Qu'Appelle Residential Care Home Limited

# Qu'Appelle Care Home

## Inspection report

Harrington Street
Bourne
Lincolnshire
PE10 9HA

Tel: 01778422932

Date of inspection visit:
08 September 2021
13 September 2021

Date of publication:
21 December 2021

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

Qu'Appelle care home is a residential care home providing personal and nursing care to 15 people aged 65 and over at the time of the inspection. The service can support up to 36 people.

People's experience of using this service and what we found
People were not protected from avoidable harm because risk assessments and care plans were not up to date and did not always identify risk. Staffing numbers were not sufficient to meet people's needs or keep them safe. Staff did not have time to monitor or supervise people who required this. Some people did not have enough to eat or drink and this was not identified, and no action was taken.

The premises and environment were poorly maintained, and this put people at risk of harm. Action required identified in the providers own fire risk assessment had not been taken. Staff had not had evacuation training and there were not enough staff to keep people safe in an emergency situation. Lincolnshire Fire and rescue service visited the service the day after our inspection and served a prohibition notice. This meant the fire service was of the opinion the use of the premises would involve serious risk to people and should not be used.

Infection control policies and procedures did not protect people from infection because government guidance was not always followed. Risks associated with COVID-19 had not always been identified or assessed.

There was a lack of formal oversight from the provider, who had failed to identify the concerns found during our inspection. Quality assurance audits were not always carried out or were ineffective. Staff had not received the training and support they required. People were not consulted about their care and support. People were not protected from the risks associated with receiving care and support.

Rating at last inspection
The last rating for this service was inadequate (published 20 May 2021). At this inspection, not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to check whether the Warning Notice we previously served in relation to Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We also received concerns in relation to staffing numbers and safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We have identified breaches in relation to safety, staffing numbers, quality monitoring and governance.

We cancelled the provider's registration.

Follow up
The overall rating for this service is 'Inadequate' and the service therefore remains 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.

## 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.

# Qu'Appelle 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 two inspectors.

Service and service type
Qu'Appelle Care Home 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
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with eight members of staff including the registered manager, heads of care, senior care workers, care workers

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

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection. Learning lessons when things go wrong.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) 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 12.

- Care plans and risk assessments were not up to date or reflective of people's needs. Where risk had been identified such as risk of malnutrition and dehydration, not enough action had been taken to reduce this risk. Some people had insufficient amounts to eat and drink and not enough action was taken in response.
- There were risks in the environment such as raised bumps in carpets causing a trip or fall hazard. There were piles of rubbish in the garden and the grass was unmown, garden furniture was broken. People had access to the kitchen and laundry and to substances which may be hazardous. Stairs were fully accessible because keylocks were broken putting people at risk of falls from height.
- There were outstanding actions in the providers own fire risk assessment. Staff did not have the training or fire drill practice required to respond safely in an emergency situation such as a fire. There was no record of routine testing of fire safety equipment.
- Some staff were not wearing face masks in line with national guidance. One member of staff did not have access to gloves in their size so was delivering personal care without gloves. Risk assessments did not protect people from the risk of contracting COVID-19.
- There had been a recent outbreak of COVID-19 but there were no individual risk assessments, this was despite some people not being able to socially isolate because of their condition.
- Despite the COVID-19 outbreak affecting 11 people, there was a delay of 12 hours from the last person's positive test being read. This meant precautions to protect others were not put into action for more than 12 hours and this put people at unnecessary risk.
- There was no effective analyses of accidents and incidents for themes and trends, and what measures had been implemented to reduce the risk of reoccurrence.
- The provider had not addressed concerns and non- compliance identified at the last inspection in May 2021 and had been rated as inadequate at three of the last four inspections.

Risks were not identified or managed and people were not protected from the risk of infection. 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

● Staffing numbers were not sufficient to meet people's needs. The staffing tool used to calculate the required number of staff did not take into account people's needs and dependency.

● People were unsupervised for most of the day during our inspection. Some people were disorientated and needed staff to be available to support them to keep safe. Some people were asleep or staring into space for hours at a time with nothing to do.

● Six people required two staff to attend to them because of their physical needs, however, at night there were only two staff on duty and only three in the afternoon/evening. This meant during the night there were times when no staff were available to attend to people's needs or monitor their safety when they were supporting one person.

