The Paddocks Care Home Ltd

# The Paddocks Care Home

## Inspection report

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Date of inspection visit:
01 October 2020
05 October 2020
06 October 2020
09 October 2020
12 October 2020

Date of publication:
17 March 2021

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
The Paddocks Care Home is a residential care home that was providing accommodation and personal care to 38 people at the time of inspection visit. The service is registered to support up to 100 people.

The home is split into three units of accommodation, each of which has separate adapted facilities. One of the units specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

Some risks to people's safety had been appropriately assessed and managed well but others had not. This placed people at risk of harm.

Systems and processes were in place to monitor the quality of care people received. However, these were not always robust at identifying shortfalls and therefore action had not always been taken to mitigate risks to people's safety.

CQC had not always been notified of important incidents as is required by law, to enable us to carry out our regulatory duties.

People received their medicines when they needed them. People's oral medications were managed safely but improvements are needed to the storage of prescribed creams to ensure they were safe to use.

Most areas of the service and equipment people used was clean. However, improvements are required to ensure the standard of cleanliness in all areas is maintained. Some practices were observed that increased the risk of the spread of infection.

Systems were in place to investigate any incidents or accidents that occurred. People and relatives had been consulted and kept fully informed during the investigation process as is required. However, lessons had not always been learnt to reduce risks to people's safety.

There were enough staff available to keep people safe. Sufficient checks on a prospective staff member's character had been performed to ensure they were safe to work in the service.

Staff felt valued and fully supported in their role. There was an open culture where people, relatives and staff felt able to raise concerns without fear.

Staff felt the home was managed well as did relatives, however the people we spoke with gave us mixed

views within this area.

Communication with people and relatives during the pandemic had been good. They told us they had been kept fully informed about what was happening within the home with reasons given for example, when visiting restrictions had been put in place.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 17 April 2020) 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
The inspection was prompted in part due to concerns received about infection control and staffing levels. We also wanted to check whether improvements had been made in relation to the key questions of safe and well-led. Therefore, 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 coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. 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 Inadequate to Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Paddocks 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 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 at this inspection in relation to the identification and management of risk, safeguarding, governance systems and failure to notify CQC of important incidents.

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.  We will work with the local authority to monitor progress. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, we will act 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 to varying the conditions 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.

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|---|---|
| **Is the service safe?**<br>The service was not always safe. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led. | **Inadequate** |

# The Paddocks 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 activity began on 1 October 2020 and ended on 12 October 2020.

Inspection team
The inspection team consisted of three inspectors, an assistant inspector and two Expert by Experiences. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The Paddocks 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 visit was announced. We gave the provider less than 24 hours' notice. This was to check if any staff or people at the service had tested positive or had symptoms of COVID-19 and to discuss arrangements for the inspection.

What we did before the inspection

We reviewed all the information we held about the provider and feedback we had received about the service from the local authority, health professionals and the public since the last inspection. We used all this information to plan our inspection.

During the inspection visit
We visited the service on 1 October 2020 where we observed the care being provided to people and spoke with four staff members including kitchen and care staff.

After the inspection visit
On 5 and 6 October 2020 we spoke with four people who lived at The Paddocks and seven relatives over the telephone for their feedback about the quality of care provided. We also spoke with a further seven staff over the telephone. On 9 October 2020 we held a meeting with the registered manager to discuss infection control and governance. On 12 October 2020 we provided feedback about the inspection to the registered manager and the provider's operations manager.

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

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 Inadequate. At this inspection this key question has now improved 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.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to robustly assess and manage risks relating to the health and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remains in breach of regulation 12.

- Toiletries, prescribed creams and razors were found in people's rooms on the dementia unit, either left out on furniture or in a cabinet that was unlocked. Risk assessments had determined these should be locked away for people's safety.
- Some wardrobes were not secured to the wall. One leaned dangerously and moved forward when light pressure was placed on the door handles. This placed people at risk of harm should the wardrobe fall.
- Staff did not decontaminate a sling or standaid when using them between two people and they did not always wear PPE correctly in line with current guidance. One staff member entered a unit without wearing a mask. Other staff wore their mask incorrectly. This practice increased the risk of spreading infection.
- On arrival at the home, inspectors had their temperature taken but were not screened effectively for COVID-19 in line with current guidance or the provider's own policy. This did not assure us that relevant checks on visitors were made, which again increased the risk of the spread of infection.

