Scotia Health Care Limited

Scotia Heights

Inspection report

Scotia Road
Stoke On Trent
Staffordshire
ST6 4HA

Tel: 01782829100

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03 February 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Scotia Heights provides accommodation and personal care for up to 60 people. On the day of our inspection 58 people were living in the home.

People's experience of using this service and what we found
People told us they felt safe living at the home. Although the registered manager was confident about the staffing levels provided in the home, people who used the service told us staff were not always available to support them when needed.

Medicine management needed to be reviewed to ensure everyone receives their medicines as prescribed. Staff did not have access to accurate and consistent guidance about how to restrain people safely. People did not always receive regular welfare checks to ensure their comfort and wellbeing. The provider's governance was ineffective to ensure the service was being assessed and monitored to drive necessary improvements.

Staff were aware of how to safeguard people from potential abuse and had shared concerns with the commission which, prompted this inspection. Systems were in place to promote good hygiene standards.

The provider had a registered manager in place who was aware of their responsibility to take action when things went wrong. However, the registered manager was unaware of some of the shortfalls we identified during our inspection visit.

The provider worked with other agencies and people were supported by staff to maintain links with their local community. The registered manager was aware of the duty of candour and to be open and transparent when things went wrong. We identified concerns during this inspection and the registered manager took prompt action to address them.

Rating at last inspection
The last rating for this service was 'good,' (published 11 February 2019).

Why we inspected
We received concerns in relation to insufficient staffing levels and poor hygiene standards. As a result, we undertook this focused inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Scotia Heights on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the management of medicines, safe staffing levels and the management of behaviours at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Scotia Heights

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of three inspectors.

Service and service type
Scotia Heights is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before this inspection staff had raised concerns with CQC about insufficient staffing levels to meet people's assessed needs and poor hygiene standards within the home. This inspection was prompted by these concerns.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We asked the local authority for any information they had which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality.

During the inspection
We spoke with five people who used the service about their experience of the care provided, two relatives and eight care staff which, also included agency staff. We spoke with three nurses, the clinical manager, the registered manager, the nominated individual, the regional director, head of house-keeping, Clinical Director, Head of Behavioural Support and Mental Health, Exemplar Health Care's Consultant Psychiatrist.

We reviewed a range of records. This included five people's care records including the records of medicine administration. We looked at a variety of records relating to the management of the service, including any quality monitoring checks.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
•Staff told us, and the care records we looked at, identified restraint was used for some people to assist them when they became unsettled and distressed.
• We did not find any evidence people had been harmed when restraint had been used. However, information contained in the person's care records stated four people were required when they had to use restraint. We found further information in the person's care record stating five people were required when restraint was used. Two staff members told us five staff members were used when restraint was carried out. When we spoke with the registered manager they were unaware staff had not been provided with clear and accurate information about the number of staff required to use restraint safely. This placed the person at risk of potential harm as the restraint being used may not have been safe or proportionate.
•Records were maintained to show when restraint was used, why and how many staff were involved.
•Three people on Moorcroft unit had complex healthcare needs and were unable to use the nurse call alarm to ask for assistance when needed. Staff told us hourly checks were carried out and the records we looked at confirmed this. This meant people had to wait an hour for their needs to be met. This placed people's health at risk. We shared this information with the registered manager. On the second day of our inspection the registered manager told us 15-minute welfare checks had been implemented. However, the registered manager had not recognised more frequent welfare checks were required until we raised concerns with them.

Using medicines safely
•The management of medicines was not safe.
•One person we spoke with handed us four tablets which they had stored in their bedroom. The person's medication administration record (MAR) evidenced that at times they could be non-compliant to take their medication. We identified two of the four tablets had been prescribed for the treatment of epilepsy and one for the treatment of diabetes. We were unable to identify the fourth tablet. This showed staff had not taken the time to ensure the person had taken their medicines even though they knew they did not always comply, and this placed their health at risk. We asked the registered manager to make a safeguarding referral to the local authority.

This is a breach of regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•We found medicines were stored in accordance to the pharmaceutical manufactures' instructions.
•Written protocols were in place for the safe management of 'when required' medicines. These medicines were prescribed only to be administered when needed.