● Care staff were also entirely responsible for preparing and serving breakfasts and administering medicines. This meant they did not have enough time to support people to get up and dressed in the morning or to supervise people to make sure they were safe.

There were insufficient staff to meet people's needs or keep them safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment procedures were safe. Checks were carried out before staff were offered employment to make sure they had the right skills and experience.

Using medicines safely

At our last inspection, people's medicines were not managed safely and in line with best practice guidance. People did not always receive their prescribed medicines. Staff did not always receive medicine training in line with best practice guidance and staff competence was not assessed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvement had been made regarding the management of people medicines at this inspection, but the provider was still in breach of regulation 12.

● Staff responsible for administering medicine had not had their competency checked to make sure they were following safe procedures and were competent.

● There were occasions at night where no staff had received medicine training, this meant people could not access their medicine should they need them until the following morning.

● Medicines were stored securely and in line with manufacturers requirements. Administration records were accurate and up to date. There were clear protocols in place about when 'as required medicines' should be given. People were given their prescribed medicines at the right time.

Systems and processes to safeguard people from the risk of abuse

● Staff understood safeguarding and how to protect people from harm and abuse. However, staff told us when they escalated any concerns to the provider, they were ignored, and no action was taken to ensure people were safe.

● People were not always protected from abuse because they were left for long periods of time unsupervised and without the staff support, they required. Staff had raised their concerns with the provider, but no response was provided.

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 inadequate. At this inspection this key question remained the same. 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 last inspection the provider had failed to ensure there were effective quality monitoring systems and processes in place to monitor quality of the service and maintain oversight. This was a breach of Regulation 17 (Good Governance) 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.

● Quality audits carried out were ineffective because shortfalls were not identified, or where they were identified, no action was taken to remedy the issues.
● There was ongoing risk in the environment due to poor maintenance, broken furniture and broken keycode locks. People living with dementia had access to hazardous substances and sharp objects. The garden was untidy and contained several trip/fall hazards caused by unmown grass, piles of rubbish and fallen apples. The provider had failed to mitigate this identified risk.
● Fire safety checks had not been carried out and staff did not have the skills and training required to evacuate people in the event of a fire. The provider's own fire risk assessment had identified deficiencies in July 2019 but the required action had not been taken to remedy the deficiencies. There was no evacuation plan and the provider had not considered the number of staff required to safely evacuate people in the event of an emergency. Therefore, despite identifying risk the provider had failed to take action and implement systems to mitigate the risk.
● There were no systems or processes in place to monitor risk or to ensure people had their needs met. People's needs were not regularly reviewed or reflected in people's care plans and risk assessments. Staff did not receive the training and support they required to meet people's needs and keep them safe. We observed staff using an unsafe moving and handling manoeuvre. The provider had failed to sufficiently assess, monitor and mitigate the risks for people.
● The provider had not ensured there were accurate records provided for the care and treatment of people living in the home. For example, one person did not have a care plan despite having lived there for several weeks.

The provider had failed to ensure there were effective quality monitoring systems and processes in place to monitor quality of the service. This was a breach of Regulation 17 (Good Governance) 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; 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 culture was not open or inclusive. Staff had no confidence in the provider and were frustrated by their lack of response to known risks and low staffing numbers.

● People were bored and spent long periods of time unoccupied in the communal lounge. People did not get the support they required with eating and drinking. Staff did not have time to spend with people to support them in a person-centred way.

● The registered manager was aware of their 'duty of candour' responsibilities and their legal responsibility to report events which took place in the service.

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

● The provider did not seek or act on feedback from people, staff and partner agencies to evaluate and improve the service.

● People and staff were not involved or consulted about the day to day running of the service, changes were imposed without consultation and people were not asked for their feedback.

● There had not been any resident or staff meetings for more than six months. There were no systems or processes in place to engage or involve people or staff.

● Staff were concerned and anxious about changes made to staffing numbers and planned staff redundancies and the impact this would have on people who used the service.

● The local authority had identified concerns and had asked the provider to make improvements.

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<br><br>People were not protected from avoidable harm |

**The enforcement action we took:**

We issued a notice of proposal to cancel the providers registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>People were not protected from avoidable harm |

**The enforcement action we took:**

We issued a notice of proposal to cancel the providers registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staffing numbers were not sufficient to meet people's needs or keep them safe. Staff did not have the skills and support they required. |

**The enforcement action we took:**

We issued a notice of proposal to cancel the providers registration