EBS Services Limited

Rodney House Care Home

Inspection report

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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
Rodney house is a care home providing accommodation and personal care for up to 57 people At the time of our inspection 55 people were using the service.

People's experience of using this service and what we found
Risk was not assessed, safely monitored and managed placing people's health, safety and welfare at risk. There was lack of information to guide staff on how to manage and monitor risk. The cleanliness, hygiene and condition of the premises and equipment were poorly maintained increasing the risk of the spread of infection. There were multiple fire doors across the service with defects and a smoking room on the ground floor was unsafe. Information required about candidates was not confirmed to ensure they were fit and suitable for the job before they were appointed. There were insufficient numbers of suitably skilled and experience staff deployed across the service to meet people's needs and keep them safe.

The service lacked clear leadership and governance. Managers were unclear about their roles and responsibilities and lacked understanding of regulatory requirements. The systems and processes used to assess, monitor and improve the quality and safety of the service were not used effectively. Audits and checks carried out at the service were unreliable and ineffective, they failed to identify risk and bring about improvements. There was a lack of provider and management oversight of the quality and safety of the service. Notifications about incidents which occurred at the service were not always submitted as required to The Care Quality Commission (CQC). The failure to identify and mitigate risk and bring about improvements to the service led to people not always receiving person-centred care with good outcomes.

Rating at last inspection and update
The last rating for this service was good (published 19 December 2017).

At this inspection we found the provider was in breach of regulations.

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of people's safety. This inspection examined those risks.

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 inadequate 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 full 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 Rodney House 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 monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety, staffing, recruitment and the governance and leadership of the service.

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.

Special Measures
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 varying the conditions of 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.

Rodney House 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 was carried out by an inspector and an inspection manager.

Service and service type
Rodney House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
All three days of the inspection were unannounced.

What we did before the inspection
We reviewed all the information we held about the service since it registered with the Commission. We also

obtained information about the service from the local authority and local safeguarding teams. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection visit
We spoke with five people about their experience of the care provided. We also spoke with the registered manager, deputy manager, provider, four care staff, the chef and two ancillary staff.

We reviewed a range of records. This included five people's care records and a selection of people's medication records. We looked at recruitment records for three staff members employed since the last inspection. A variety of other records relating to the management of the service, including audits and checks were reviewed.

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 good. 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; Learning lessons when things go wrong
- There was a lack of robust assessment, monitoring and management of risks to people's health and safety.
- No risk assessment had been completed for one person to guide staff on how to safely manage the risks the person presented to themselves and others following a recent serious incident.
- Records lacked information about people's needs to minimise the risk of harm to them. For example; Robust risk assessments had not been completed for aspects of people's care which it was known presented risk. This included risks associated with diabetes, epilepsy and wounds.
- Each person had a personal evacuation plan (PEEP) kept in their care file. There was no grab file or any other means of making them easily accessible to those that needed them in the event of an emergency.
- There were multiple fire doors across the service which were unsafe due to ineffective closure devices, gaps and damaged door seals. Some fire doors were held open using items of furniture. The designated smoking room on the ground floor presented a number of fire hazards.
- Accident and incidents were reported and recorded however records lacked information about action taken and lessons learnt to minimise further occurrences.

The provider failed to assess, monitor and mitigate the risks relating to the health safety and welfare of service users. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment; Systems and processes to safeguard people from the risk of abuse;
- The deployment and recruitment of staff was not safe.
- An agency staff member was providing a person with one to one support without any knowledge of the person, their background and the reason for providing the one to one support. The staff member had not been briefed through a handover prior to providing the support. In addition, they had not been given access to the person's risk assessment to guide them on how keep the person and others safe from the risk of abuse. The staff member had no means of calling for assistance if needed. This was immediately raised with the deputy manager who was asked to replace the agency member of staff with an experienced staff member.
- The registered manager informed us there were serious shortfall of staff. They told us a number of staff had left, and recruitment to replace them was proving difficult.
- The rota showed that there were significant staff shortages and the provision of the one to one support recently implemented for one person had created additional staffing pressures. It had been difficult to plan for the provision of one to one support due to the shortage of staff.

● Rotas covering the 29 and 30 October showed a significant shortage of staff with only one senior carer, one other permanent staff member and one staff member covering only part of the day. All other staffing was being supplied by care agencies and only two agency staff had been confirmed.

