Elysium Neurological Services (Badby) Limited

Badby Park

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?	**Inadequate**

Summary of findings

Overall summary

Badby Park is a care home service that is registered to provide care for up to 68 people. There are three units providing care for people with high dependency support needs, complex care and rehabilitation. At the time of the inspection there were 64 people living in the home.

People's experience of using this service and what we found
The provider failed to have sufficient systems and processes to assess, monitor and improve the safety and quality of the service. Audits failed to identify areas that required improvement such as infection prevention and record keeping.

People were at risk of abuse due to the lack of robust systems of recording, reporting and investigating incidents and unexplained injuries.

People were at risk of not receiving all their planned care, or person-centred care due to the lack of effective communication between managers and staff in all areas.

The provider had not responded to verbal complaints or negative feedback from surveys in a timely way. People were not always provided with equipment they required to communicate effectively. People did not have free access to an advocacy service.

There were enough staff deployed to provide people with their care. Regular agency staff were used to ensure continuity of care until permanent staff could be recruited. There were not enough allied health professionals or clinical psychologists employed to meet people's needs. Recruitment for these posts was on-going. Staff were recruited using safe recruitment practices.

Staff training was ongoing. The registered manager ensured staff with specific skills to meet people's needs were deployed on every shift. New staff received an induction and all staff received supervision.

Staff ensured people received their food and drink safely. Staff used evidence-based tools to assess people's risks and needs.

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.

We made two recommendations, one to keep the rotas under review to ensure an appropriate skill mix and the other to ensure enough resources are allocated to facilitate people's moves to their new homes.

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

Rating at last inspection. The last rating for this service was requires improvement (published 6 January 2021) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management and safety of the service. As a result, we undertook a focussed inspection. This report only covers our findings in relation to 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 coronavirus and other infection outbreaks effectively.

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 have identified continued breaches in relation to safe care and treatment, and lack of governance and oversight of the service. We also identified a breach in relation to safeguarding service users from abuse or improper treatment.

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

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 continue to monitor information we receive about the service until we 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Inadequate**

Badby Park

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
This inspection was carried out by two inspectors.

Service and service type
Badby Park 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 both the registered manager and 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. We sought feedback from the local authority, the clinical commissioning group and Healthwatch Northamptonshire. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all 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. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and four relatives about their experience of the care provided. We spoke with 11 members of staff including the manager, unit leaders, care staff and the chef.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at four 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. We looked at training records and the provider's quality improvement plan. We telephoned staff and relatives for their feedback. We spoke with clinical commissioning groups and the advocacy service.

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 remains rated as 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.

Preventing and controlling infection including the cleanliness of premises. Assessing risk, safety monitoring and management. Using medicines safely.

At the last inspection, the provider had failed to ensure care, treatment and medicines were provided in a safe way. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- The provider did not always follow government guidelines or their own infection prevention policies. Where people were required to be in isolation there was no signage to inform staff, nor personal protective equipment outside their rooms for staff to use. They did not ensure frequent touch areas and environment were cleaned regularly as planned. They did not have a system to ensure frequently used equipment was cleaned between uses, such as hoists. This places service users at risk of cross contamination of infection.
- People did not always receive their prescribed medicines. Staff recorded some medicines were out of stock, when they were not. Some staff did not know where to locate medicines, and there was no system to identify this issue.
- The provider did not ensure risk assessments were accurately calculated. People were at risk of not receiving care to mitigate their known risks.
- The provider did not ensure people received their planned care. For example, one person did not receive their two hourly personal care. This put the service user at risk of poor skin integrity.
- People were at risk of not being accurately assessed by health professionals in the case of emergency as not all information was available on people's emergency grab sheets. Information such as infection risk, swallowing difficulties and falls history had not been completed.

We found no evidence that people had been harmed however, the provider had failed to ensure care and treatment was provided in a safe way for all service users. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- 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 assured that the provider's infection prevention and control policy was up to date.
● The provider had made improvements to the safe management of medicines since the last inspection. Systems had been implemented to ensure staff had information about the management of diabetes, safe storage of medicines and the rotation of transdermal patches.
● Protocols were in place for 'as and when required' (PRN) medicines and people received their medicine when they needed it. Where people were administering their own medicine there were care plans in place to support this and guide staff on the level of support needed.