The above evidence demonstrates a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection visit, the registered manager told us all wardrobes had been fixed to the wall. Staff had been reminded of the importance of keeping potentially hazardous items secure and to decontaminate equipment between use. The provider's representative acknowledged inspectors had not been subject to enough checks but advised this was not normal practice and had been an oversight.
- The staff we spoke with demonstrated good knowledge regarding what actions they needed to take to reduce several risks to people's safety including falls, choking and not eating and drinking enough. However, the control measure required to guide staff on how to mitigate risks to people's safety were not clearly recorded within people's care records. Having clear and concise records would reduce the risk of staff not taking the action needed.
- Other risks to the environment such as risks associated with Legionella had been assessed and managed

sufficiently to reduce risks to people's safety. A long-standing issue in relation to fire safety was being rectified during our inspection visit. This had been delayed due to the coronavirus pandemic.
●Lifting equipment had been serviced in line with relevant regulations to ensure it was safe to use.
●We were assured the provider was admitting people safely to the service and they were accessing regular testing for staff and people using the service in line with current guidance.

At our last inspection, the provider had failed to ensure the home and equipment people used was clean. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 15. However, further improvements to monitoring cleanliness are required to ensure all areas of the home are cleaned regularly.

●Most of the home and equipment people used was clean. This included communal areas, people's rooms and equipment such as hoists. People and relatives said they were happy with the standard of cleanliness within the home. One person said, "My bathroom is spotless. It is cleaned every day."
●Some areas of a room that was used to store people's medicines had some dusty shelves and cobwebs were visible. Some people's cabinets in their rooms where their toiletries were stored were not clean. The registered manager acknowledged these shortfalls and acted immediately to rectify them.

Systems and processes to safeguard people from the risk of abuse
●A passive infrared sensor (PIR) was used on the dementia unit at night to monitor people when they were in their rooms. This covered their room and alerted staff when people were moving, for example getting out of bed. People's consent for the use of the PIR had not been sought and where it was felt they lacked capacity to consent, the principles of the Mental Capacity Act (2005) had not been followed. For example, no assessment had been completed to ensure it was being used in the person's best interests.
●It had been recorded in one person's care record that staff were to respect their privacy as they liked to be alone. Risks to the person's safety had been assessed as low. Despite this the PIR was switched on at night which had resulted in staff regularly entering this person's room when they were going to the bathroom. When asked, the registered manager could not provide a suitable rationale for the use of the PIR to monitor this person's movements at night. This had resulted in the person not being supported in the least restrictive way possible which breached their right to privacy.

The above evidence demonstrates a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●After the inspection visit, the registered manager told us they would review the application of the PIR and ensure it was being used appropriately and in line with the relevant legislation.

●Staff had received training in safeguarding and demonstrated they understood abuse and who this needed to be reported to for investigation.
●People told us they felt safe living in the home and relatives agreed with this. One relative told us how staff had quickly identified their family member's illness and involved the GP immediately to resolve this.

Learning lessons when things go wrong
●Lessons had not always been learnt at provider level. For example, some repeated concerns were found at this inspection as were found in February 2020. Also, no consideration had been given to the use of zoning

the service or cohorting people into various groups should an outbreak of COVID-19 occur within the home to help reduce the spread of infection. This was despite the home having previously experienced an outbreak.

●Staff understood the need to report and record any incidents or accidents that had occurred to people living in the home. These incidents were investigated by the registered and deputy managers and action was taken to reduce the risk of the incident from re-occurring. For example, staff told us they monitored a person more closely who often fell as they had did not understand the risks to their safety when walking unaccompanied.

●After our inspection visit, the provider's representative confirmed risks associated with people not self-isolating had been assessed and policies put in place to consider how this would be managed and people supported.

Staffing and recruitment

●Mixed feedback was received from people and relatives regarding staffing levels in the home. One person told us, "There is always someone to see me and help me." Another person said, "There are not enough staff. I ring the bell. It can be a long time to wait".

●Staff told us they felt there were enough of them to keep people safe but not to spend time talking with people and providing them with stimulation.

●On the day of our inspection visit, staff responded to people's request for assistance promptly. Staff were seen to spend time with people on the residential units but less so on the dementia unit.

●The registered manager told us they were closely monitoring staffing levels. A tool was used to calculate staffing levels based on people's needs. Records showed this had been regularly reviewed and matched current staffing levels.

●Most of the required checks had been completed on new staff before they were employed by the provider. This ensured they were of good character and safe to work within the home.

●Agency staff were working in the home. These staff had been subject to relevant checks to ensure they were safe to do so and the same staff were being used to reduce the risk of spread of infection.

Using medicines safely

●Oral medicines had been stored securely for the safety of people living in the home. However, some topical creams were not.

●The date prescribed creams were opened, and the expiry date had not been written on the label in line with best practice. This enables staff to quickly identify if the cream is still likely to be effective.

●People told us they received their medicines when they needed them and records confirmed this. One person said, "They bring my pills in the morning before breakfast."

●Staff had received training in medication management and their competency to give people medicines safely had been assessed. We observed staff using good practice when giving people their medicines.

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 has 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 effective systems were in place to assess and monitor the quality of care and to drive improvement. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider was still in breach of regulation 17.

