Clearwater Care (Hackney) Limited

Searsons Way

Inspection report

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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
Searsons Way is a residential care home providing personal care to people with learning disabilities and/or autism.

The home is an adapted two floor building with facilities, including en-suite bathrooms. The home's building design fitted into the residential area and other large domestic homes of a similar size. There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home.

The service was registered to provide support to up to four people and there were four people using the service at the time of our inspection.

People's experience of using this service and what we found:
The service was not always safe. Medicines were not managed safely because robust procedures were not in place to ensure staff administered medicines in a safe way. Protocols for staff were not in place for medicines that were given to people when needed.

People were not always protected from abuse because there were some serious incidents that occurred prior to our inspection, which put people at risk of harm. We have made a recommendation in this area.

We were not assured with the way staff were deployed in the home because some people required additional support, particularly when they went out. This could lead to shortages of staff and we have made a recommendation about this.

People's care plans and risk assessments were not always up to date or reviewed when needed.

The provider had implemented a service improvement plan. However internal audits had not identified the concerns we found with medicine management.

The provider had failed to notify us within a suitable timeframe of when it had received authorisation to deprive people of their liberty.

Accidents and incidents that had taken place in the home were not always reviewed to learn lessons to prevent them re-occurring. The provider had a plan in place to improve this.

The service didn't always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. However, the was situated next door to another home managed by the same provider. People were supported by staff who

sometimes worked in the other home. Staff from the other home could easily access Searsons Way via the front door or garden. Both services operated as one larger service, for example by having a shared staff rota and food menu. This meant the provider had not mitigated against environmental factors which could make the environment feel institutional and had not ensured they could provide truly person-centred care.

We have made a recommendation about seeking advice and guidance about Registering the Right Support.

Premises and equipment safety was maintained to ensure the home environment was safe.

Staff had knowledge of people's needs, wishes and routines. They received training and support. The provider sought feedback from people to help make improvements to the service.

People and relatives told us staff were kind and caring but felt there could be better communication from the service. Staff had opportunities to discuss important topics and go through concerns they had with the management team.

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 good (published 20 February 2018).

Why we inspected
We received concerns in relation to people not being protected from the risk of abuse and the management of the service. As a result, we undertook a 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 improvements. Please see the safe and well-led sections of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines management, good governance of the service and registration regulations at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection 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.

Searsons Way

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 was carried out by one inspector.

Service and service type
This service is a care home. People in care homes receive accommodation and nursing or personal care as a 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 did not have a manager registered with the Care Quality Commission. A registered manager 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 took place on 1 September 2020. We announced our inspection one hour before our arrival to enable us to check if there were any Covid-19 related matters we needed to take into account before our site visit.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with

three members of staff including senior care workers. We also spoke with the regional director.

We reviewed a range of records. This included two people's care records and medication records. We looked at three staff recruitment files. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with two relatives by telephone for their feedback about the home. We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records.

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 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.

Using medicines safely

- Medicines were not being managed safely as there were not robust procedures in place for the administration of some medicines.
- Each person had a medicines folder detailing the medicines they were prescribed, the dosage, what they were for and any side effects. However, there was a lack of information about some people's prescribed medicines and how they were to be administered.
- One person, used a PEG tube (Percutaneous endoscopic gastrostomy) which is inserted into their stomach to help them consume food and drink. They were prescribed a medicine to treat a health condition and were required to take one dose a day. Records showed the person received this medicine daily. However, in the person's medicine file, the reason they were taking this medicine was not included, although for other medicines they took, the reason was included.
- The prescribing instructions indicated the tablet is to be placed on their tongue. A senior staff member told us as the person had a PEG tube and could not take it that way, the tablet was dissolved in water instead. There was no guidance about this alternative method of administering this medicine in the person's medicine file to confirm it was safe.
- The senior staff member said they were not sure where the decision to dissolve the medicine in water came from or who advised it. We did not see notes from the GP or pharmacy about how best to administer the medicine to this person and to confirm the alternative method was safe. There was no risk assessment with clear guidance as to why the prescribing information could be overridden for people who could not swallow. This meant there was a risk the medicine could lose its effectiveness if staff did not follow the correct guidance.
- The same person had PRN medicines prescribed for two laxative medicines that were used to treat constipation. These are medicines that are taken 'as and when required'. However, there was no PRN protocol in place for when to administer these medicines, what they were for and what the risks were. This could put the person at risk of harm, as laxative medicines can have a serious impact on people's health if they are not used appropriately.
- Following our inspection, the provider sent us PRN protocols as part of our factual accuracy process. However, these were not evident at inspection and these issues were raised at feedback. We believe if we struggled to find this information at inspection, a staff member could also find it difficult which could lead to errors.
- We saw PRN protocols for other people and other medicines. This meant there was not a consistent approach towards medicines management.
- People's medicines were stored in a lockable medication cabinet in an office. Boxed medicines were labelled with the date they were opened. We saw that one packet had not been dated, which would make

