AKM Care

East Cosham House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
East Cosham House is a residential care home providing accommodation and personal care for up to 24 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 15 people using the service, although 13 of them were moved to alternative accommodation by the local authority on the day of the inspection. The remaining two people were found alternative accommodation the day following the inspection.

People's experience of using this service and what we found
The service was not safe, people had experienced avoidable harm and the provider had failed to take action to manage the risks people faced. Plans to keep people safe from the risk of falls and skin damage were inconsistent and did not give staff the information they needed to provide safe care. Some care plans had been reviewed by the provider and transferred to an electronic system, but staff did not have access to them. Staff did not demonstrate a good understanding of people's needs or the support they needed to stay safe.

The home was dirty and infection prevention and control systems placed people at increased risk of avoidable harm. Clinical waste was not securely stored. The kitchen was dirty and contained out of date and mouldy food. The temperature of the kitchen fridge was too high for the safe storage of food. A fire exit had been blocked by a vacuum cleaner and fire extinguishers had not been serviced within the correct timescale.

Medicines were not managed safely. People were not supported to take their medicines as they had been prescribed. Medicines were not securely stored in the home, with large quantities of medicines stored in a hallway.

Staff were not provided with the right training and induction to ensure they knew how to provide safe care for people.

The failings in the service placed people at increased risk of avoidable harm.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 30 September 2022). At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook this targeted inspection to check on a specific concern we had about management of risks, medicines, infection control and staffing. The overall rating for the service has not changed following this

targeted inspection and remains inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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

Enforcement
We have identified breaches in relation to safe care and treatment, staffing and good governance 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, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

East Cosham House

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 Health and Social Care Act 2008.

This was a targeted inspection to check on concerns we had about the safety and welfare of people using the service.

Inspection team
The inspection was completed by two inspectors and an assistant inspector.

Service and service type
East Cosham House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. East Cosham House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We inspected all areas of the home, the care records for three people using the service, accident records, fire safety records and medicines management records. We spoke with a director and operations manager for the provider by phone, as they were not present in the service. We spoke with three care staff, the chef, two staff from the local authority who were based at the service due to safeguarding concerns and a safeguarding specialist nurse.

Inspected but not rated

Is the service safe?

Our findings

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

At our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to follow up concerns we had about people's safety and wellbeing. We will assess the whole key question at the next comprehensive inspection of the service.

Preventing and controlling infection
At our last inspection the provider had failed to effectively assess and control the spread of infection. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● The provider had failed to ensure measures were implemented to protect people from the spread of infection. For example, the main clinical waste bin for the home was locked and staff were unable to find a key to open it. Bags of clinical waste had been left beside the bin and not securely stored in the bin, making them accessible.
● Areas of the home were dirty and required maintenance. We found three bedrooms with extensive mould growth on the windows. The ground floor shower room was mouldy.
● The kitchen was dirty and there were two packets of mouldy crumpets and out of date bread and fruit loaf. The kitchen fridge temperature was too high at 9.1 degrees Celsius and the last temperature check was on 20 November 2022. There was no evidence to show temperature checks had taken place since 20 November 2022.
● Two bedrooms on the ground floor smelt of damp. In one of the bedrooms there was a hole in plaster separating the bedroom from an adjoining toilet room.
● A downstairs toilet was soiled with faeces and had been left like this by a staff member.
● Legionella checks completed on 30 September 2022 demonstrated 18 cold taps in the service were running above the temperature of 20 degrees Celsius. Legionella bacteria ceases to be dormant above 20 degrees Celsius. There was no record of any action to reduce the risk of harm to people and no further checks had been recorded since 30 September 2022. This placed people at increased risk of avoidable harm.

Systems had not been established to effectively control the risk of infection. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection we identified systems were either not in place or robust enough to demonstrate risks were effectively managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Risks people faced were not effectively identified and action was not taken to keep people safe.
● We were informed by the local authority that a person had choked whilst eating fudge given to them by staff. Staff from the service failed to assist the person who was choking. The person had a risk management plan in place and required a soft diet and staff were unaware of their needs. A visiting health professional provided emergency treatment to the person and paramedics were called and attended. The local authority found the person an alternative care service as they were not assured the person was safe.
● During the inspection we observed the mealtime. The meal of sausage casserole was served in bowls and spoons were given. People were not given a knife and fork to cut up their food by the staff, which included sausages. This placed people at increased risk of chocking. We raised our concerns with staff who failed to provide additional cutlery. A member of the inspection team provided knives and forks for people to mitigate the risk people might choke.
● Staff failed to support and observe people during mealtimes. No staff members sat in the dining room with people throughout their meal to monitor how much they ate and drank or to monitor any potential risks. One person fell asleep into their meal.
● One person's daily care notes recorded they had oedematous legs with small visible open wounds on them. There was no reference to this in their skin integrity care plan so staff did not have information on how to care for them. There were no risk mitigation plans in place for the risk of skin damage during moving and handing.
● People were at increased risk of falls. For example, one person's daily notes recorded they had falls and were injured in October and November 2022. Their moving and handling assessments and risk management plan stated they had no history of falls. Another person had a history of falls recorded in their records. Their moving and handling assessment stated they had no history of falls. This meant there was no guidance for staff about how to mitigate their falls risk to help prevent a recurrence.
● For one person there was inconsistent and conflicting information to mitigate their risk of falls. The risk assessment stated they needed staff support and a walking frame. However, their moving and handling assessment stated they walked independently with a walking frame.
● A staff member we spoke with was not aware of the system for recording accidents and incidents. Accident records were found in several parts of the home. For example, in piles in the kitchen and an office. The accident records were not stored securely. There was no record of any management actions in response to the accidents to review whether plans to mitigate identified risks were effective.
● Staff lacked knowledge of people's needs. Some paper care plans were available. However, other care plans were held on an electronic system and staff working did not have access to this information. The shortfalls in the accurate and accessible information for staff to be able to provide safe care placed people at risk of harm.
● The provider had failed to ensure fire safety systems were implemented effectively. A fire exit was blocked with a vacuum cleaner and staff told us it was difficult to open. Fire extinguishers had not been serviced, fire alarm tests were not always completed weekly and checks of fire safety equipment were not completed consistently.

