Carleton Court Residential Home Ltd

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Inspection report

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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
Carleton Court Residential Home Limited is a residential care home providing personal care to people aged 65 and over. At the time of the inspection, 18 people were living at the service. The service can support up to 25 people.

People have their own bedrooms with access to communal toilets and bathing facilities. There are also two lounges, a dining room and a conservatory which is being used as another dining room and visitors' pod. The service is wheelchair accessible and has lift access to the ground and first floors.

People's experience of using this service and what we found
The provider and staff were not working to COVID-19 guidelines to ensure people were kept safe from the transmission of infection.

Care plans were not always updated when people's needs changed and protocols to administer 'as and when required' medicines did not include appropriate guidance to enable staff to consistently administer these medicines. We made a recommendation to review this. Audits were not robust in picking up shortfalls, however, there was no impact on people using the service.

People were supported to have maximum choice and control of their lives but records did not detail how to support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People who used the service and their relatives spoke highly of the care and staff.

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

Rating at last inspection
The rating at the last inspection was good (published 22 November 2019).

Why we inspected
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.

Initially, we undertook a targeted inspection to look at infection prevention and control practices and review the service's response to COVID-19. At this inspection we identified practice concerns, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

We reviewed the information we held about the service and no areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. 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.

We raised the concerns identified with the provider who took prompt remedial action to ensure practices were in line with COVID-19 government guidelines.

You can read the report from our last inspection, by selecting the 'all reports' link for Carleton Court Residential Home Limited 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 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 breaches in relation to poor infection control practices and quality assurance audits.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will 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.

Carleton Court Residential Home Limited

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 completed by one inspector on the first day of the inspection, and two inspectors on the second day.

Service and service type
Carleton Court Residential Home Limited 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. There was a registered manager in post at the time of inspection.

Notice of inspection
We gave a short period of notice of the inspection because of the Coronavirus pandemic. We had to arrange safe working procedures for our inspection. The second day 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 and professionals who work with the service. 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 this information to plan our inspection.

During the inspection
We spoke with three people who used the service and three relatives about their experience of the care provided. We spoke with six members of staff including the registered manager, senior care workers, care workers and a cleaner.

We reviewed a range of records which included two people's care records and multiple medication records. We looked at three 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 data and quality assurance records. We spoke with four professionals who regularly visit the 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 good. At this inspection this key question has now 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.

Preventing and controlling infection

- Staff did not follow best practice to prevent and control the transmission of infection.
- A cleaning regime was in place and staff wore personal protective equipment (PPE). However, this was not in line with national guidance and placed people at increased risk of infection through transmission.
- Staff had allocated areas to put on and remove PPE, though they were not easily accessible throughout the premises, which increased the risk of infection transmission.
- Visitors were not screened effectively for symptoms of COVID-19 and the visitor's policy was not consistently applied.

The provider had failed to implement effective infection prevention and control practices which placed people at 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.

Following the inspection, the provider took immediate action to improve the visitors screening procedure, ensure staff wore PPE in line with national guidance and placed hand sanitiser and PPE throughout the premises.

Using medicines safely

- Medicines were not consistently stored and dispensed in line with the providers policy.
- Creams and ointments were not consistently dated when opened and records did not accurately reflect when or why creams and ointments had been applied. This meant changes in the condition of people's skin could not be effectively monitored.
- Staff understood when people needed 'as and when required' medicines, such as laxatives. However, important information to support staff to make the decision when to give people this medication was not verbally handed over between staff teams.

We recommend the provider reviews their medication processes to ensure they are followed correctly and important information is appropriately shared.

- Senior care staff, who administered medication, had the necessary training and competency checks to undertake their role. They had a good knowledge of people's health needs and medication requirements.

Learning lessons when things go wrong

- Opportunities to learn from accidents and incidents were missed. Records of accidents and incidents had

not been completed since August 2020 and had not been reviewed by the registered manager to identify patterns or trends. This meant opportunities may have been missed to minimise risk to people.

Assessing risk, safety monitoring and management
● The assessment, monitoring and management of risk was not consistent but we did not find this impacted on the people using the service.
● Risks to people's health, wellbeing and safety had been assessed and appropriately managed. However, records were not always signed and dated which made it difficult to monitor any changes.
● Staff had a good knowledge of people's needs and associated risks, though this was not reliably communicated in handovers.

Staffing and recruitment
● People were recruited safely. The provider's recruitment processes helped ensure only suitable staff were employed.
● There were enough staff available to meet people's needs.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place to safeguard people from the risk of abuse or neglect. Processes were in place to report safeguarding concerns to the local authority
● Safeguarding concerns had been appropriately reported to the local authority and CQC. Staff had a good knowledge and understanding of safeguarding risks and when to raise concerns to the registered manager of local authority.
● Staff were able to raise concerns about people's wellbeing or changes in people's health with the registered manager.

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 now 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

- The management team did not promote continuous learning and celebrate success to improve care.
- When things had gone wrong, lessons were not learnt from this or trends identified to reduce the risk of a similar incident reoccurring. This placed people using the service at increased risk of harm.
- Quality assurance systems had not identified or addressed the shortfalls identified during the inspection. These included infection prevention and control practices, medicine processes, risk management and learning from accidents and incidents.
- Care plan audits did not identify issues. For example, they had not identified missing dates, missing mental capacity assessments and best interest decisions and updates not being made when there was a change in people's needs.

The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service and had failed to keep accurate records. 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

- People benefitted from a positive culture. People had good relationships with staff where people were supported to have choice and control over their lives.
- People had choice over their decision making but there was a failure to record this in care plans.

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 acted within its legal responsibility to be open and honest when things went wrong and informed relevant people.
- Staff were able to access the registered manager at any time for advice and to raise any concerns. However, supervision was not provided in line with the provider's policy. One member of staff told us, "[Registered manager's name] has an open-door policy where if you have a problem, you can go straight to themher. [Registered manager's name] is very understanding."

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

characteristics

● The registered manager had reviewed and updated their engagement processes with people due to the challenges of maintaining people's involvement in the service during the coronavirus pandemic. The management team engaged with people and their relatives on an individual basis to involve people in decisions about the service and care delivery. One relative told us "I speak with my [relative] every day." Another relative told us "I ring up every other day to get an update on [relative]. The staff do a good job."

Working in partnership with others

● The service had good working relationships with commissioners, the local authority and external healthcare staff. This ensured people received the right care. Staff engaged with partners to provide a multi-disciplinary approach to support people living at the service.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2)(a)(b) Systems were not in place to monitor the quality of care provided and to ensure risks were assessed, monitored and reviewed. Records were not accurate or up to date including records in relation to consent.

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 The service was not compliant with Infection Prevention and Control guidelines.

The enforcement action we took:

We issued an urgent notice of decision to impose conditions on the registration.