Care UK Community Partnerships Ltd

Harry Sotnick House

Inspection report

Cranleigh Avenue
Buckland
Portsmouth
PO1 5LU

Tel: 02392820703
Website: www.careuk.com/harry-sotnick-house

Date of inspection visit:
03 October 2017
04 October 2017
05 October 2017

Date of publication:
06 November 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out this unannounced urgent inspection of the home on 3, 4 and 5 October 2017. The inspection was prompted in part by notification of two incidents which had occurred in the home. Following the first of these incidents a person who lived at the home died. This incident is subject to further investigation and as such this inspection did not examine the circumstances of this event.

However, the information shared with CQC about the incident indicated potential concerns about the management of risks associated with; a failure to follow professional guidance adequately, the safe monitoring of people's hydration and nutrition needs, the administration of medicines and the changing needs of people as they move towards end of life care. A second incident reported to CQC did not involve a person who lived at the home; however this raised serious concerns about the risks associated with the management of medicines in the home. All of these identified risks have been examined in this inspection.

The registered provider has an extensive history of non-compliance with the required regulations in this home. You can see the reports which have been published about our inspection program at this home on www.cqc.org.uk .

In December 2016 the home was rated as Inadequate and placed into special measures by the Commission. Two separate conditions were imposed on the registered provider's registration for this home which required the registered provider to provide information to the commission on a fortnightly basis showing the actions they were taking to comply with all the required Regulations and provide information on the number of agency staff working in the home.

This home was last inspected in May 2017 where we found the home to be compliant with all the Regulations and was fulfilling the requirements of these conditions. However, further work was required to embed good practices in the home. The home was moved out of special measures although the two conditions imposed on the registered provider's registration of this home remained in place. The registered provider applied to have these conditions removed from their registration on 14 July 2017; however they remained in place at the time of this inspection.

At this inspection we have identified four breaches of the Health and Social Act 2008 (regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

□□Ensure that providers found to be providing inadequate care significantly improve.
□□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

□□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The home provides accommodation, nursing and personal care for up to 92 older people, most of whom live with dementia. Accommodation is arranged over two floors with stair and lift access to all areas. A third floor provides staff facilities. At the time of our inspection 70 people lived at the home.

A registered manager was 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.

Medicines were not always managed in a safe and effective manner to ensure the safety and welfare of people. Medicines errors had not always been identified or investigated and learned from.

We identified a number of incidents in the home during our inspection relating to the poor clinical knowledge and understanding of registered nurses.

There was a lack of good clinical leadership in the home. Nursing staff did not always demonstrate a good understanding of their roles and responsibilities. Where clinical errors had been made learning from these was not always recognised and shared in the service.

Whilst there were safe recruitment practices in the home, there were not always sufficient staff with suitable skills, knowledge and experience deployed to meet the needs of people. There was a high dependency on the use of agency registered nurses in the home.

The risks associate with people's changing clinical needs were not always assessed and actions taken to mitigate these in a timely way.

We saw there was confusion and misunderstanding about what constituted end of life care in the home; care plans in place and actions taken by staff were not always consistent and appropriate to ensure people received care which was in line with their needs and preferences at the end of their life.

People were cared for in a kind and compassionate way. Their plans of care were mostly person centred.

People were encouraged to interact with each other and participate in a wide variety of stimulating activities and events.

There was a system in place to allow people to express any concerns or complaints they may have, and people had the opportunity to express their views on the quality and effectiveness of the service provided at the home.

Where people could not consent to their care, staff sought appropriate guidance and followed legislation designed to protect people's rights and freedom.

People received nutritious food in line with their needs and preferences. Food and fluid records were well maintained and people enjoyed the food they received.

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 not protected against the risks associated with medicines. The provider did not have appropriate arrangements in place to consistently manage people's medicines safely.

There were not always sufficient registered nursing staff with appropriate clinical skills and knowledge deployed to meet people's needs and ensure their safety and welfare.

Staff had an understanding of safeguarding policies and procedures.

Risks associated with people's care had been identified; however there was a failure of nursing staff to respond to the risk associated with changing clinical needs.

Staff recruited to the home had been assessed as to their suitability to work with people.

Is the service effective?

Good

The service was effective

Where people could not consent to their care, staff sought appropriate guidance and followed legislation designed to protect people's rights and freedom.

People received nutritious food in line with their needs and preferences.

Most staff had received training to enable them to meet the needs of people.

Is the service caring?

Requires Improvement

The service was not always caring.

People's end of life preferences and choices were not always kept under review and acted upon promptly.

People's privacy and dignity was maintained and staff were caring and considerate as they supported people. People were valued and respected as individuals and were happy and content in the home.

Arrangements were in place to ensure people were involved in planning their care and their views were listened too.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care which was person centred and individual to their specific nursing needs.

There was a wide range of meaningful activities and interactions in the home to reduce the risk of social isolation for people.

A system was in place to allow people to express any concerns or complaints they may have.

Is the service well-led?

Inadequate

The service was not well led.

Whilst a registered manager was in place there was a lack of strong and effective nursing leadership and accountability in the home. Nursing staff did not have a good understanding of their roles and responsibilities.

Whilst the registered provider had systems in place to monitor and review the quality and effectiveness of the service provided, these had not always been effective in identifying and dealing with the concerns we noted at our inspection.