Staffing and recruitment
•There were not always enough suitably trained and experienced staff on duty to meet people's needs. We received several comments from people who used the service and staff with regards to the staffing levels. One person who used the service told us, "Not having enough staff means I can't get out of bed when I want to, and my medicines are sometimes late. I feel neglected." A staff member told us, "When people need one to one support this sometimes means others do not always receive the appropriate level of support." Another staff member said, "The shortage of staff means there are sometimes delay in repositioning people." A third staff member said, "I am disappointed with my job because the staffing levels are shocking and that means you can't give the care and support people need."
•One person told us about the impact of how not having enough staff compromised their dignity because they were not always available to assist them with their personal care needs. They told us they had been incontinent and had to wait for an hour for staff support.
•A staff member told us a lot of people on Moorcroft unit have complex care needs and required a lot of support. They told us, "This is difficult when three staff are on duty with one person who requires one to one support, leaving two staff to meet the needs of eight people."
•Staff told us during the night time there were not always enough staff on duty to safely restrain people when needed. Staff also informed us that due to insufficient staffing levels, care was usually rushed.
•The registered manager told us agency staff were used to cover vacant staff posts and sick leave and this was confirmed by all the staff we spoke with. Albeit the registered manager told us they used the same agency staff, staff told us it was frustrating working with agency staff because they were unaware of people's specific needs and this added to their workload.

These issues constitute a breach of regulation 18, Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The provider recruitment process ensured staff who worked in the home were safe to do so. All the staff we spoke with confirmed safety checks were carried out before they started working in the home.

Systems and processes to safeguard people from the risk of abuse
•People were not always protected from the risk of potential abuse.
•We found staff did not have access to clear accurate information about how many staff were required when restraint was used. This placed people at the risk of potential abuse through the inappropriate use of restraint.
•We found one person had not been appropriately supported to take their prescribed medicines. This placed them at risk of becoming unwell due to not having had their prescribed medicines and could be deemed as potential abuse.
•Prior to our inspection visit staff had shared their concerns with the commission under whistleblowing about staffing levels, and the negative impact this had on people's care and treatment which, prompted this inspection. This demonstrated staff were aware of their responsibility of sharing concerns with relevant agencies to safeguard people from the risk of further harm.

Preventing and controlling infection
•Prior to this inspection we had received concerns about hygiene standards within the home. We observed the home was clean and tidy.
•Staff told us they had access to essential personal protective equipment (PPE), such as disposable gloves

and aprons and we saw these in use. The appropriate use of PPE should reduce the risk of cross infection.
•An infection, prevention and control (IPC) lead was in place. They were responsible for monitoring and promoting hygiene standards within the home.

Learning lessons when things go wrong
•The shortfalls we identified at the inspection visit were shared with the registered manager, who took prompt action to address them.

Requires Improvement

Is the service well-led?

Our findings

Our findings - Is the service well-led? = Requires Improvement

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care
•Before our inspection visit we had received a number of whistle-blowing concerns about insufficient staffing levels and the frequent use of agency staff. We had also received concerns about hygiene standards which, prompted this inspection.
•At the inspection visit a staff member told us they had worked in the home for a number of years and said, "Things are worse than ever because of the lack of communication with management, and their unawareness of people's needs."
•The provider did not have a clear oversight of how people's behaviours were managed, to ensure people were supported safely.
•Medicine monitoring and auditing systems of medicine practices, did not identify one person had not been adequately supported to take their prescribed treatment which, could compromise the person's health.
•Systems in place to monitor people's wellbeing were ineffective and compromised their health. For example, we found where people were unable to access the nurse call alarm due to their health condition, monitoring systems did not identify more frequent welfare checks were required to ensure people's specific needs were met.

This is a breach of regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•People who used the service and staff told us meetings were carried out. However, one person who used the service told us they did not feel the management always listened to them about staffing levels and the impact this had on the service. A staff member told us, "I love the residents but not the management of the service because they don't listen to us."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
There was not a positive culture in the home to ensure the service was person-centred to achieve good out

outcomes for people who used the service. For example, people shared concerns with us about the shortage of staff and the impact this had on their specific care needs not being met.
Some staff members told us they did not feel supported in their role by the management. A staff member told us, "I don't feel supported by management."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•There was a registered manager in post who was present during the inspection. The registered manager demonstrated a good understanding of people's needs. However, they were unaware of the quality of service provided to people until we shared this information with them.
•Our records showed the registered manager and provider had submitted notifications to the commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale.
•We observed the last inspection rating for the service was displayed on their website and within the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
The provider had a system in place to investigate incidents or concerns when they had been made aware of when things went wrong, action would be taken to mitigate further risks. However, the provider's governance systems were not effective in ensuring that concerns about people's care were identified and promptly acted upon. The registered manager was aware of the importance of being open and transparent when things went wrong.

Working in partnership with others
The provider worked with other agencies such healthcare professionals, social workers and people told us they were supported by staff to maintain links with their local community.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive person-centred care to ensure their specific needs were met in a timely manner. People were not always appropriately supported to take their prescribed treatment. Staff did not have access to clear and accurate information about how to safely manage people's behaviour.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's monitoring systems were not entirely effective to ensure sufficient staffing levels were provided to meet people's assessed needs in a timely manner. Monitoring systems did not identify staff had not been provided with consistent information about how to use restraint safely. Systems were ineffective to ensure a person received their treatment as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient staffing levels were not always provided to ensure people's assessed needs were met in a timely manner.