Hamra Associates Limited

Cana Gardens Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.
This was a focused inspection which we carried out on 6 June 2018. The visit was unannounced.

Cana Gardens Residential Home provides care and accommodation for up to eight adults with learning disabilities. Cana Gardens is registered to provide care for up to 8 people. At the time of our inspection there were 4 people living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This unannounced inspection was undertaken to check that improvements to meet legal requirements by the provider following our inspection of 21 November 2017. We inspected the service against two of the five questions we ask about services: 'Is the service Safe?' and 'Is the service Well Led?' This is because the service was not meeting some legal requirements in these areas.

At our previous inspections of this service in October 2016 and December 2017 we found improvements were needed as the provider had not sent us notifications which involved the people living in the home. This was a continued breach of Regulation 18 (Registration) Regulations 2009, Notification of incidents.

We again found that the provider had not ensured they sent us notifications, around a medicine error and infestation in the home.

At our previous inspection of this service in December 2017 we found we found that we found the medicines system was not safe as staff had failed to ensure the correct medicines were given to a person.

There were issues around infection control, and an unsafe environment as some work was required to ensure the environment in the home and gardens were safe. We found the decoration of some parts of the home was poor and a carpet was dirty and stained.

These were all continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We also found that the service had not ensured that people's health and welfare needs were protected and promoted as good governance systems were not comprehensively in place. This was a breach of Regulation 17 HSCA RA Regulations 2014 Good governance.

Following the inspection we asked the provider to complete an action plan to show what they would do and by when to improve the key questions 'Is the service safe?' and 'Is the service well-led?' to at least 'Good'. The provider did not send us an action plan.

At this inspection we found the provider had made some changes, but overall there was little improvement in the overall safety or governance of the home.

We found there was a continued lack of oversight by the provider's representative to check quality monitoring had been carried out effectively. The quality monitoring systems included reviews of people's care plans, food temperature checks and checks on medicines management. These checks and systems were still not reviewed by the nominated individual to ensure people received a good, safe quality of service.

Safety audits were undertaken by staff, which was demonstrated at out last inspection. The shortfalls we saw at that time had not been improved upon, which meant that audits fell short of covering all the areas necessary to ensure people's safety in the home. For example, audits of the medicine system had not revealed the absence of up to date photographs or homely remedy policy.

Where people had been provided with a 'homely remedy' this had not been followed up with the GP to ensure there were no potential reactions with medicines prescribed for the person. There was no homely remedy policy or procedure to ensure staff were able to follow them and ensure the person remained safe.

The potential for cross contamination or cross infection in the home had not been reduced. We found where there was no separation between clean clothes and the storage of cleaning equipment which allowed the potential for the transfer of infection. These issues became apparent as the provider had not produced procedures to ensure staff knew what the processes included from beginning to end. Similarly, there was no process or procedures to ensure audits were comprehensive and covered all areas to ensure people were safe in the home, or that policies covered where homely remedies were administered.

Some areas of the environment had improved and most of the electrical issues had been completed areas had been decorated and the carpet had been cleaned.

The provider had not comprehensively ensured that good governance systems had improved. These remained ineffective.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. One breach has continued from the last two inspections. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were still at risk from harm as staff did not ensure all areas of medication administration was safe. Infection control procedures were not detailed, and people were placed at risk from the potential for transfer of infection from a poorly secured environment.

Policies and procedures had not been updated to include information for staff to ensure policies were followed consistently.

Periodic safety tests of the environment had been recorded by staff, though gaps were not identified and shortfalls were not identified. Safety certificates produced by external contractors were available, but remedial work had not taken place to ensure the safety of people.

Is the service well-led?

Inadequate

The service was not well led.

Some quality assurance systems were in place, however there was no oversight or governance by the nominated individual to ensure people' safety was not compromised. Records of some tests were completed by staff, however these were not overseen by the nominated individual to ensure that shortfalls were identified, resolved or improved. The provider did not ensure CQC were informed of events that involved people in a timely way.

Cana Gardens Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 June 2018 and was unannounced. The inspection team consisted of one inspector.

We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We considered their concerns and on-going intervention to improve the service provided to people.

We reviewed the provider's statement of purpose and looked for notifications they had sent to us. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

People living at the service were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. Therefore, we used the short observational framework tool (SOFI) to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with the nominated individual (registered manager), the manager and two support staff.

We looked at records relating to all aspects of the service including care, staffing, and quality assurance.

Inadequate

Is the service safe?

Our findings

At our last inspection in April 2018 we found people were not protected from the potential of cross infection or cross contamination in the home.

The provider did not send us a plan of action following the last inspection to state how and when they would address the concerns we raised.

At this inspection we again found the laundry door propped open, and chemicals stored in the room. The door has no lock and cannot be secured to stop people entering and being placed in danger from the chemicals stored there.