There was an open and transparent culture within the home and staff felt supported by the registered manager.

Harry Sotnick House

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 had made the improvements required following our inspection in September 2016 and was 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.

Two inspectors, a pharmacist specialist and an expert by experience completed this unannounced responsive comprehensive inspection on 3, 4 and 5 October 2017. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home and information of concern we had received from health and social care professionals and the local authority. We looked at previous inspection reports, various action plans and service improvement plans the registered provider had sent to us since the last inspection. We also reviewed notifications of incidents. A notification is information about important events which the service is required to send us by law.

We spoke with four people and seven relatives to gain their views of the home. Some people who lived at the home were not able to talk with us about the care they received, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to understand the experience of people who could not talk with us. We observed care and support being delivered by staff and their interactions with people in communal areas of the home.

We spoke with the registered manager, the regional director and regional manager for the registered provider. We spoke with the deputy manager, a regional clinical lead and clinical lead as well as three registered nurses, a team leader, four members of care staff, a member of catering staff and an activities coordinator.

We looked at the care plans and associated records for 14 people and the medicine administration records for 19 people. We looked at a range of records relating to the management of the service including records of; accidents and incidents, quality assurance documents, five staff recruitment files and policies and

procedures.

We received feedback from four health and social care professionals who supported some of the people who lived at the home.

Inadequate

Is the service safe?

Our findings

People and their relatives felt the home was safe and staff were available when they needed them. However some said there was a lack of consistency in staff and a lot of new [staff] faces in the home. Health and social care professionals identified some concerns about the number of medicines errors and poor clinical judgements in the home and this reflected the findings of this inspection.

At our inspection in November 2016 we found there was a lack of clear and effective systems in place to monitor and record the proper and safe management of medicines to ensure the safety and welfare of people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of enforcement action taken by the Commission following this inspection, a condition was placed on the registered provider's registration for this location. This required the registered provider to provide information to the commission on a fortnightly basis as to how they would attain and sustain compliance with this Regulation.

At our inspection in May 2017 we found the registered provider had taken sufficient action to be compliant with this Regulation. However, the condition remained on the registered provider's registration and they continued to send us information as required. At this inspection, in October 2017, we found the registered provider had failed to remain compliant with this Regulation and we identified a number of new concerns.

We had received information of concern from the local authority about the high number of medicines incidents and errors reported in the home. Registered nurses administered all medicines at Harry Sotnick House although the registered manager told us they were looking to train team leaders in the safe administration of medicines to support registered nurses with this work.

We reviewed the records of 21 medicines incidents recorded in the service since our last inspection. Some of these incidents identified missed medicines and others identified incidents where a person may have not received their medicines if they had not been rechecked (this is referred to as a near miss incident). The registered manager is not legally required to inform CQC of these incidents; however they had been open and transparent in their reporting of all incidents associated with medicines to both the local authority and CQC as there had been significant concerns in the past in this home with the poor administration of medicines.

During two days of our inspection we were informed of five medicines errors where medicines were not administered correctly or were omitted and were not identified in a timely way. Following our inspection we were informed of a further medicines concern which occurred on the third day of our inspection. Whilst incident forms were completed for these errors, we were not assured robust systems were in place to prevent medicine errors.

For one person, who was due a medicine to thin their blood, their morning dose of this medicine was omitted on 4 October 2017 and this was not identified until their evening dose was administered on the same day. The registered nurse did not follow a protocol which was in place for in the event this medicine

was omitted. For another person, who was acutely unwell, prescribed antibiotics had not been administered in a timely way. For a third person an incorrect medicine was administered due to medicines being stored in incorrect packaging. For a fourth person a medicine was administered to the wrong person and for a fifth person a medicine was omitted and not identified in a timely way.

A system of medicines checking and audit was in place however this was not effective in preventing medicine errors. Two members of clinical lead staff were unable to explain why medicine errors persisted in the home. One clinical lead told us, "There is a lack of consistency in nursing staff, so they are not used to the people and their medicines."

Registered nurses did not always ensure that medicines were safe to use. The dose times for two medicines were not clear, but registered nurses had not contacted the prescriber or pharmacy for advice. We found unopened antibiotic syrups for two people that were at least one month past their expiry date in the medicines fridge. One person's insulin was correctly stored in the medicines trolley and the manufacturer says this insulin should only be used for up to 28 days when stored at room temperature. Registered nurses had not recorded the date when this medicine was moved to room temperature and therefore we could not be assured that this medicine was safe to administer. A clinical lead told us registered nurses had not followed the proper procedures and dated this medicine or disposed of others held which were out of date.

We were not assured people received their medicines in a timely and therapeutic way. Four registered nurses started medicines administration rounds between 08:00am and 08:30am. However, during the three morning medicines administration rounds we observed all were completed between 11:00am and 11:45am. A clinical lead told us that as registered nursing staff did not know people well and as the medicine rounds and people's needs were complex this meant they took a very long time to complete these medicine rounds. This meant that some people did not receive their morning medicines in a timely way and may not have a suitable gap between doses of medicines which may cause side effects or make them less effective.

