Inspection Report on

Caerleon House Care Home

Goldcroft Common
Caerleon
Newport
NP18 1BE

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Description of the service

Caerleon House Nursing Home is in the village of Caerleon, Newport and is owned by Gwent Nursing Homes Ltd. The home is registered to provide accommodation with personal and or nursing care to 54 people over 50 years of age. At the time of inspection there were three vacant beds. The company have nominated a responsible individual (RI) to act on their behalf.

Summary of our findings

1. Overall assessment

The previous inspection report identified a number of areas where improvement was required. At this inspection we found actions had been taken to address some of the areas identified and people are on the whole content and feel well supported by staff who demonstrate empathy and care in their work. There are further actions required to ensure the management team have a robust oversight of all areas of the home to ensure people's safety and wellbeing.

2. Improvements

Improvements were identified in relation to people being supported with dignity and respect and the quality of the environment.

3. Requirements and recommendations

Section five of this report sets out the areas where the registered provider is not meeting legal requirements which include the following:

- Activities and wellbeing of people living at the home
- Leadership and management of the home
- Care and support practices

1. Well-being

Summary

There have been improvements made in respect of activity provision. This is a very recent change and the role is still being fully developed. People are content overall, particularly with regards to nutrition, although they feel care is not always immediately available when needed. People are treated with dignity and respect.

Our findings

People living at the home enjoy improved opportunities to participate in meaningful activities. We saw that since the last inspection, two dedicated activities co-ordinators had been appointed and were developing an activities programme within the home. We saw a weekly programme of events was on display throughout the home and we were shown both future planned activity programmes and photographs from recent events held at the home. We identified these changes are very recent and the role is under development. We saw there were files in place for residents to record their interests but these had not all been fully completed. There were also monthly forms to record people's activities; however, we saw some documentation had not been updated since December 2018. We noted some activities had been postponed but it was not clear what contingency plans had been implemented. One person told us they had not been consulted about participating in an activity, which they had previously enjoyed. We saw there was allocated time for people to have one-to-one contact which was welcomed by residents who told us they "would love to have a chat", but this was only scheduled on one afternoon each week which was a limited time for a large service. We also observed one activities coordinator was left to supervise a person in a dining area rather than being able to undertaking their dedicated role. We concluded improvements have been made in this area and people are enjoying more opportunities to enjoy activities, but considered this is an area which requires further attention.

People are treated with kindness and respect. We observed care staff speaking with people with sensitivity and consideration. We particularly noted examples of caring and patient practice during mealtimes and during the administration of medication, with choice and reassurance being readily provided, although it was clear care staff were very busy at these times. People expressed their satisfaction with their care, telling us, *"(They) are lovely*." We considered people's wellbeing is maintained through positive care delivery.

People do not always feel their needs are responded to in a timely manner. People told us they felt the home was "*Short-staffed*" and we were told by three different residents they would often have a long wait if they pressed their call bell and needed assistance. During our visit we noted one resident had to wait for both a staff member and manual handling equipment to be made available so they could return to bed. We were informed by the manager that manual handling equipment is stored away from the dining area and if equipment is already in use elsewhere, there may be an unavoidable delay at times.We also heard some call bells did ring for sustained periods. We found people may not always receive prompt attention to their needs.

People enjoy variety and choice around nutrition. We saw there were a number of breakfast choices displayed on menu boards in both dining areas. While there was one lunch option displayed on the board, we heard staff offering choices to people. Residents told us they enjoyed the food and particular items they liked were provided. We found generally people's weights were maintained, suggesting food is provided in appropriate quantity. We concluded people were offered an appropriate diet.

2. Care and Support

Summary

People living at the home are not assured of a consistent level of care and support to meet their needs and prevent risks to their health and wellbeing. There is insufficient oversight of the quality of care notes. People do not feel they are always given choice about their care.

Our findings

People receive an inconsistent level of care and support. We saw examples of patient and respectful support being provided. We saw a process had been put in place to ensure all residents were monitored and reviewed regularly; each person was nominated in turn as "Resident of the day" with the aim of ensuring their rooms were deep cleaned and files reviewed each month. However, we noted that care was not always delivered or recorded appropriately, resulting in risks to people's health. We saw there were sometimes gaps in the recording of people's care, and saw clinical notes where a period of several days had elapsed between recordings. We also saw care entries which simply said "*Checked*" rather than giving an adequate reflection of people's presentation. We looked at seven files and in all files there were significant gaps in the provision of oral care, particularly in the evenings. We saw one person had sustained an injury but had not been referred to a General Practitioner for four days, despite the injury site being blistered. We were informed by the manager this was because the area had been dry and care for by nursing staff in this time, however this was not clear from the documentation seen at inspection. We noted one person who was scheduled for a routine catheter change every three months had not received this for an eight month period. We shared our findings with the local safeguarding team. We concluded people cannot be assured of an appropriate standard of care at all times.