Systems and processes to safeguard people from the risk of abuse
● The registered manager did not always follow the provider's systems and processes which were designed to protect people from the risks of abuse.
● The registered manager failed to ensure all unexplained wounds and injuries were recorded and investigated.
● The registered manager did not always report allegations of abuse to the relevant safeguarding authorities or take the appropriate actions to protect all people from the risk of abuse until an investigation had been carried out. We raised a safeguarding alert.

Failure to ensure systems to safeguard people from the risk of abuse were followed meant there was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were enough staff deployed to provide people with their care. Regular agency staff were used to ensure continuity of care until permanent staff could be recruited.
● People received care form allied health professionals and clinical psychologists.
● Staff were recruited using safe recruitment practices whereby references were checked and their suitability to work with the people who used the service.

Learning lessons when things go wrong
● The communication between the three separate units needed to improve to ensure all staff had the opportunity to learn from incidents.
● Where accidents and incidents were recorded, these had been monitored for trends and themes. Learning from these findings are used to mitigate risks.
● The registered manager had made improvements in the areas we identified at the last inspection, and where other agencies had recommended improvements.

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 inspection this domain was inspected in 2018 it was rated Good. At this inspection the rating has deteriorated to requires improvement. 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

- People's complex needs were met by a small team of staff who had all the necessary training to meet their needs. For example, care of spinal cord injuries and tracheostomy care. The registered manager told us the number of staff with complex needs training would increase once more staff had been recruited.
- Not all staff had received training in the safe management of people's behaviour that challenged others. The provider had been unable to provide the training required for new staff due to the pandemic. The registered manager ensured staff who had received the necessary training were on duty to manage people's behaviours safely. Training had been booked for future dates to increase the number of staff with required training.
- New staff received an induction and all staff received supervision.
- Agency staff received an induction to the service and were supervised by permanent members of staff.

We recommend the registered manager and provider keep the rotas under review to ensure an appropriate skill mix across shifts whilst training and updates of training continue.

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

- People who required their food and drink via feeding tubes (PEG) received their prescribed nutrition and hydration. People's PEG sites were checked and monitored for signs of trauma and infection.
- Staff ensured people received their food and drink safely. For example, where people had been assessed at risk of choking, staff followed health professionals' advice by giving modified diet such as a pureed food or thickened fluids.
- Staff monitored people's weight regularly and referred people to health professionals if they were not eating and drinking well. Staff followed health professional's advice to fortify foods where necessary.
- Staff ensured people could choose what they ate at mealtimes.

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

- People's needs were assessed before they commenced using the service to ensure staff understood people's needs and preferences.
- Assessment documentation showed all aspects of a person's needs were considered including the characteristics identified under the Equality Act and other equality needs such as peoples religious and cultural needs.
- Staff used evidence-based tools to assess people's risks and needs.

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

● People were at risk of not always receiving consistent care. Timely updates and changes to people's care plans were sometimes delayed as the communication within the multidisciplinary care team was disjointed. Improvements are required to ensure decisions about people's care is always shared with all members of the team and updating care plans is not delayed by constraints in roles. For example, where care plans needed to be changed to incorporate people's changing needs, care staff were unable to do this as it was the role of the therapist, however, the therapist was not available.

● People who wanted to live at home or move to an environment where they would have more independence had access to a social worker employed by the provider. Due to the pandemic there had been many delays in enabling people to reach their goals. As the restrictions were being lifted and people wanted to make their respective moves, there was an increased need for staff to be made available to help facilitate people to move to their desired new homes.

● An advocacy service was provided for four hours once a week. However, the access to the advocacy service was curtailed as the social worker chose who the advocacy service would see. People could not freely access the advocacy service. Two people told us they were frustrated by the lack of access, we discussed this with the registered manager.