A visiting healthcare professional informed us of an incident of incorrect administration of a medicine which had been investigated following the death of a service user in 2016. This had been investigated by the coroner and the outcome of this investigation was made available to CQC at this inspection. Whilst no further actions were required in relation to this incident, CQC had not been made aware of this medicines error during the two previous inspections of this home when concerns about the management of medicines had been reviewed. We were concerned this information may have better informed previous inspections of this home and the management of medicines within it.

Following our inspection the registered manager notified us of an incident which had occurred on 5 October 2017 where an urgent medicine to improve a person's health condition was not administered as requested by a GP. This person was subsequently admitted to hospital on 7 October 2017 having not had this medicine and the registered manager told us an investigation into the reason for this incident was on-going. We were not assured this person had received medicines in a way which ensured their safety and welfare.

Medicines were not always managed in a way which ensured the safety and welfare of people. This was a breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider has an extensive history in this service of non-compliance with this section of this Regulation.

At the completion of our inspection we sought urgent assurances from the registered provider about systems they planned to have in place to address the persistent issue of medicines errors. We received these assurances on 5 October 2017.

The risks associated with the administration of medicines had been assessed and documented in care plans. The effectiveness of these medicines was monitored. For example, three people were prescribed medicines that may cause an increased risk of bruising. Their care plans described the management of the potential bruising and other side effects. Nine people lived with medical conditions such as diabetes, epilepsy and mental health conditions and their care plans gave clear information on how medicines should be used to prevent deterioration in these conditions.

Registered nurses signed medicine administration records (MARs) to show when they had given medicines. MAR and care plans contained supporting information about a person's medicines needs, such as allergies, ability to communicate, 'how I like to take my medicines' and "when required" or "variable dose" protocols. These protocols give additional guidance to staff about when these medicines might be needed

At our inspection in November 2016 we found there was a lack of risk assessments in place to identify and mitigate the risks associated with people's care. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of enforcement action taken by the Commission following this inspection, a condition was placed on the registered provider's registration for this location. This required the registered provider to provide information to the commission on a fortnightly basis showing how what steps they were taking to attain and sustain compliance with this Regulation.

At our inspection in May 2017 we found the registered provider had taken sufficient action to be compliant with this Regulation. However, the condition remained on the registered provider's registration and they continued to send us information as required.

At this inspection, in October 2017, we found whilst the registered provider continued to ensure risk assessments were in place for identified risks associated with people's care, there was a failure of nursing staff to respond to the risk associated with changing clinical needs.

The registered manager had notified us of one incident which occurred in the home where the risks associated with one person's nursing needs were not met in a timely way when a continence aid had broken. This could have resulted in significant harm to this person. The registered manager had taken appropriate action to address this matter. However, during and immediately following our inspection three further incidents occurred where registered nurses failed to identify the risks associated with people's clinical care needs and ensure they received a prompt and appropriate response to their individual needs to ensure their safety and welfare.

We observed an incident where one person was found by care staff to be unresponsive and in need of urgent support. All registered nurses were in a meeting at this time. We were present in this meeting when a member of care staff alerted registered nurses to the need for their assistance although they did not convey the potential seriousness and urgency of the incident. The deputy manager identified in the meeting that this person often did this as a "way of seeking attention". An agency registered nurse working on their first day in the home, and not knowing the potential urgency of the situation, did not make themselves immediately available.

Care records did not identify that this person regularly became unresponsive in this way and there were no risk assessments in place to identify this risk and how staff should respond to this. We were not assured registered nurses had responded appropriately to the risks associated with this persons care and ensured this person had received the individualised care and support they required to ensure their safety and welfare. Whilst the person recovered shortly after this incident we were not assured all practical actions had been taken to mitigate the risks associated with this person's care.

A second incident occurred during our inspection when registered nurses failed to ensure a person received prompt medical treatment as prescribed by a GP when they became unwell. Registered nurses failed to identify the risks associated with this person's care and ensure clinical care was provided promptly and as advised by a health care professional for this person in response to their clinical needs. We were not assured all practical actions were taken to mitigate the risks associated with this person's care.

Following our inspection, the registered manager notified us of a third incident of concern which occurred on 5 October 2017. Registered nurses did not respond promptly to the risks associated with the nursing needs of a person as advised by a GP. This person had subsequently been admitted to hospital for treatment on 7 October 2017 as an on-going result of their condition. We were not assured all appropriate actions had been taken to mitigate the risks associated with this persons care and ensured this person had received the individualised care and support they required to ensure their safety and welfare.

The lack of assessment of the risks associated with peoples clinical care and the implementation of all practical actions to mitigate these risks was a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider has a history in this service of non-compliance with this section of this Regulation.

Whilst the registered manager was open and transparent in their reporting of incidents and accidents which occurred in the home, there was a clear lack of learning and oversight of clinical incidents in the home.

A serious medicines incident was reported to the Commission on 24 August 2017. This had not been appropriately investigated and escalated by staff who had the clinical accountability and expertise to understand the impact of these concerns and ensure the safety and welfare of people. The registered provider had failed to take appropriate actions to investigate this safety concern and ensure the safety and welfare of people in relation to these medicines. Appropriate actions had not been taken to identify and share learning from this incident. During our inspection we identified further concerns about this incident and requested a full formal investigation of this incident be completed and forwarded to the Commission in a timely manner. This investigation is on-going at the time of this report.

