Shaftesbury Care GRP Limited

Redworth

Inspection report

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29 July 2020
30 July 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Redworth House is a nursing care home providing accommodation and nursing care to 57 older people. At the time of the inspection the service provided support for 46 people some of who were living with a dementia type illness.

Redworth House accommodates people across four separate wings, each had their own adapted facilities. One of the wings provided intermediate/short term care to support people to regain independence following a period of illness, hospital admission or following an accident.

People's experience of using this service and what we found
We received mixed feedback from people, relatives, staff and visitors about the safety and care provided to people and the overall management of the service.

The home was recently placed into the local authority's planning protocol due to the areas of concern found during their visits regarding medicines and care records; concerns raised by some relatives, and staff. This meant the local authority was supporting the home to raise standards and ensure people remained safe.

People were not always protected from the risk of harm due to care records not being kept up to date. Staff were not always able to identify people's current needs. Changes to people's health needs were not always reported, recorded accurately or identified in a timely manner to allow action to be taken.

Medicines were not always effectively managed to ensure people received their medicines at the right time and as prescribed. Staff were not following the provider's medication policy and procedures.

The provider's infection prevention and control procedures were not always followed to keep people safe and reduce the potential spread of infection.

The provider's quality assurance checks had not been effective in highlighting some of the areas of concern found during the inspection. Risks to people's health needs, care records, management of medicines and infection prevention and control procedures had not been safely monitored. The home had appropriate checks and maintenance systems in place to ensure the environment and equipment was safe for people living at the service.

The provider had a safe recruitment system in place. A new clinical lead nurse had recently been appointed.

The provider encouraged people and relatives to give their views. Where possible meetings had been held for people and their relatives. All relatives spoken to during the inspection with were positive about the service and the support their family member received.

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 good (published 16 November 2017).

Why we inspected
We received concerns in relation to the management of people's health and care needs, records and quality monitoring of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

Ratings from previous comprehensive inspections for the key questions we did not inspect were used in calculating the overall rating at this inspection.

The overall rating for the home has changed from good to requires improvement. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified two breaches in relation to the safe care of people's needs, management of medicines, records and quality monitoring of the service.

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

Follow up
We have met with the provider and discussed how they will make changes to ensure they improve their rating to at least good. The provider has produced an action plan of what they will do to improve the standards of quality and safety. We will continue to work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Redworth

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.

Inspection team
One inspector, one specialist nurse advisor and an Expert by Experience undertook the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Redworth 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.

The home 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 announced. Having consideration of the coronavirus pandemic, we gave the registered manager a short period of notice of our arrival. This was to ensure safe systems were in place to protect everyone.

Inspection activity started on 28 July 2020 and ended on 30 July 2020. We visited the home on 28 July 2020. Telephone calls with relatives, staff and external professionals were undertaken on 29 and 30 July 2020.

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 and external professionals who work with the service.

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
We spoke with five people who used the service and nine relatives about their experience of the care provided. We spoke with ten members of staff including the provider, operations manager, registered manager, care team leader, one nurse, senior care workers and care workers. We also spoke with two external professionals who regularly visited the service.

We reviewed a range of records. This included six 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. We looked at maintenance and quality assurance records and spoke by telephone to external professionals who worked with the home.

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 good. At this inspection this key question has deteriorated 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.

Systems and processes to safeguard people from the risk of abuse
• Care records for people's specific health needs were not always in place to guide staff on how to manage and monitor those needs safely.
• Staff were not acting in a timely manner when people's health needs were changing. One visiting external professional told us, "Staff are not always quick on picking up early signs of when people's health is changing and taking the action needed."
• Staff did not always know the needs of the people they were supporting and were unable to tell us how they would identify and minimise risks to people's health and care needs. One staff member said, "I tend to work across the whole home, so I don't always get to know the people that well."
• Wound management records were not always in place to direct staff on how to monitor, manage and report changes to people's wounds.
• The service had policies and procedures in place to guide staff on how to keep people safe. However, observations during the inspection indicated staff were not always adhering to these and responding to people's needs in a safe manner.

Systems were either not in place or robust enough to demonstrate people's safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action to review all care records and risk assessments. An urgent face to face assessment was requested from the Tissue Viability Team to review pressure wounds.

• All people and relatives spoken with told us they felt safe with the service. One person said, "I feel safe here, the staff are very nice, and the food is good too." One relative told us, "[Person's name] was in bed for long periods of time after being in hospital, we were worried [person] might develop sores, but no, [person] was and remains sore free. Staff are very good at changing [person] position regularly."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Risks to people's health were not being accurately assessed. For example, risk of pressure damage to their skin or risk of falling.
• Staff were not always acting consistently and in a timely manner to identify, monitor and seek advice for some people's health needs.
• Care plans and risk assessments were not always updated to accurately reflect people's current needs. For example, one person's care records had not been updated to show they no longer had a urinary catheter in

place and staff were recording they were providing catheter care. One acting senior member of staff told us, "I am ok with the care part, but all the rest [care plans], I'm not that great with."
• The provider had not always reflected on lessons learned and shared this with staff to promote and ensure safer working practices.

Systems were not robust enough to demonstrate people's safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• One relative said, "[Person's name] came into the home following a fall, they [staff] put them back on their feet and [person] is now able to walk with a frame. [Person] is very happy there and says how lucky they are to live there."