People's notes are not consistent with their care needs. We saw one person was assessed on their care plan as having "full capacity" but was also subject to a Deprivation of Liberty Safeguard application (DOLS). One person was listed as requiring weekly weights but was also on a monthly weight chart, creating potential confusion for care staff. One file contained information relating to a different person. We concluded better oversight is needed to ensure people's care needs are correctly reflected.

People do not always feel they are given adequate choice in their care, We spoke to one resident who told us they had been unable to have a shower for a number of days due to unforeseen staff shortages, We also were told people "*Sometimes feel rushed*" when care is provided. We also spoke to one person who lived alone in a shared room but told us they were not always consulted when an additional person was admitted to their room. It is considered people may not always be consulted about the care they receive. We shared our concerns with the management team of the home who told us they always assess a new resident's suitability before admission, including their compatibility with the existing residents of the service.

3. Environment

Summary

The home is appropriately maintained and issues are generally addressed when they occur. People live in a comfortable and homely environment.

Our findings

People live in an environment which overall meets their needs, although modifications are required to ensure the home meets health and safety requirements going forward. During our visit we noted that issues identified during the previous inspection had been addressed. We saw fire doors were all locked and secured and food in the kitchen area was appropriately stored. We saw relatives had raised issues about repairs needed and found these had been responded to in a timely manner. We noted the home was clean and had a homely atmosphere throughout. There were seasonal decorations on display reflecting recent annual events such as Valentine's Day. We saw there had been a recent call bell audit and additional resources had been purchased as a result. We considered the environment was appropriately maintained and was comfortable for residents.

However, further renovations are required to ensure the home remains suitable for people's needs and people's safety is maintained. We saw some preventative fire works were being undertaken; however we saw this was not yet complete and it was unclear how this was progressing. We saw evidence that fire evacuation plans had been considered since the last inspection. We were told that one of the lifts in one area of the home had been broken recently; this had been repaired but a second lift had failed on the day of our visit. This was also repaired during the day, however we felt the long term sustainability of the lifts needed to be considered to ensure people living on the upper floors were consistently able to access the lower communal areas of the home for both health and wellbeing purposes. We concluded that in the short term, the home is being maintained but there are potential environmental issues to consider going forward.

4. Leadership and Management

Summary

People cannot be assured there is robust leadership and management of all aspects of the service. Some actions have been implemented to improve quality assurance but there are further improvements required to ensure the service can meet people's needs fully and with confidence.

Our findings

There a lack of oversight of the home which has the potential to result in negative outcomes for people. During our visit we considered the issues found at our last inspection and found there had been some movement to respond to some of these but there were continued issues outstanding. We saw there had been no formal visits by the Responsible Indvidual (RI) since the last inspection. We saw the manager had contacted the RI twice to request this visit but this had not yet transpired. Staff told us they "never saw" the RI at the home. We were also told there was often a lack of visible managerial presence throughout the main areas of the home. One relative told us they felt unable to approach the manager with any queries as they were "*Made to feel like it's too much trouble*." The manager informed us the home operates an open door policy and has a suggestion box for written requests, which we saw at inspection. We concluded there is insufficient leadership in place to offer consistent reassurance to staff and residents alike.

Recruitment processes and staff management are considered, but this is not of an adequate standard currently. We looked at three staff files, as well as supervision and training records. We saw that all the staff files had gaps in employment histories which had not been fully explored. We also found one person's reference showed dates that did not match their application form but this had not been identified. We saw there were insufficient induction processes in place and while an induction form was given to new staff there was no evidence of shadowing or mentoring. This was also identified in the previous inspection. We discussed our findings with two senior staff members as the manager and RI were not present on the day of our visit and they told us plans were being put in place to ensure new starters would be assigned to a team leader in future to be given a more thorough induction. We also noted that while health care staff and qualified staff had disclosure and barring information on file (DBS) there were several domestic staff listed whose information was out of date. We found at present there is insufficient oversight of recruitment practices.

There have been some actions implemented to consider areas of quality assurance and oversight of the home but these currently require more improvement. We looked at a range of documentation during our visit and saw complaints were being filed and recorded, although from people's daily notes we identified some verbal complaints were still not being recorded. We also saw one complaint which had not been signed off although we were told by senior staff the issues had been addressed. We saw safeguarding referrals were now being centrally collated and staff meetings had been held since the last inspection although we did not see evidence of resident or relative meetings taking place. We noted some supervision sessions had been undertaken although there were significant gaps for some staff and also noted some gaps in people's training. We also considered the lack of

oversight of some aspects of residents' care files and concluded overall people cannot currently be assured there is robust oversight of all areas of the service.

5. Improvements required and recommended following this inspection

5.1 Areas of non compliance from previous inspections

At the previous inspection we identified the registered persons were not meeting legal requirements regarding Health and welfare - Regulation 16 (2) (n) of the Care Homes (Wales) Regulations 2002, relating to the provision of activities in relation to recreation, fitness and training. At this inspection we found some improvements had been made and two activities co-ordinators were now in post to oversee and implement a programme of activities. However we found this was a recent development and further improvements need to be made to ensure all residents are consulted and have opportunities to participate in meaningful pursuits. Care documentation needs to be completed and maintained to support the process. We therefore find this area of non compliance remains outstanding at this time.