There had been one significant clinical incident prior to our inspection in the home when staff had not followed the advice of health care professionals and summoned their help appropriately. There had been a failure to learn from this by clinical staff. During our inspection two further incidents of failure to respond promptly to professional's advice in the event of people being unwell had placed people at the risk of harm or not receiving the care they needed in line with their preferences and needs.

The failure to learn from previous clinical incidents and accidents and assess, monitor and mitigate the risks associated with people's care was a breach of Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in November 2016 we found there was a lack of sufficient staff deployed in the home to meet the needs of people and ensure their safety and welfare. Our concerns related in particular to the high use of agency staff who did not sufficiently know the health and care needs of the people who lived at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of enforcement action taken by the Commission following this inspection, a condition was placed on the registered provider's registration for this location. This required the registered provider to provide information to the commission on a fortnightly basis showing how the number of agency staff had reduced in the home and further plans to attain and sustain compliance with this regulation.

At our inspection in May 2017 we found the registered provider had taken sufficient action to be compliant with this Regulation. However, the condition remained on the registered provider's registration and they continued to send us information as required.

At this inspection, in October 2017, we found the registered provider had addressed the very high use of agency care staff within the home through a recruitment drive and the use of a recruitment agency. Although some agency care staff were employed the use of agency care staff in the home had decreased by more than 75% since December 2016.

However, permanent registered nurse staffing levels in the home remained poor and there was a high reliance on the use of agency registered nurses. The registered manager and clinical lead told us some registered nurses were employed regularly through an agency to work in the home and had a good understanding of people's needs. However, there had been a significant turnover of permanent registered nurses in the home. During our inspection we observed a lack of registered nursing support and expertise available for people to ensure their safety and welfare.

Two senior members of staff told us the home was, "More like a cottage hospital," and described how the home required more registered nurses with sound clinical skills and knowledge and a good understanding of their accountability. This was reflected in our findings during this inspection.

There was a lack of sound registered nursing leadership and accountability in the home to ensure the safety and welfare of people. This was identified through several incidents identified in this report such as medicines errors and lack of sound clinical judgements to ensure people received care which was safe, effective and responsive to their needs.

The registered provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed at all times to meet people's needs and provide nursing leadership and support in the home. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider has a history in this service of non-compliance with this section of this Regulation.

At the completion of our inspection we sought urgent assurances from the registered provider about systems they planned to have in place to address the lack of staff with appropriate nursing leadership skills and accountability in the home. We received these assurances on 5 October 2017.

People and their relatives told us there were a lot of new care staff in the home although this was beginning to settle. One person said, "There are a lot of new faces, I get a bit muddled." A relative said, "Staff don't seem to be around long, there have been lots of new faces, but I am sure it will settle down." Another relative told us, "The problem is the lack of consistency; some staff know my [relative] whilst others don't. My [relative] can find this very distressing." The registered manager had acknowledged people and their relatives concerns about the high number of new staff at a recent meeting and assured them this would settle quickly.

The registered provider had a dependency tool in place. This is a tool which is used to identify the needs of people and give guidance on the number of staff required to do this. This tool was informed by registered nurses assessment of people's needs and was updated whenever changes in people's needs were identified.

Rotas showed there were consistent numbers of staff deployed in the home to meet the needs of people

according to this tool. However some staff told us these numbers did not always reflect accurately the staff available to support people, for example with their morning personal care. One member of staff said, "People are still getting care at 11.30am. I know there's something they [management] use to work out the staffing levels but I think it's done more on the number of people needing care rather than what care they need. It feels that way". A second member of staff said, "I would say half the week there aren't enough staff." Another said, "We don't have much time to spend with people. It's just a case of getting things done. At least once a week there aren't enough staff. Then the people who are one to one care get left on their own sometimes."

We observed some people who received one to one care were occasionally left unattended whilst staff who were assigned to them supported other people. During our inspection we observed there were usually sufficient staff around the home to meet people's needs although staff did not always have time to sit and interact with people.

Whilst the registered provider had taken steps to ensure there were adequate numbers of regular care staff available to meet people's needs each day, this needed further review and embedding in the service.

The registered manager had a good understanding of their responsibilities in reporting any matters of a safeguarding concern to the local authority. Records showed they had worked with the local authority to investigate any matters of concern and address these. Staff had undertaken adult safeguarding training within the last year. They understood the correct safeguarding procedures should they suspect abuse. They were aware of the provider's safeguarding policy and that a referral to an agency, such as the local Adult Services Safeguarding Team should be made. One staff member told us, "I would speak to them (staff member acting abusively towards a person) and tell my team leader or nurse. If they wouldn't do something I would go to the manager". Another staff member told us, "If the manager didn't do something I would let you (CQC) know". However we did identify one incident where staff had not raised concerns appropriately about the potential abuse of one person. We identified this matter to the registered manager who took immediate actions to address this concern.

There were safe and efficient methods of recruitment in place. Recruitment records included proof of identity, two references and an application form which provided a full employment history. Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed.

Recruitment checks and information was available for all agency staff who worked in the home. People who work in the United Kingdom as nurses must be registered with the Nursing and Midwifery Council (NMC) and have a personal identification number (PIN) for this. Providers must ensure all registered nurses provide the relevant documentation to show they have this registration. This information was held on file for registered nurses employed at the home.

Good

Is the service effective?