auditing medicines more difficult to ensure they were still safe to use.
● The temperature of the medicines cupboard and room was taken daily to check that it did not exceed the recommended temperature. We saw the recorded temperatures were within the recommended range but some weekly entries were left undated. This meant it was unclear what date or week they referred to. These issues showed there was a lack of robust medicines procedures.

We did not find evidence of people being harmed in relation to medicines but medicine processes were not robust enough to demonstrate they were safely managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● People told us they received their medicines on time. Medicines administration records (MAR) were completed to record when medicines were given. We looked at MAR charts and found these were up to date, had been completed correctly and were signed for. Stock checks took place and staff counted medicines to ensure the correct number of medicines remained in their packaging after they had been administered. Records we viewed showed these were accurate.

Staffing and recruitment
● Staff arrangements were not always effective to ensure people were safe at all times. People told us there were enough staff and one person said, "Yes the staff are always here. Enough staff, yes." However, a relative said, "I am a bit concerned about the service when they only have one staff around. If [family member] needs help, who is going to look after everyone else?"
● Three staff were required during the day with support from the deputy manager and one staff at night. One person in the home required two members of staff to accompany them when they went outside. The home (number 40 Fairkytes Avenue) was situated next door to the provider's other home (number 42) on the same street. If the home required some staff cover, the management team would bring a staff member in from the home next door. The deputy manager worked across both services but they were on leave on the day of our inspection. When we arrived, there was no manager available on site but a senior support worker was on duty to supervise staff.
● We were concerned this could put pressure on staffing levels if the person needing two staff went out. This could put people at risk of harm as there would not always be enough staff to support people at particular times.
● Staff had mixed views about staffing levels in the home and were not fully confident they had the necessary support. One staff member said, "There are not enough staff, they could do with extra staff. I get taken away sometimes to cover the other house and that leaves them short." Another staff member told us, "We have had a lot of staff changes and a few issues but we manage." Another comment from a staff member was about changes to the rota not being communicated to them, which could cause confusion about when they were expected on shift.
● We looked at weekly staff rotas and saw how they were devised. They were colour coded to show which home staff would be working in (either number 40 or number 42). This showed how both homes worked together as one service.
● A staff member told us they were not required to sign in when they arrived for their shift. We discussed this with the regional director as we were concerned it was not clear what systems were in place to confirm staff had arrived for their shift, such as a staff register. The regional director said staff were only required to fill in their own organisational weekly timesheets to confirm they had attended their shift as well as in daily shift handover sheets. After our inspection we were sent copies of timesheets and handover records. The regional director told us they would also implement another measure other than the staff rota to confirm staff were on shift, should there be an emergency such as a fire. After the inspection they showed us a new daily fire register record for staff to enter their names and times on and off shift. This helped to assure us more

adequate systems would be in place to confirm staff attendance.

We recommend the provider follows best practice guidance on maintaining safe and suitable staffing levels and staff deployment at all times.