The provider failed to ensure sufficient numbers of suitably skilled and experienced staff to safely meet service user's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Information required about candidates was not confirmed to ensure they were fit and suitable for the job before they were appointed into their role.
● There was no evidence of a criminal background check for two staff appointed. All candidates were required to complete a check with the disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National computer. The information helps employers make safer recruitment decisions.
● Other information required prior to their appointment had not been obtained for two staff including a completed application form, complete and sufficient references and interview records.

The provider failed to ensure the proper and safe recruitment of staff. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always used safely.
● Good practice guidance set out by National Institute for Health and Care Excellence (NICE) was not always followed for the safe management of controlled drugs (CDs). The administration of CDs and stock checks which had been carried out were not always witnessed and signed by two staff. There were multiple entries in the CD register which were signed by one staff member only. A controlled drug is tightly controlled by the government because it may be abused or cause addiction.
● We were not assured that staff were competent to safely manage people's medicines. Both the registered manager and deputy manager completed medication competency checks on staff, however neither were able to provide evidence of their competence, skills and knowledge to carry out the required checks.

The provider failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Safe infection, prevention and control measures were not followed.
● Parts of the premises and equipment were unclean and unhygienic increasing the risk of the spread of infection.
● Kitchen surfaces, appliances, floors and walls were heavily stained with food debris and spillages.
● Furniture, walls and flooring in the dining room were heavily stained with a build-up of food debris and a hot trolley located in the dining room was encrusted with a build-up of food debris.
● Equipment people were using including walking aids, crash mats and wheelchairs were heavily stained and unclean. Many items of furniture in people's bedrooms including wardrobes, cabinets and chairs were unclean and in poor condition.

The provider failed to assess the risk of the spread of, infections. This was a breach of regulation 12 (Safe

Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediate action was taken to mitigate risks to people. We shared our concerns with the relevant local authorities and made a referral to the community IPC team and Fire and Rescue Service.

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 good. At this inspection this key question has 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.

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

- Learning had not taken place which resulted in a significant decline in the quality of the service people received.
- The lack of effective management, leadership and governance of the service failed to drive improvements to the quality of care people received.
- The systems and processes operated at the service to monitor quality and safety, to identify and mitigate risk and bring about improvements were not used effectively.
- Audits and checks which were completed failed to identify and mitigate the risks relating to people's health, safety and welfare which we found during this inspection. This included risks relating to people's care and the cleanliness, hygiene and safety of the environment and equipment.
- The registered manager did not fully understand their role and responsibilities, risk management and, regulatory requirements. They failed to submit allegations of abuse notifications to CQC and when we raised this with them during the inspection, they showed a lack of understanding of this requirement.
- The management arrangements at the service were not effective. Both the registered manager and deputy manager had managerial responsibilities for the running of the service. However, both the registered manager and deputy manager worked the same shift pattern during office hours Monday to Friday each week. This left the service without any managerial support or oversight during the evenings and at weekends.
- There was a lack of robust oversight and scrutiny by the provider to ensure effective management, leadership and governance of the service.

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

- The provider did not always plan, promote or ensure people received person centred with good outcomes.
- People's safety, health and welfare was seriously compromised which led to them receiving poor outcomes.
- Care records were not always person centred, they contained generic information which was not relevant to the person. There were multiple examples were the outcomes for people were generic and not specific to the person.
- Some practices carried out at the service were not person-centred. People were served meals with disposable tableware including paper plates and plastic cutlery and there was no clear reason for this.

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 did not always notify CQC of incidents and events that occurred at the service. Providers are required by law to submit the required notifications to CQC without delay. The information provided in notifications helps CQC to decide if further action is needed to ensure people's safety.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others;

● There was a lack of engaging and involving people in decisions about their care.

● Care plans reviews did not evidence people's involvement and their agreement to their plan of care. Changes made to care plans were not discussed and agreed with the person, when this was appropriate or relevant others.

● External health and social care professionals were consulted however there were missed opportunities to make referrals for people when they experienced a decline in their physical and mental health.

The provider failed to operate effective systems for checking and improving the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 failed to assess, monitor and mitigate the risks relating to the health safety and welfare of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure the proper and safe recruitment of staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably skilled and experienced staff to safely meet service user's needs.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems and processes for checking and improving the quality and safety of the service and mitigate risk.

The enforcement action we took:

Warning notice.