●Following our inspection in February/March 2020, the provider told us they would act to rectify the breaches we found. Although we found some improvements, two breaches of regulation remain with some identical issues found.
●The provider had not considered how they would reduce the spread of infection where people would not self-isolate. No policy was in place regarding this. This was despite the home having experienced an outbreak of COVID-19 in the past.
●There was a lack of understanding at management level that the passive infrared sensor being used on the dementia unit, was a potential restriction that required careful assessment to ensure it did not infringe unnecessarily on people's human rights.
●Regular audits conducted had not identified several issues we found during the inspection to help drive improvement. For example, audits of people's care records had not identified that the principles of the Mental Capacity Act (2005) had not been followed where appropriate. Fluid charts had been audited but these audits had not identified that there was no daily target amount recorded to help staff understand if people were drinking enough.
●Some areas had not been subject to regular monitoring to ensure they were safe. The provider's representative told us all wardrobes should be fixed to the wall to mitigate any risk of injury. This was not the case and no audit had been put in place to monitor this risk. An inspection of slings in August 2020 had identified one of them as being in poor condition. Although this passed the inspection at the time, no regular monitoring of slings had been introduced meaning staff had continued to use it when it had not been appropriate to do so.
●There was a lack of effective oversight in some areas of the home that resulted in staff using poor practice which exposed people to the risk of harm or not receiving the care they wanted. For example, staff did not

always wear PPE in line with current practice and creams and toiletries had been left unsecure when they should have been locked away. One person told us how they had not had a bath for many weeks due to a bath being out of order. They said, "I have been unable to have a bath due to a fault with one of the taps. I have had to beg for a bath which I really miss." A staff member confirmed this was the case and instead, the person had had to have a daily strip wash. We raised this with the registered manager who discovered the bath tap had been fixed in August 2020 but the sign to say it was out of order not removed, leaving staff and people thinking it was still not safe to use.
●The provider's systems had not been effective at ensuring we were notified of several important incidents to enable us to carry out our regulatory duty.

The above evidence demonstrates a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify us of several incidents that we are required to be told about by law. This included an incident of physical abuse between two people using the service, serious injuries and a person who was the subject of an approved deprivation of liberty.

The above evidence demonstrates a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

●Staff told us they felt the home was managed well with the managers being approachable and supportive. Their risk of complications from contracting COVID-19 had been assessed and actions taken to reduce the risk to them where appropriate. However, the provider had not included the staff member's ethnicity in the assessment to enable them to gain a full overview of potential risk. The registered manager told us they had taken this into account during their conversations with staff even though it had not formed part of the written risk assessment. After the inspection visit, they confirmed this had been added to the provider's risk assessment to ensure it was considered.
●People gave us mixed views as to whether they felt the service was well-led. One person told us, "[Registered manager] comes by my room and always waves and says `hello'. I wish she would come by more often." Another person said, "I don't think it is well led as the managers don't always act on issues." Relatives expressed no concerns about the care being provided although some told us it was difficult to get through to the home when they rang.
●People, relatives and staff said they felt comfortable raising concerns. However, two people felt their concerns were not always listened to. They said they had regularly raised issues regarding the lack of choice food but that this had not changed. We spoke with the registered manager about this who confirmed she was aware of this and was working on a solution.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●The provider and registered manager understood the duty of candour and had involved people and relatives as necessary when things had gone wrong.
●People and relatives told us they had been kept informed about the pandemic and visiting policy. Relatives said how staff had used different methods of communication with their family members depending on their individual needs. One relative said, "I speak to [family member] regularly on Skype."
●No official survey had been completed to gain people, relatives or staff views about the quality of care being provided. The registered manager explained this had been delayed due to the pandemic. They said however, they regularly asked people and staff for their views to gauge how they were feeling at that time.

Working in partnership with others

- The registered manager had worked closely with the local authority and health protection team during the pandemic. They shared appropriate information with these organisations as required. However, they had not shared information with us when it had been appropriate to do so.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>CQC was not notified of all notifiable incidents. Regulation 18 (1) (2) (a) (b) (e) (4) (a) and (b). |

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>Risks to service users safety had not always been adequately assessed or mitigated. Risks in relation to the spread of infection were not always adequately managed. Regulation 12 (1) (2) (a) (b) and (h). |

**The enforcement action we took:**

We imposed a condition on the provider's registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Control and monitoring of service users movement was not always a proportionate response to risk of harm posed to the service user and on occasions, significantly disregarded the service users individual needs. Staff did not always support people in the least restrictive way possible. Regulation 13 (1) (4) (b) and (d). |

**The enforcement action we took:**

We imposed a condition on the provider's registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Effective systems were not in place to assess, monitor and improve the quality of care service users received or to monitor and mitigate risks to there health, safety and welfare. Regulation 17 (1) (2) (a) and (b). |

**The enforcement action we took:**

We imposed a condition on the provider's registration.