Parkcare Homes (No.2) Limited

Melling Acres

Inspection report

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19 September 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 & 15 July and 1 August 2016. After that inspection we received concerns in relation to the management of risk, the administration of medicines and the response of managers when issues had been raised. As a result we undertook a focused inspection on the 15, 16 and 19 September 2016 to look into those concerns and the progress of the provider's action plan. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Melling Acres on our website at www.cqc.org.uk.

Melling Acres is a residential service that provides specialist intensive support and rehabilitation facilities for up to 16 people with a learning disability and autistic spectrum conditions. The accommodation is provided in several properties on one site, which is located in a rural location of Melling. It is set in three acres of private gardens and woodlands.

A registered manager was not in post. The home was being managed by in interim manager with support from a regional manager.

Prior to the inspection we received information indicating that risk was not being safely managed. In particular, we were concerned that risk assessments were not being followed or appropriately reviewed following incidents.

We found multiple examples of risk assessments that had not been reviewed following incidents. In one case we saw that a person had been involved in numerous incidents which followed a similar pattern. The person's risk assessment clearly indicated this risk and provided basic strategies for diffusing situations. The incident forms demonstrated that staff had deployed these strategies with varying degrees of success. It was clear that the behaviours were more likely to occur with younger female staff. However, the risk assessment had not been reviewed following these incidents and the person continued to be supported by young females on a regular basis.

At the previous inspection we identified that specific unsafe behaviours (putting liquids in eyes & cutting wrists) a person presented with were not being managed effectively, which meant the person's health and wellbeing was at risk. Since the previous inspection, we identified that there had been a further eight occasions whereby incidents had occurred involving these unsafe behaviours. The incidents had happened even though the person had continuous staff support.

We saw that the care records for a person with epilepsy were incomplete. We were unable to locate a risk assessment or management plan and staff equally could not find these documents.

Staff had not always followed people's care plans. Failures to follow care plans had exposed people living at the home, staff and members of the public to risk of harm.

People were exposed to risk of harm because the safety of the physical environment was not adequately managed. We saw that fire doors were wedged open or not fully operational. We also saw that access to dangerous chemicals and materials was not adequately restricted.

At the previous inspection we identified a breach of regulation in relation to the safe management of medicines. The errors were in relation to stock control, missed doses and recording. However, additional staff had received training from an external pharmacy and the overall level of medicine's errors had reduced since the last inspection.

At the previous inspection we saw evidence that restraint was being used inappropriately by staff who were not trained in the relevant techniques. At this inspection we saw evidence that additional staff had been trained and that other training had been arranged. None of the records that we saw indicated that restraint had been used unsafely or inappropriately since the last inspection.

Following our inspection on 12 and 15 July and 1 August the provider produced an action plan which detailed actions would be undertaken to improve safety and quality at the home. We used this as a point of reference in discussions with the interim manager and regional manager and looked at other sources of evidence to see what progress had been made towards the objectives.

We saw that a number of important elements of the action plan had not been completed as planned. These included; daily checks at the home, the recruitment of nurses to cover all scheduled administration of medicines, the provision of personal alarms to staff and an urgent review of health and safety. The failure to complete the action plan compromised the safety of people living at the home and staff.

Prior to the inspection we received information of concern relating to the quality and effectiveness of management responses when issues were raised by staff. We saw evidence that records and care practice had not been reviewed and updated as required when staff reported concerns.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Risk was not being managed safely in accordance with people's risk assessments. Risk was not always reviewed following incidents.

Health and safety at the home had not been reviewed by an external specialist as planned. Internal checks had failed to identify fire doors that were wedged-open or did not function safely. Access to harmful chemicals and other materials was not adequately controlled.

Staff had not always followed care plans resulting in incidents were harm was caused to people living at the home and a member of the public.

Medicines were not always managed safely.

Is the service well-led?

Inadequate

The service was not well-led

The action plan that was produced following the previous inspection had not been completed.

Essential checks on quality and safety had not been completed consistently meaning that opportunities for improvement were missed.

Managers did not always respond in an appropriate and timely manner when concerns were reported by staff.

Melling Acres

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 is 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.

This focused inspection took place on 15, 16 and 19 September 2016 and was unannounced. The inspection was completed in response to the receipt of information of concern and to check that improvements to meet legal requirements identified at the comprehensive inspection on 12 and 15 July and 1 August 2016 had been met. The inspection was undertaken by two adult social care inspectors.