Using medicines safely
• Medicine administration systems were in place. However, staff did not always follow the provider's medicines policy and procedures. Audits had failed to identify the issues found during the inspection.
• Medicines which are required to be administered at an exact time for people who were living with Parkinson's disease were not being administered as prescribed. When asked, staff were unaware these medicines were time critical and the reasons why.
• Medicines administered in the form of a patch had a system in place for recording the site of each application. However, for one person these records were not up to date and therefore we could not be sure the position of the patch was being rotated following the manufacturer's guidance. This is necessary to prevent side effects.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) and a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, the provider took immediate action to have competency assessments undertaken on appropriate staff to ensure they were competent to administer medicines safely.

• Medicines were received, stored and disposed of safely.
• Guidance was in place to support the administration of medicines prescribed on a 'when required' basis.
• One relative told us, "Staff are very good at discussing [person's name] medicines. We felt a review was needed of [person's] medicines and staff were straight onto it and it's been done."

Preventing and controlling infection
• Infection control systems were in place. However, we observed staff did not always adhere to current guidance and safe practices exposing others to the risk of infection.
• Staff were observed to not always be following the correct handwashing procedures and wearing the appropriate Personal Protective Equipment (PPE). External professionals told us they had regularly needed to remind staff to wear PPE correctly.

Systems were not robust enough to demonstrate infection prevention and control was being managed effectively. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) and a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• One external professional told us the home had managed and coped well with the coronavirus pandemic and the extremely difficult challenges this had brought to them.
• The provider had appropriate supplies of PPE such as disposable gloves, face masks and aprons.

Staffing and recruitment
• Staffing levels appeared to be suitable and the provider reviewed these according to the needs of people or, where changes were required.
• A new clinical lead nurse had recently been appointed and was due to commence their position imminently.
• The service had safe recruitment procedures in place.
• The provider had contingency plans in place to support people in emergency situations for example, to manage an outbreak of coronavirus, adverse weather conditions or passenger lift failure.

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 good. At this inspection this key question has deteriorated to 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; Continuous learning and improving care
• Quality monitoring and audits of the service were in place. However, these had failed to identify the issues found during this inspection regarding the management of people's health and care needs, risk, medicines and, infection prevention and control.
• Records related to the care people received, medicines and the management of the service were not always accurate, detailed enough and up to date.

We could not be confident that the governance and quality monitoring of the service was robust enough to ensure people were being protected from the risk of harm. This was a 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 provider had missed opportunities to improve the service following complaints and feedback they had received. Staff, relatives and external professionals had raised concerns about the providers approach to acting and responding on concerns and feedback.

The provider failed to consistently act and respond to feedback shared through concerns and complaints. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider was committed to improve and learn from the outcome of this inspection working with the local authority to ensure standards of care were raised.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Due to the coronavirus pandemic, it had been a difficult time for the home to engage and involve people in meetings due to people self-isolating and the restrictions on visiting.
• Relatives told us during this time communication with them was good and they had been kept informed about their relative's health and care. One relative said, "As a family we are very involved in [person's name] care. Staff keep us well informed. Due the coronavirus outbreak we received regular updates every step of the way, sometimes every day".

• Outdoor visiting restrictions were in place. Staff had contacted relatives and friends of people to explain the new appointment system and social distancing rules. One relative said, "We had a lovely visit in the garden, [person's name] looked so nice, in nice clothes. It was lovely to see [person] looking so well."
• Staff meetings had recommenced now pressures on the workforce were reducing. These were held with social distancing controls in place and supported the staff with the opportunity to express their views and opinions on the running of the home. Staff spoken with told us they felt listened to and could approach the manager or provider with any concerns. One said, "It's a great place to work, it's been hard recently but the managers are great."

Working in partnership with others
• External professionals told us they were consulted regarding people's individual needs. However, responses to their instructions were not always, "implemented into people's care records and shared with the staff team". One said, "There appears to be a lack of communication within the service, staff lack the understanding of people's individual needs and don't always follow up on any actions when asked."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The provider was committed to making the necessary improvements to the home.
• Staff involved people and their relatives in discussions about their care. One person told us, "Its ok in here, staff spoil me, I had some concerns which I discussed with the manager and they sorted them for me." One relative said, "We have been able to keep in touch with [person's name] via video calls, we could see [person] nicely propped up on pillows and all the staff wearing PPE. Staff helped [person] to hear us as they are hard of hearing."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always ensure care and support was provided in a safe way. There was a failure to properly assess, monitor and mitigate risks to the health and safety of people. Medicines were not being managed properly and safely The risks associated to preventing and controlling the spread of infections was not being managed to keep people safe Working with others who shared responsibilities for care and treatment of service users was not being undertaken in a timely manner to ensure the health,safety and welfare of service users. Regulation 12 (1)(2)(a)(b)(c)(g)(h)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were operated effectively to ensure compliance with regulations. The governance systems in place were not robust enough to identify shortfalls in quality and safety of service users care. The provider failed to ensure the service was assessed and monitored to improve quality and

safety. Record keeping was not always accurately completed and up to date.

Feedback about the service was not always listened to, recorded and responded to appropriately.

Regulation 17 (1)(2)(a)(b)(c)(e)(f)