Our findings

People who were able to express their wishes felt they were involved in their care and were offered choices and support to maintain their independence. Health and social care professionals felt staff requested their support appropriately and that some staff knew people very well.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had a good understanding of the MCA and had undertaken training in this. Care plans for people reflected issues of consent and capacity and clearly identified information about the person's level of ability to make their own decisions. Where required, mental capacity assessments and best interests decisions were clearly documented. One person who lacked capacity to make many decisions about their care had no relatives or friends to act as a representative. We saw they had been appointed an Independent Mental Capacity Advocate (IMCA) to ensure the care they received was in their best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards. At our inspection in November 2016 we found the home was not meeting all the requirements of the Deprivation of Liberty Safeguards. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of enforcement action taken by the Commission following this inspection, a condition was placed on the registered provider's registration for this location. This required the registered provider to provide information to the commission on a fortnightly basis showing how this Regulation was being met.

At our inspection in May 2017 we found the registered provider had taken sufficient action to be compliant with this Regulation. However, the condition remained on the registered provider's registration and they continued to send us information as required.
At this inspection, in October 2017, we found that 48 people who lived at the home were subject to these safeguards and the home was meeting the requirements of the Deprivation of Liberty Safeguards. Care plans reflected these safeguards and any conditions associated with these. A register of people with any Deprivation of Liberty Safeguard in place was kept and was monitored by the registered manager. However, some improvement was required on the timeliness of the renewal process for these safeguards.

At our inspection in November 2016 we found there was a lack of regular supervision in place for staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. As a result of enforcement action taken by the Commission following this inspection, a condition was placed on the registered provider's registration for this location. This required the registered provider to provide information to the commission on a fortnightly basis showing how this Regulation was being met.

At our inspection in May 2017 we found the registered provider had taken sufficient action to be compliant with this Regulation. However, the condition remained on the registered provider's registration and they continued to send us information as required.
At this inspection, in October 2017, we found a system of staff supervision and appraisal was in place and was closely monitored by the registered manager. It was noted that a very high number of new staff in the home had required support and supervision during their induction and this would have an impact on the availability of senior staff to provide supervision for others. Most of the care staff we spoke with had received induction and supervision and all felt supported in their role.

There was a robust induction program for all new staff at the home. This induction included a period of shadowing other staff, training and supervision meetings with their line manager or the registered manager. Newly recruited staff were completing the Care Certificate as part of their induction process. This certificate is an identified set of standards that care staff adhere to in their daily working life and gives people confidence that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. We spoke with staff about their experiences of induction to the home when first coming to work for the provider. One member of care staff told us, "It's really good now for new staff. There is a lot of training and we have a nutritionist who talks to new staff about people's diets. There's a buddy system in place so new staff always have someone to go to".

There were no new permanent registered nurses employed at the home who had commenced work since our last inspection. The registered manager had recently identified the need for new registered nursing staff who were employed in the home through an external agency to have a thorough induction to the home prior to starting work there. This need had been identified following consistent concerns about the familiarity of these staff to policies and procedures of the registered provider.

A new half day induction to the home was being delivered by the regional clinical lead to ensure new agency registered nurses had a good understanding of the systems in place to try to improve the safety and welfare of people. This included an introduction to the electronic record system and medicines administration systems in place. We saw a new registered nurse who worked in the home was provided with this training on one day of our inspection. This need had been identified following consistent concerns about the familiarity of new agency registered nurses to medicines management and medicines errors which had occurred in the home as well as the policies and procedures of the registered provider.

A member of administrative staff monitored and updated all staff training records which were held electronically. These showed all staff had access to a wide range of training which included: moving and handling, equality and diversity, infection control, fire training, diabetes, safeguarding, mental capacity and deprivation of liberty, dementia awareness and health and safety. Staff were encouraged to develop their skills through the use of external qualifications such as nationally accredited qualifications.

Registered nurses were supported to remain up to date with current practice and able to meet the requirements of their registration with the Nursing and Midwifery Council (NMC).

One staff member told us, "There's a mixture of face to face and on-line training. I like it". Another staff member said, "There is plenty of training and we're expected to do it". Whilst staff completed and had access to suitable training to fulfil their role, some staff felt this was not always a priority for the registered provider as staff shortages had prevented this. One member of staff said, "I would say three times out of five [times] I don't get the chance to do training because there aren't enough staff on the floor." Another said, "I've been asked not to do training because we are short staffed. I had an exam to do which I had to cancel at the last minute".

Whilst staff had access to a wide variety of training further work was required by the registered provider to ensure staff had access to training in a timely way.

We had received concerns from health and social care professionals about the monitoring and provision of appropriate food and fluids for people. This was specifically in relation to the needs of people who had swallowing difficulties, or were at risk of choking or dehydration. However, we did not find evidence at our inspection to support this.

The risks associated with malnutrition, dehydration and choking had been assessed for people and actions were taken to reduce these risks. Records showed a dietician or speech and language therapist had been consulted if this was required. Records of people's daily food and fluid intake were maintained if required and people's weight was monitored and actions taken appropriately to ensure people received adequate nutritional intake to maintain their health and wellbeing.