● There were safe recruitment procedures in place. Records showed criminal record checks via the Disclosure and Barring Service (DBS) were carried out for new staff. Applicants completed application forms and provided two references and proof of their identity. This ensured the provider could determine if staff were suitable to provide care and support to people. We found it difficult to find references for staff due to the ongoing reorganisation of the service. After the inspection, the regional director confirmed references had been sought and received. They provided us with evidence of this.

Systems and processes to safeguard people from the risk of abuse
● People were not always safe from the risk of abuse. Prior to our inspection, we were notified by the provider about serious incidents where a person was at risk of physical abuse.
● The incidents were being investigated and the provider took appropriate disciplinary action. They complied with requests for information made by the police and local authority. Staff had taken appropriate action by raising concerns with the management team after witnessing possible abuse by another staff member.
● Staff told us they understood their responsibilities to keep people safe. They could identify different types of abuse and who they should report it to. One member of staff said, "I have received safeguarding training and I would report it to my manager, if I saw someone being abused." Meeting minutes we viewed showed that safeguarding and whistleblowing procedures were discussed with staff to encourage them to raise concerns.
● People and relatives told us the home was safe. One person said, "Yes, I feel safe. Staff are good. Staff help me." A relative told us, "The home is generally safe but I think they could organise rooms better."

We recommend the provider follows best practice guidance on developing a culture of keeping people safe from exploitation and abuse.

Assessing risk, safety monitoring and management
● There were systems in place to minimise risks to people. Assessments of risks were carried out and these included risks around behaviours, health conditions and mobility. For example, there was guidance for staff should people experience epileptic seizures.
● From records we looked at, it was not always clear how often risks were being reviewed. We found some people's records show the planned date for review but there was no evidence to show the review had been completed. However, the regional director told us work was in progress to ensure all care plans and risk assessments were up to date.
● Checks on systems such as fire extinguishers, water, gas and equipment used to assist people were carried out. People had personal evacuation plans in the event of a fire or other emergency.

Learning lessons when things go wrong
● There was a procedure for reporting any accidents or incidents that took place.
● Incidents, including safeguarding concerns, were reviewed and action was taken to ensure people remained safe. For example, if there were incidents between people, staff recorded the action they took to de-escalate situations. The provider worked with the Positive Behaviour Support team to support some people and reviewed incidents relating to their behaviour. However, it was not clear if incidents were being reviewed to identify what lessons were being learned to prevent them reoccurring. The regional director told

us the provider was implementing a new system of capturing this information and told us this was a work in progress.

Preventing and controlling infection

● The home had procedures to prevent and control infections, including Covid-19. There were hand washing facilities available throughout the home. There was a daily schedule for the home to be cleaned and disinfected every three hours, which maintained the home's cleanliness and hygiene.

● Staff used personal protective equipment such as disposable gloves, aprons and anti-bacterial hand gels when providing personal care to people. Staff told us they washed their hands thoroughly before and after providing personal care to help contain the spread of infection.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection, this key question has 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 was failing to follow regulatory requirements, such as submitting notifications. The provider was aware that it was their legal responsibility to notify CQC of any allegations of abuse, serious injuries or any serious events that may stop the running of the service and be open and transparent to people should something go wrong.
- The provider is also required to notify the CQC of approvals to deprive a person of the liberty following Deprivation of Liberty Safeguard (DoLS) applications made to the local authority. Approvals from the local authority were granted earlier in the year but the provider did not inform us of these. We discussed this with the regional director, who told us these would be submitted as soon as possible. After the inspection, the notifications were received.

Failure to notify the CQC of approvals made by a court in relation to depriving a person of their liberty is a breach of Regulation 18 (Registration Regulations 2009).

