, "Communication is good with the home, they contact us for advice when needed."
● Notifications were submitted to the CQC, as required. The previous CQC rating was prominently displayed in the home and on the provider's website.
● People and relatives confirmed that the provider kept their website up to date with changes from the government regarding visiting and COVID-19.

Continuous learning and improving care
● The management and staff team made sure they continually updated their skills and knowledge by

attending training, and having regular meetings as a team.
● The provider consistently questioned what they could do to improve the service and made any changes they felt necessary. However we have found they require improvement due to poor governance and missed opportunities to improve the environment and the quality of care/recording. When a safeguarding had been raised, the registered manager worked with the local authority and confirmed that lessons had been learnt and learning taken forward.

Working in partnership with others:
● The management team took up opportunities to work in partnership with local health care and community services to improve people's health and wellbeing. There had been close working with the medicine optimisation team and GP during the pandemic.
● Staff worked closely with local healthcare providers such as the GP surgery, district nurses and the local pharmacy. The registered manager and provider worked in partnership with the local authority commissioners to share information and learning around local issues and best practice in care delivery.

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 provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the service. The provider had failed to assess, monitor and mitigate risks to people and failed to act on feedback. The provider had failed to maintain accurate, complete and contemporaneous records.