Systems had not been established to effectively identify and manage risks to people. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely. The provider could not be assured people were supported to take their medicines as prescribed.
● There were omissions in the medicine administration records for all of the nine people whose records we inspected. This included multiple gaps in the signing of administration. There were no records of medicines being checked in to the service to be able to establish whether medicines had been administered.
● The provider had failed to ensure medicines were stored safely. There were large boxes of medication to return to the pharmacy and new medicines unsecured on the stairwell leading to the office.
● One person was at increased and avoidable risk of a medicines overdose. Instructions required the person was weighed in order to follow the prescriber's instructions and to reduce the dose of their medication if their weight dropped below a certain point. There were no records of their weight.
● There was no photograph of one person to enable staff to identify them to ensure they had their prescribed medicines. This was particularly important due to a high number of temporary staff working at the service.
● There was a prescribed medicated cream left on the kitchen work surface. The kitchen was not consistently locked and the medicine was therefore accessible.
● We found a loose tablet on the lounge floor. There was a risk that another person could take this and be harmed. This also meant another person had not been supported to take their medicine safely.

Systems had not been established to ensure safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection we identified the provider had failed to have a systematic approach to determine the number of staff required and to effectively meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 20014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The provider had failed to ensure there were sufficient competent and skilled staff able to support people's wellbeing and safety.
● Staff on duty on 24 November 2022 had not received sufficient training at induction to ensure people were cared for in a safe way. One staff member confirmed they had been in post for one month and had not received any first aid training.
● A staff member was not able to demonstrate a good understanding of people's needs. They said they had read people's care plans on the day they had started but not since.
● Another staff member told us they had not received any moving and handling training to safely move people. Two people living at the service were using wheelchairs and two people were using walking frames. This placed people at risk of harm from unsafe moving and handling.
● The chef told a member of the inspection team they were not aware of any allergies and did not know who to ask if people had any. Medicine administration records were not fully completed so staff did not know what allergies people had. This placed people at risk of harm.

The lack of competent and skilled staff places service users at risk of harm. This was a continued breach of

regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

Is the service well-led?

Our findings

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

At our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to follow up concerns we had about people's safety and wellbeing. We will assess the whole key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection we identified the provider had failed to have effective systems to assess, monitor and ensure the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 20014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider failed to establish systems to assess, monitor and improve the quality of the service provided at East Cosham House, or mitigate the risks relating to health, safety and welfare of people.
- Following the last inspection in August 2022, we served warning notices on the provider in respect of safe care and treatment and good governance. At this inspection we found the provider had failed to take action to meet the requirements of the regulations.
- The local authority safeguarding staff reported that neither the provider nor their representative, had been present at the service since the local authority had placed a management team in the service. The provider, or their representative, did not have effective oversight of the care provided to people.
- We tried to contact the provider by telephone and email on 21 November 2022. We requested urgent contact regarding the safeguarding concerns at the service. The provider did not contact us.
- Following this inspection, we wrote to the provider to seek assurance about the actions they would take to keep people safe. The response from the provider did not address the breaches of regulation we have identified at the service or demonstrate how they could provide a safe service to people.

Systems had not been established to effectively assess, monitor and improve the quality of the service. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to effectively control the risk of infection, identify and manage risks to people or ensure the safe management of medicines. This placed people at risk of harm. Regulation 12 (1) (2) (a) (b) (g) and (h).

The enforcement action we took:

We imposed a condition to restrict the provider admitting new people to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to effectively assess, monitor and improve the quality of the service. This placed people at risk of harm. Regulation 17 (1) (2).

The enforcement action we took:

We imposed a condition to restrict the provider admitting new people to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient competent and skilled staff. This placed people at risk of harm. Regulation 18 (1) (2).

The enforcement action we took:

We imposed a condition to restrict the provider admitting new people to the service.