- Quality assurance audits did not identify some of the shortfalls we found. The provider had implemented a service improvement plan that was reviewed and updated monthly but there were further concerns found at the inspection, particularly with the management of medicines and ensuring robust procedures were in place.
- Protocols for some 'as required' medicines were not available and there was little information about why some medicines were not administered according to prescribing instructions. This could put people at risk of harm.
- During the inspection, paper copies of references for staff were unable to be located in their files. Due to IT issues, the electronic versions were also unavailable and they were sent to us following our visit. The provider's service improvement plan set a timescale of 24 August 2020 for staff files to be reviewed both for hard and electronic copies but this had yet to be completed.
- There was not a registered manager in place at the time of our inspection. The previous manager had left their post seven weeks before our inspection and the service was being managed by the deputy manager with support from the regional director and an operations support manager. The regional director came to meet us later in the day. They provided assurance they intended to make improvements to the service and was in the process of reviewing systems. They told us a lot of work to improve current systems, was still in

progress and confirmed a new registered manager would be recruited.
● People and relatives were positive about the regional director. A relative said, "I have been impressed with [regional director]. They seem very receptive and have really improved things since the manager left. The staff work really hard and are very nice. The problem I find is communication between some of the senior staff. They don't call us or share information that we request. They don't use the resources we send them to help [family member] such as the communication board." Another relative said, "They don't have a manager and I find that a problem. The last manager was only here for a short time but they were amazing and really understood my [family member]. I was shocked when they left as it has not been the same since then."

Due to the concerns found, there was a lack of overall good governance in the service and medicines were not being managed safely. This meant the provider was not suitably assessing and monitoring the risks to the health and safety of people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● Staff understood their responsibilities but had mixed views about how the service was managed. A staff member said, "[Regional director] and [deputy manager] are ok." Another staff member said, "There have been a lot of changes of manager which has not been great but [regional director] is nice and supportive."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We were concerned that the service worked alongside the sister service next door, in a way that implied both were part of one service. The provider registered them with us as two separate services. This arrangement did not meet the requirements of registering the right support for people because there was joint working between the services. For example, we found that both services shared the same food menu and staff rota. There was a lack of clarity about where staff worked. This could have an impact on people's right to privacy as staff from the other service could sometimes come and go. This meant the provider was not mitigating the risk of making the environment feel like a large institution.
● Meetings with people to discuss their thoughts about the home had not been carried out and scheduled for this year. These issues meant people did not always receive a consistent good quality service. The regional director and records confirmed there was a plan to register both locations as one.

We recommend the provider seeks advice and guidance about Registering the Right Support from the CQC registrations department before re-registering the service.

● Staff attended meetings with the management team to go through any issues and get to know the regional director and their plans for the service. Staff were reminded of what was expected of them, such as maintaining high standards of care and remaining professional in their approach.
● The management team also obtained feedback from people and relatives about the service and staff. We saw that feedback was mostly positive. Surveys and questionnaires were to be analysed as part of the home's action plan to help further improve the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was not always a positive culture in the home. Feedback from staff and managers indicated some staff were resistant to changes made by members of the management team. Minutes from team meetings showed that some staff felt demotivated and there was a culture of gossip.
● We discussed this with the regional director who acknowledged they had faced challenges and improvements were needed, so that staff would feel more valued and motivated. This would help make the

home more inclusive, open and empowering for people.

Continuous learning and improving care

● Systems were in place to obtain feedback for continuous learning and improving care. Following the serious incidents that occurred the regional manager and other members of the management worked together with staff to review these incidents. They acknowledged the mistakes made and were working to ensure there was a safe working environment for all staff and people in the service. There was a plan for feedback from people, professionals and relatives to be analysed.

● The provider's quality improvement plan for the home was monitored by the regional director and other senior managers to create a cycle of continuous improvement. The regional director told us they wanted a set target of the next three months for improvements to take effect.

Working in partnership with others

● The home worked with other agencies such as health professionals and local authorities if people were not well, to ensure people were in the best possible health.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the CQC of approvals made by a court in relation to depriving a person of their liberty. Regulation 18 (4A)b

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users. Medicines were not being managed in a proper and safe way. There was a lack of policies and procedures for the safe management of prescribed medicines and as required medicines. Regulation 12(2)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was failing to assess and monitor risks to people. Quality assurance audits had not identified concerns with how controlled drugs were managed. Notifications to the CQC, including notifications

of DoLS approvals were not sent in a timely manner. The service was not meeting the requirements of registering the right support. Regulation 17(1)(2)(b)