We recommend the provider considers what resources are required to facilitate people's moves to their new homes.

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

● People who were unable to communicate verbally had not been provided with equipment they required to communicate effectively. For example, one person had been identified as requiring equipment to allow text to speech, however, they had not been provided this in a timely way. Another person had equipment to enable some independence with their electronic devices, however, staff had not connected the equipment. Both people told us they were frustrated by the lack of assistance with their communication devices.

● People who could mobilise could access all the areas of the service they needed with ease. The corridors were wide enough to manoeuvre wheelchairs and most rooms were large with en-suite facilities.

● People's rooms had items that helped them to connect with their families and friends such as photographs. People's interests were evident in people's rooms, such as sport posters.

Ensuring consent to care and treatment in line with law and guidance

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.

● People were at risk of not receiving care that matched best interest decisions due to information in the care plans not matching the decisions. For example, one person was at risk of falls, to help mitigate the risk

a best interest decision had been made about their footwear. The information in their care plan did not reflect this.

● People were supported in the least restrictive way possible. Individualised, decision specific mental capacity assessments had been completed and best interest decisions recorded. Were people were deprived of their liberty DoLS were in place and people were supported in line with their agreed plans.

● People were encouraged to make their own decisions and choices as much as possible. People were supported to explore their options around the deprivation of their liberty and the staff worked with appropriate professionals to support understanding of the legal process.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Continuous learning and improving care; Working in partnership with others

At the last inspection, the provider had failed to implement a robust system of quality assurance or to identify and address the shortfalls in the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance.

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

● The provider's systems to assess and monitor the infection prevention and control measures failed to identify shortfalls in the cleaning of high touch, entire environment and frequently used equipment. They did not identify where government guidelines were not being followed. This placed people at increased risk of infections.
● The provider failed to have a reliable and robust system to identify, record and act upon incidents of injury or abuse. This failure has led to injuries not being investigated or reported to the relevant safeguarding teams. This has put service users at risk of harm as unexplained injuries and allegations of abuse have not been investigated or used to improve the safety of care.
● The provider failed to have a system to identify, record and act upon service user feedback to improve the quality and safety of care. Where staff recorded people's verbal complaints in care notes and handover records, these have not been identified as complaints or managed in accordance with the provider's complaints policy. In the March 2021 survey, people raised concerns such as feeling ignored, not having their wishes acted upon and staff speaking in languages other than English. The provider failed to respond to people's feedback or make the necessary changes in a timely way to improve the quality of the service.
● The provider failed to have a system to assess and monitor the welfare of service users. People did not have free access to an advocate as the advocacy service provided is limited to those people identified by the social worker. People's welfare is at risk as they are hindered in seeking assistance due to the gatekeeping of the advocacy service.
● The provider's audits failed to identify where risk assessments were not accurate, emergency grab sheets were incomplete, care plans and best interest decisions did not match, or monthly risk assessments had not

been consistently reviewed. Medicines audits did not identify where medicines were being recorded as out of stock. There was no audit for the accessibility and response to call bells.

● The provider failed to have reliable systems and processes to record service users risk assessments and care records. The transfer of paper to electronic records had been delayed causing confusion amongst staff about where to record information. There is a potential risk of not identifying clinical signs of ill health such as changes in bowel habit, nutrition and hydration.

● There was a lack of effective communication between managers, units and disciplines. People were at risk of not receiving all their planned care as there was insufficient accountability for the care provided. People were not always receiving person centred care.

We found no evidence people had been harmed however, the provider failed to have sufficient systems to improve the quality and safety of care and maintain a good oversight. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that care and treatment was provided in a safe way for all service users.

The enforcement action we took:

We issued a Warning notice which required the provider to be compliant by 25 June 2021.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems to safeguard people from the risk of abuse were being followed.

The enforcement action we took:

We issued a Warning notice which required the provider to be compliant by 25 June 2021.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have sufficient systems to assess, monitor or improve the quality and safety of care and maintain a good oversight.

The enforcement action we took:

We issued a Warning notice which required the provider to be compliant by 28 August 2021.