Food and fluid balance records were in place for some people. For example, records showed one person had a poor intake of fluids and was at risk of dehydration. A daily target had been set for this person's daily consumption of fluids which had been consistently met. The person also experienced difficulty in swallowing. They had been assessed by a Speech and Language Therapist who advised that the person should have a pureed diet and thickened fluids. We saw staff supported this person with diet and fluids in line with their needs.

Food and fluid charts which were in place were audited daily by the registered manager and deputy manager or clinical lead to ensure people were receiving adequate food and fluid intake and that this was being accurately recorded.

People said the food provided at Harry Sotnick house was good and there was a variety of foods available to them. People received a diet which was in line with their needs and preferences. Care plans identified specific dietary needs and the cook had records of these. Special diets such as those for people who required a soft or diabetic meal were catered for and the cook had information about any allergies people may have and their likes and dislikes. All food was freshly prepared and there was a three week rolling rota of menus. People enjoyed the food available to them and they and their families were encouraged to meet the cook and give them feedback on meals and discuss their preferences.

Records identified a wide range of health and social care professionals were involved in people's care. These included GP's, speech and language therapists, community nurses, mental health team staff, hospital consultants and NHS Nurse Specialists. This meant staff involved professionals appropriately.

Visiting health and social care professionals told us some staff at the home knew people very well although there was a lack of consistency in registered nurses available in the home. Health and social care professionals identified at times there was a breakdown in communication about advice they provided to registered nurses in the home to ensure the safety and welfare of people. We have dealt with this concern further in the well led domain of this report.

Requires Improvement

Is the service caring?

Our findings

There had been a high number of new members of care staff join Harry Sotnick House since our last inspection and this meant people and their relatives did not always recognise new members of staff. This was sometimes unsettling for people; however they and their relatives said staff were kind and caring. One person told us, "The staff are very caring," and another said, "They are all lovely, I like it here." A relative told us, "The staff are very caring, they cannot do enough for [relative]." Another relative told us how their loved one always appeared well cared for and content in the home. They said, "The staff are really kind and do their very best for [relative]". Visiting health and social care professionals told us they saw staff interact in a kind and caring way with people.

At our inspection in November 2016 we found people were not always provided with sufficient support and action taken to ensure this privacy. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of enforcement action taken by the Commission following this inspection, a condition was placed on the registered provider's registration for this location. This required the registered provider to provide information to the commission on a fortnightly basis showing how what steps they were taking to attain and maintain compliance with this Regulation.

At our inspection in May 2017 we found the registered provider had taken sufficient action to be compliant with this Regulation. However, the condition remained on the registered provider's registration and they continued to send us information as required. At this inspection we found the registered provider was compliant with this Regulation.

People's privacy and dignity was maintained and staff had a good understanding of the need to ensure people were treated with respect at all times. Doors remained closed when staff supported people with personal care and staff knocked and waited for a response before entering people's rooms. Previous concerns raised in the home about people walking into other people's rooms without permission resulting in a lack of privacy and dignity for people had been addressed. Assistive technology such as electronic alarm mats and sensors were used effectively to ensure people's privacy and dignity was maintained.

However, for people who were moving towards the end of their life we found care staff were not always clearly directed and aware of these people's needs and how to care for them appropriately.

Every person had a plan of care in place called, "End of Life Care." This gave general information on the current situation for each person, whether they wanted to be resuscitated in the event their heart should stop and often their preferred place of death. However, we saw these care plans were not always in line with people's current needs and the care which was being provided for them. Whilst staff were kind and caring in their interactions with people, we saw there was confusion and misunderstanding about what constituted end of life care; care plans in place and actions taken by staff were not always consistent and appropriate. We were not assured people's preferences and choices for their end of life care were being kept under review and acted upon. We have dealt with this further in the responsive domain of this report.

People's rooms were personalised with their own furniture and belongings if they chose and memory boxes outside and inside people's rooms were personalised to reflect people's life, likes and preferences.

We observed some good interactions between people and care staff who consistently took care to ask permission before providing care or assisting people to do things. There was mostly a good level of engagement between care staff and people although there were some short periods of time, particularly when care staff were busy supporting people with personal care in the morning and up to lunchtime, when people remained in communal areas without a member of care staff present and minimal interactions were going on in the room.

Staff were calm and friendly in their manner to people as they moved around the home. For one person who needed encouragement to have a good meal, staff spoke gently and in a caring way to encourage them to have a meal of their choice. For another person who called out frequently staff interacted with them in a calm and supportive way to ensure their safety and comfort. For two people who remained in bed for their care and support we saw staff were not rushed and spoke in a calm and friendly way to them. A fourth person regularly burst into song with little or no notice. Staff joined in with their singing on many occasions and it was very evident the person enjoyed this very caring, personal and effective interaction.

People and their relatives were involved in providing information to inform their care plans. A system of 'Resident of the Day' was in place to ensure people and their family or representatives were given the opportunity to review the care they received and discuss any changes they may need.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were encouraged to express their views and be involved in making decisions about their care. Whilst some staff knew people well and understood how to support them to be as active and independent as possible, other staff had not been working in the home for very long and were developing working relationships with people.

We had received concerns from health and social care professionals about how responsive registered nurses were to people's changing care needs. There were concerns these needs were not always identified and managed promptly and effectively, particularly as people moved towards the end of their life.