At the previous inspection we identified the registered persons were not meeting legal requirements regarding Regulation (10) (1) of the Care Homes (Wales) Regulations 2002, relating to the management of the care home with sufficient care, competence and skill. At this inspection we found the manager of the home had taken some action to address some of the outstanding issues. However we also found there were considerable gaps remaining with regard to a lack of RI oversight, employment and recruitment procedures and oversight of care files and other documentation. We therefore find this area of non compliance remains outstanding.

At the previous inspection we identified the registered persons were not meeting legal requirements regarding Regulation 13(4)(c) of the Care Homes (Wales) Regulations 2002, relating to the management of the environment and the health and welfare of residents. At this inspection we found actions had been taken to ensure the correct storage of food and fire doors were closed and secured. We therefore conclude the registered persons are now compliant with this regulation.

At the previous inspection we identified the registered persons were not meeting legal requirements regarding Regulation (12)(4)(a) of the Care Homes (Wales) Regulations 2002. At this inspection we observed people were treated with respect and kindness and people's dignity and privacy was promoted. We therefore conclude the registered persons are now compliant with this regulation.

5.2 Recommendations for improvement

During this inspection, we identified areas where the registered persons are not meeting the legal requirements and this is resulting in potential risk and/or poor outcomes for people using the service. Therefore we have issued a non-compliance notice in relation to the following:

At this inspection we identified the registered persons are not meeting legal requirements in relation to Regulation 12(1)(b) of the Care Homes (Wales) Regulations 2002, regarding care and support of residents. During inspection we found people were not being consistently given care in accordance with their care plans. We also found gaps in people's

care notes and conflicting information about their needs. We found people requiring treatment were not consistently receiving this in a timely manner.

We have issued a notice of non-compliance in relation to this issue. Details of the actions required are set out in the non-compliance notice attached.

We expect the registered persons to take action to rectify the areas where they are not fully meeting the legal requirements. These will be followed up at the next inspection.

6. How we undertook this inspection

Two inspectors visited the home on 6 March 2019 and carried out an unannounced focused inspection to consider the areas of non-compliance identified at the previous routine inspection. The following information was used in the collation of the report:

- Discussions with people living at the home;
- Discussions with care staff.
- The Short Observational Framework for Inspection (SOFI 2) was utilised. The SOFI tool enables inspectors to observe and record care to help understand the experience of people who cannot communicate.
- Examination of seven residents' care documentation.
- Examination of three staff personnel files.
- Examination of supervision and training records.
- Examination of other relevant documentation, where available, including accidents/ incidents and complaints records.
- Consideration of the home's policies and procedures.
- Observations undertaken regarding the environment of the home
- Discussion with other professionals working with the home.
- Questionnaires were sent out to residents, staff and relatives; at the time of writing this report none had been returned.

Further information about what we do can be found on our website:
www.careinspectorate.wales

About the service

Type of care provided	**Adult Care Home - Older**
Registered Person	**Gwent Nursing Home Ltd**
Manager	**The manager is registered with Social Care Wales**
Registered maximum number of places	**54**
Date of previous Care Inspectorate Wales inspection	**4 September 2018**
Dates of this Inspection visit(s)	**06/03/2019**
Operating Language of the service	**English**
Does this service provide the Welsh Language active offer?	**This is a service that does not provide an 'Active Offer' of the Welsh language. It does not anticipate, identify or meet the Welsh language needs of people who use, or intend to use their service. We recommend that the service provider considers Welsh Government's '*More Than Just Words'* follow on strategic guidance for Welsh language in social care.**
Additional Information:	

Description of Non Compliance / Action to be taken	Timescale for completion	Regulation number
Action to be taken: Action must be taken in a timely manner to ensure people receive care in accordance with their care plans and appropriate treatment is sought and provided in a timely manner.	1 July 2019	12(1)(b)

The registered persons are non-compliant with Regulation 12(1)(b) of the Care Homes (Wales) Regulations 2002. This is because they failed to ensure there is adequate provision for the care and treatment of service users.

Evidence: Two inspectors visited the service on 6 March 2019 and looked at seven people's daily notes and files. It was identified there were gaps in the provision of care, with particular reference to the provision of oral care in the evenings. Catheter care for one person was not recorded for eight months, placing them at significant risk of infection. Some clinical notes had gaps in recording and others held details of other residents, or gave information conflicting with their care plans. We saw in some cases there was a delay between in incident occurring and appropriate medical treatment being provided. We found people were not always able to receive care in accordance with their wishes.

Impact: In one example a resident sustaining a scald to their leg was not seen by their GP for four days, by which time an infection had developed. We were told one person was unable to have a shower when they chose, causing them distress. We considered there were negative outcomes for people and risks to people's health as a result.