We also saw the kitchen door was propped open and though the COSHH cupboard was locked shut the keys had been left in the door which meant people would have access to the cupboard. COSHH stands for the Control of Substances Hazardous to Health Regulations. These Regulations require employers to control exposure to hazardous substances to prevent ill health. Hazardous substances include: certain chemicals and any other substance which has comparable health effects. This reflected what we found at out April 2018 inspection. It again placed people at risk from entering a dangerous area, and swallowing dangerous chemicals.

Following this inspection, we asked the nominated individual to send us the policy and procedure on infection control. However, these were not sent so we could not ensure they had been updated to inform staff how to ensure people were safe. Staff were therefore without specific instructions on how to keep the home clean and hygienic. We also asked the nominated individual to send us the latest training matrix so we could ascertain what training had been undertaken by staff since our last visit. This document was sent but included no training details for the registered or consultant managers'. We could not ensure either of these staff had the latest knowledge of best practice to ensure people were protected from the risk of dangerous chemicals.

The mop buckets used when staff cleaned the floors in toilets and public areas were stored on a shelf in the laundry. These were next to unclean and clean clothes. These all posed a clear cross infection and cross contamination issue, which was found at the last inspection in April 2018. The colour coded mops, used to distinguish which area they should be used in, were still stored together on the floor. That meant they was a high chance of cross contamination from one mop to another. The way the mops were stored would not allow them to 'air dry', which would assist in lessening the possibility of people contracting acquired infections in the home.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The system to manage medicines was not safe. At our last inspection in April 2018 we found improvements were needed as the provider had not ensured staff administered medicines safely.

We found the medicine trolley was still not appropriately secured to the wall, which was also apparent at the April 2018 inspection. This meant the provider had not ensured that medicines were securely kept in the home.

We also saw that none of the photographs to the medicine administration records (MAR charts) had been updated. Staff told us about three people that came in for short or respite care stays. There were no photographs for these people. That allowed potential for people to be given the incorrect medicines.

We also found a tub of petroleum jelly which had no prescription label attached, or name on the pot. The manager told us it was brought in by the person's family and was considered a 'homely remedy'. Homely remedies are medicines and other preparations that can be bought over the counter. We looked for a homely remedy policy, but the provider had not written one. The manager said they had not sought permission from the GP to use the petroleum jelly. It is important to seek the permission of a medical professional in case a homely remedy reacted with any prescribed treatment. This placed people at risk from a medicine that could have produced an unsafe reaction.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The dining room and lounge had new glass doors leading to the garden area. However, we were not sure the glass windows at the side of the doors were made of strengthened glass so that a person would not fall through and hurt themselves. The registered manager said these areas had still not been risk assessed, something we highlighted at the last inspection. That meant we could not be assured the area was safe for people.

The door to the laundry was still being propped open, even though this issue was stated as unsafe in our last report. The laundry door had no lock and could not be secured to stop people entering and being placed in danger from the chemicals stored there. The door, if secured properly, would also guard against fire and protect the people whose bedrooms are close by. We spoke to the registered manager about this. He said that staff would be disciplined if they did not follow safety guidance, and he would look at having a lock fitted to the door.

We saw there was a radiator in one bedroom which had not been guarded. We asked for a risk assessment to ensure the risk had been assessed. Staff could not find a risk assessment that had been completed for this issue.

The greenhouse in the garden has now been risk assessed. However, the glass still posed a risk if anyone who lived at the home accessed the area unaccompanied.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there had been several improvements in the environment and improved safety of some areas of the home and gardens. A number of areas had been decorated and the height of the first floor bannister had been raised, lessening the risk that people would fall over this banister.

The door into the lounge had had a new magnetic closer that now released automatically when the fire alarm sounded. The main staircase had been painted and the carpet has been cleaned. The flaking paint and bare plaster in a ground floor toilet had also been painted. This will now allow proper cleaning and

disinfection.

Staff were now aware of the correct temperature for soiled clothing to be washed. This reduced the potential for cross infection or cross contamination. Risks to people posed by the environment were documented. These included hot water temperatures being regulated and radiators in most of the home being guarded to reduce the risk of scalds and burns. The faux leather settee in the dining room has been replaced as this was an infection control issue.

The pond in the rear garden of the home had now been fenced off, which lessened the danger to anyone using the garden.

Staff we spoke with understood their responsibilities to keep people safe from abuse. Staff told us they had received training that ensured they recognised the signs when people may have been at risk of harm. Though we were sent the training matrix, there was no training information for the registered manager or consultant manager. That meant we could not be assured that staff were supervised by staff that had been trained in the latest techniques and up to date practices.
Staff said if they suspected or observed anyone being harmed they would share their concerns with the registered manager or staff in charge at the time and that if no action was taken they knew which agencies to contact.

Staff we spoke with had a good understanding of the different kinds of potential abuse. They were aware of their role and responsibilities in relation to protecting people and what action they would take if they suspected abuse had occurred within the home.

One member of staff said, "I would speak to [registered manager] then if nothing was done I would call you [Care Quality commission] or social care. Staff we spoke with were aware of whistle blowing, and said they had not witnessed anything that required to be reported on or caused them concern.