Most people who live at Harry Sotnick House have complex physical and mental health needs which require close monitoring and support to ensure their safety and welfare. Plans of care need frequent monitoring and review to ensure staff are aware of people's changing care needs. These changes need to be addressed promptly and with the appropriate support and guidance from competent clinical staff who recognised the changing needs of people.

Whilst care plans were updated monthly and were mostly person centred, we were not assured people's changing clinical needs were always met and supported in line with their individual needs and preferences.

We looked at the care records and reviewed the care for six people who had been prescribed anticipatory medicines. These medicines are prescribed by a GP when it is anticipated they may be required to ensure the comfort and dignity of people at the end of their life. They are most often used in the last few days of life. There was a lack of clarity in care records as to when staff should consider these medicines were required and how they should implement this treatment. Some care records did not identify these medicines were available or may need to be considered although staff knew they were available. It was unclear how staff should support these people in the event of an acute incident of illness such as dehydration, an infection or fall and injury. There was a risk staff would not take appropriate actions to ensure the safety and welfare of people who had been identified as end of life care.

For example, a daily hand over sheet identified one person was for, 'end of life care'. Their care plans remained unchanged and did not reflect that this person was receiving end of life care. We asked a member of staff what 'end of life care' for this person meant. They told us, "We don't move them unnecessarily, and only change their pad if necessary." They told us this person was not taking much fluid. We observed this person in their room with the door closed and asleep. Their sleeping care plan identified they preferred to have the door closed when asleep. Care records showed they had been moved in bed regularly, had taken some diet and over 1400mls of fluid in the previous day. When this person was awake we saw they were able to interact with others and identify their needs.

Care plans for this person identified they wished to be, "sent to hospital for acute issues such as infections, fractures etc." Care records showed a discussion had taken place between the person and a medical

consultant during a recent admission to hospital for an 'advanced care plan for hospitalisation'. There was no information as to what this plan was. It was unclear how this person would be supported in the event of an acute incident of illness such as dehydration, an infection or fall and injury. We were not assured care needs had been accurately identified and planned for this person in line with their personal needs and preferences. We raised this concern with a clinical lead who told us this would be addressed immediately.

For a second person an undated care needs entry in their care plan stated that the person, "was very drowsy and unable to eat at times. [Person's] doctor is aware and believes it is because [person] is end of life". Further entries in their care records identified the GP had stated, "not to go for new interventions in [their] best interests and to keep [them] comfortable".

However registered nursing staff had requested a referral to a wound care specialist nurse who had recommended treatment in the form of a high protein diet and increased fluids, which staff were complying with. It was clear this person was not at the stage where active treatment was not indicated or necessary, the end of their life was not imminent. However, a further entry in this person's care records on 1 September 2017 showed a member of staff had told an out of hour's doctor that this person was for "End of life care." This person did not have the mental capacity to make a decision about their end of life care. No best interests meeting had been held. Therefore the GP was not authorised to act in the person's best interests, nor was their assertion that the person was in receipt of end of life care correct. Staff had not challenged the GP about this when they had requested a referral to a mental health professional for this person, despite providing and following other active treatment not consistent with end of life care.

The registered provider had failed to ensure people's care and treatment was designed with a view to best achieving a person's preferences and ensuring their needs are met at the end of their life. This was a breach of Regulation 9 (1)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a protocol in place for the gradual increase in admissions to the home following previous enforcement and actions taken by CQC over the past 12 months. This protocol was being followed and the numbers of new people admitted to Harry Sotnick House had gradually been increasing.

An assessment of people's needs was completed before they came to live at the home and these assessments provided clear information to inform plans of care for the person. Records showed people were encouraged with their relatives to inform this process. People's preferences, their personal history and any specific health or care needs they may have were documented.

Information about people's life history and personal preferences, likes and dislikes was held in 'Life Books' held in people's rooms. This encouraged people to share their life experience with staff.

People had access to a very wide variety of activities in the home to provide social interaction and stimulation for people. Activities were clearly advertised in people's rooms and around the home to encourage people to participate. A large activities area in the home provided access to music, television and computer activities and this area was used regularly for group activities such as sing-along and games.

Rummage boxes, books and fashion items such as handbags and scarfs were placed around the home and in people's rooms to stimulate conversation and encourage people to interact with each other. Activities were available seven days per week and for people who remained in bed, one to one activities allowed them time to socially interact and have personalised activities to meet their needs. Areas around the home provided stimulation and activities such as a tea room and shop and pet budgerigars in the central hall of the home were very popular. On one day of our inspection a walking club took place and staff took people

out into the local community. A minibus was available to provide outings for people and was shared with another of the registered provider's homes.

The complaints policy was displayed in the entrance and around the home. People and their relatives were aware of the policy and felt confident any concerns they raised would be addressed promptly by the manager or other staff. Records of three formal complaints received in the home in the past year showed these were responded to in a timely way and in line with the registered provider's policies and procedures.

Meetings were held every month for people and their relatives. Minutes from these meetings showed they were well attended and people and their relatives were asked their views of the home and made suggestions for improvements such as new activities or ideas for meals. For example, at a meeting on 27 September 2017 the registered manager had discussed with people and their relatives their concerns about the number of new staff in the home and recognised the impact this may have on people. New activities and planned events were discussed and any other matters of concern for people.

Inadequate

Is the service well-led?

Our findings

People and their relatives were aware who the registered manager was and that they could meet with them when needed. One relative told us, "Oh I regularly speak with the manager and she is always helpful." Health and care professionals told us the registered manager was visible in the home and was always responsive during their visits. However, whilst we saw the registered manager had taken steps to improve the leadership of the home, we found a lack of clinical leadership which had not been addressed and meant people were at risk of not receiving safe and effective care in line with their needs and preferences.

At our inspection in November 2016 we found there was a lack of consistent and effective leadership in the home. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of enforcement action taken by the Commission following this inspection, a condition was placed on the registered provider's registration for this location. This required the registered provider to provide information to the commission on a fortnightly basis as to how they would attain and sustain compliance with this Regulation.

At our inspection in May 2017 we found the registered provider had taken sufficient action to be compliant with this Regulation. However, the condition remained on the registered provider's registration and they continued to send us information as required. At this inspection, in October 2017, we found the registered provider had failed to remain compliant with this Regulation.

Whilst a registered manager was in post and had a good understanding of their role, they had no clinical knowledge or expertise. They were reliant on the deputy manager, who had some previous clinical knowledge, clinical lead staff and registered nurses in the home to provide clinical oversight and leadership. Whilst there was a clear clinical team structure in place, there was a lack of cohesive working in this team. This was not effective in ensuring there was adequate clinical support in the home for people and care staff.

Health and social care professionals recognised the complex and high level of nursing needs many people who lived at the home had. One professional told us that whilst some registered nurses had a high level of clinical knowledge, "There is a lack of clinical leadership and support in the home." They told us this sometimes made it more difficult to effectively communicate in the home and ensure the safety and welfare of people. Another professional told us they found sometimes the clinical actions they had requested be completed for people to ensure their safety and welfare, such as urine or blood tests which had not been carried out.

There was a lack of effective clinical oversight in the home. This meant several serious incidents and events, including medicines errors and incorrect clinical judgements, had occurred which had the potential to have brought serious harm to people. Senior staff did not always identify their responsibilities in managing and learning from these incidents. For example, when we spoke with one senior member of staff they identified another member of staff had not done something correctly. There was no recognition that this error should have been identified by a member of staff with oversight of the clinical needs in the home.

Whilst the incidents and events which are recorded in this report had mostly been reported to CQC, there had not been sufficient action taken by the registered provider to ensure all staff had a good understanding of their roles and responsibilities in overseeing the clinical needs of people and minimising the risks associated with these.

Systems which had been put in place to regularly monitor people's health care needs were not used effectively. A daily 'Flash' meeting of registered nurses and clinical lead staff was held to review the on-going needs of people and review any clinical events which occurred in the home such as falls, illness and deteriorating health conditions. This was to ensure all registered nursing and clinical lead staff had a good overview of all care being provided in the home. Records of these meetings were kept. We were not assured this meeting was effective in sharing information and ensuring care was always responsive to people's needs.

Notes from 'Flash' meetings we reviewed did not always reflect incidents or concerns which had been raised in the home. For example, we sat in one of these meetings and saw that information which had been collected by a GP during their morning round, prior to the meeting, was not shared accurately. One person had become acutely unwell and a plan of treatment from a GP for this person was not implemented for over 18 hours due to a lack of information being shared by registered nursing staff. This person was placed at high risk of harm by the failure of staff to respond appropriately to professional guidance. This was not discussed in the meeting and there was no evidence of any learning from this incident.

A clinical risk register was completed weekly with a regional clinical lead for the registered provider. This identified the risks associated with each person's care and risk assessments which were in place. We saw this register was not an accurate reflection of the risk associated with actions staff had taken when caring for people. For example, on the first day of our inspection we noted 13 people had sensor mats or crash mats in place in their room which were not identified as being required on the clinical risk register. Risk assessments were not in place for these pieces of equipment. Information on the risks associated with people's care was not accurately recorded on this register. We were not assured the registered provider had adequate systems in place to ensure people's clinical needs were monitored and acted upon effectively and efficiently.

This lack of leadership in the home to ensure the clinical safety and welfare of people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a programme of audits to be completed at the home each month to ensure the safety and welfare of people. These had been completed by the registered manager, deputy manager or clinical lead and any actions from these audits had been added to the service improvement plan for the home. These audits included those for infection control, nutrition, medicines, health and safety and documentation. An action plan which was submitted to the Commission fortnightly was a reflection of the actions the registered provider had taken to address the concerns we identified at our inspection in November 2016. However this plan and completed audits had failed to identify and address the serious lack of clinical leadership in the home in a timely way.

The failure to accurately assess, monitor and improve the clinical safety and effectiveness of the service provision at Harry Sotnick House was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Records were legible and stored securely. An electronic system of record keeping identified the need for care plan and risk assessment reviews and this was mostly completed in a timely way.

The registered manager was visible in the home and promoted a culture of open and honest communication with people, visitors and staff. Staff said they felt supported. One member of staff said, "I think the place is well run. The manager is very approachable." A second said, "It is definitely better than it was."

People and their relatives were asked for their views of the service and the quality of the care delivered at the home. A survey of people's views was carried out between May and August 2017 2016 and showed people were generally happy with the care provided at the home. Any actions identified in this survey were discussed at the monthly meeting with people and their relatives.