Staff told us they felt there was enough staff to care safely for the people in the home, as the number of people who used the service had decreased recently. There was now a manager or senior carer and two care staff in the mornings and afternoon and senior carer and two care staff in an evening and two care staff at night.

Care plan assessments were in place and demonstrated that that peoples' abilities had been assessed. The registered manager told us they used a detailed plan of people's one to one hours, to ensure there were enough staff on duty, and someone always remained in the home in case one of the other people who used the service returned early from time out of the home. This information was used to provide staff cover throughout the day and night.

We looked at the people's personal evacuation plans (PEEPs). These inform staff how to safely assist people to leave the premises in an emergency. Copies of the PEEPs continued to kept on people's files so were readily available in an emergency. However, these were stored at the front door of the home and could easily be taken or defaced. We spoke to the registered manager about this who said, he would consider moving them to a more secure area. Staff we spoke with were aware of the location of the PEEPs and fire and emergency evacuation equipment.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. There had been no new staff employed since our last inspection.

There continued to be a lack of consistent overseeing by the nominated individual. There was no review of incidents or documents to ensure shortfalls were identified and addressed. This continued lack of analysis resulted in lessons not being learnt to ensure a safe environment.

Inadequate

Is the service well-led?

Our findings

Following our previous inspection during April 2018 the provider failed to send us an action plan stating how they intended to address the shortfalls identified in the report.

During our inspection in October 2016 and December 2017 we found improvements were needed as the provider had not sent us notifications, as legally required, which involved the people living in the home.

This was a continued breach of Regulation 18 (Registration) Regulations 2009, Notification of incidents.

At this inspection we found that the staff had not communicated concerns to us using the appropriate means of notifications. For example, at this inspection, we were made aware by the local authority of a significant medication error that placed people at risk. We were also informed by the local authority of an infestation that required specialist treatment. These were not communicated by the home.

We were also aware a person had died, we were on this occasion informed by the provider. However, the form was only partly completed and no explanatory information was included. This meant we were not informed of the circumstances around the person's death.

This was a continued breach of Regulation 18 (Registration) Regulations 2009, Notification of incidents.

At our previous inspection in December 2017 we found the service had not ensured that people's health and welfare needs were protected and promoted. This was because good governance systems were not comprehensively in place and those that were had failed to identify shortfalls in the service.

At this inspection there were still systematic and widespread failings in the oversight and monitoring of the service. This meant people did not always receive safe care. Despite the previous inspection identifying shortfalls in governance systems and the overall safety in the home, we found that insufficient progress had been made to the auditing and governance systems of Cana Gardens.

No checks had been put in place by the provider to ensure staff have followed through with changes required to ensure the people's safety improved. The provider has not ensured guidance was in place that staff could follow and confirm they had completed needed tasks.

We found that the provider had arranged for some audits to be undertaken. However, the nominated individual had not undertaken any checks to ensure audits completed were accurate or ensured that audits were comprehensive and covered all of the homes environment, policies and procedures, care planning and support documentation. For example, the medicines audit was partly completed by staff. The provider had failed to ensure a procedure was in place to ensure all areas were audited and safe. This meant the audit system was not comprehensive and areas that required to be checked were missed. There was a similar situation with the checking of the environment and control of infections and with the infection control policy and procedure. They were not fully descriptive and staff were not adhering to the policy or procedure in

place.

People were not included the running of the home. There was no evidence people were included in decisions about their care, support and service they received. At the time of our inspection, surveys or other methods of collating opinions or views about the service provided had not been undertaken with people or their relatives. This meant that opportunities had not been taken to gather feedback to improve the service for the people living at Cana Gardens.

The provider did not have systems or methods in place to continuously learn, and therefore improve the service. For example, whether the information we supplied through the last inspection report was actioned and changes made to the environment policies and procedures. Improvements have been limited.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

We again found the last report rating was not displayed in the home, which is a legal requirement.

There have not been any questionnaires sent out or contact with families to explain and involve them in the changes that have taken place in the home.

The provider does not have a consistent and clear vision to deliver care in the home. Communication is fragmented and inconsistent. The employment of four management staff who are in charge of the home one or two days of each week, has led to the absence of clear communication and likely to have detracted from the progress that could have been made between inspections.

Staff told us the home was a good environment to work in. One staff member said, "This is a really good place to work. If I had a member of my family that needed a home I would use this one."

We found the provider did work with other agencies. for example, a referral had been made to follow up a person's communication needs, as staff had identified that communication with them was becoming more difficult.

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 There were inadequate systems and processes to enable the provider to notify us, without delay, of an incident involving an error with a service user's medicine.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were inadequate systems and processes to enable staff to safely administer medicines. Checks were not in place to ensure homely remedies were administered in lines with GP instructions. There were inadequate systems and processes to enable staff to ensure the safety of people and guard against cross infection and cross contamination in the home. There were inadequate systems to protect people accessing unsafe areas and being exposed to dangerous chemicals.