We inspected the service against two of the five questions we ask about the service; Is the service safe and is the service well-led? This was because the information of concern and notifications submitted by the provider indicated that the service was not meeting legal requirements in relation to these questions.

Before our inspection we reviewed the information we held about the service. At the visit we spoke with one person living at the home, the interim manager, the regional manager and three other staff members. We looked at four care records and other records relating to the management of the home. On each of the three days we walked around the home and completed observations.

Inadequate

Is the service safe?

Our findings

Prior to the inspection we received information of concern including; the management of risk, adherence to care plans, the safety of the physical environment and the administration of medicines. At our comprehensive inspection of this service on 12 and 15 July and 1 August 2016 we found multiple breaches of regulation relating to safety. These breaches related to; the unsafe use of restraint, administration of medicines and maintenance of a safe environment. Following the comprehensive inspection the provider sent us an action plan which indicated what steps had been taken to address these breaches. They included; an audit of staff skills and competencies, the retraining of staff in appropriate restraint techniques, the appointment of a nurse to oversee all scheduled administration of medicines, the reinstatement of a personal alarm system for staff, an urgent review of health and safety at the home, a weekly audit of incidents and a 'daily walk-around' to monitor the safety of the physical environment. At this inspection we spoke with people and checked records to make sure that the actions had been completed as planned. We also looked at evidence relating to the information of concern.

Prior to the inspection we received information indicating that risk was not being safely managed. In particular, we were concerned that risk assessments were not being followed or appropriately reviewed following incidents. During the inspection we looked at four care records, incident forms and the provider's electronic database of incidents.

We found multiple examples of risk assessments that had not been reviewed following incidents. In one case we saw that a person had been involved in numerous incidents which followed a similar pattern. The person's risk assessment clearly indicated this risk and provided basic strategies for diffusing situations. The incident forms demonstrated that staff had deployed these strategies with varying degrees of success. It was clear that the behaviours were more likely to occur with younger female staff. However, the risk assessment had not been reviewed following these incidents and the person continued to be supported by young females on a regular basis. On 24 August the person was alleged to have perpetrated a serious assault on a young female staff member. The incident report described this as 'a new behaviour'. By failing to effectively analyse recent incidents, the provider exposed staff to a heightened risk of assault and missed an opportunity to safely manage the risk.

At the previous inspection we identified that specific unsafe behaviours (putting liquids in eyes & cutting wrists) a person presented with were not being managed effectively, which meant the person's health and wellbeing was at risk. Prior to this inspection we had been alerted to a number of incidents related to these unsafe behaviours. We looked in detail at the person's care records and related incident reports. Since the previous inspection, we identified that there had been a further eight occasions whereby incidents had occurred involving these unsafe behaviours. The incidents had happened even though the person had continuous staff support. By not putting adequate safety measures in place to prevent the incidents occurring in the first place meant staff had not learnt lessons from the previous inspection and the person's health and wellbeing continued to be at risk.

Whilst looking at the person's care records we noted that they had a history of epilepsy. We were unable to

locate a risk assessment or management plan and staff equally could not find these documents. The staff that we spoke with were unsure how to manage the risks associated with this person's epilepsy. One member of staff said, "I've not seen a care plan about this for a while." Not having a management plan in place meant that staff, particularly new or agency staff, did not have access to information to provide them with an understanding of how the person's epilepsy presented and how associated seizures should be managed. This therefore meant that the person was at risk of harm should they have a seizure that was not effectively managed.

Prior to the inspection we received information of concern alleging that staff were not always following care plans. It was further alleged that this had increased the risk of harm for the people, staff and members of the public. We looked at the care records for four people and reviewed care plans and incident forms.

In one example records showed an incident had occurred in the community involving a member of the public. The potential for this to happen was clearly identified in the person's care records. We spoke with staff who provided detailed information about how these type of incidents could be prevented from occurring. We noted the approach described was outlined in the person's behavioural support (PBS) plan. However, the information recorded on the incident form indicated the PBS plan had not been followed by staff. By not doing so it meant the situation had not been effectively managed by staff and had resulted in a member of the public being assaulted by the person.

Prior to this inspection we had received information to suggest there were safety concerns in relation to a person using tools and equipment. We had been assured by the manager on 31 August 2016 that a risk assessment and system was in in place to minimise this risk. This involved a daily count of tools taken and returned. However, we could not locate a risk assessment in the care records and, despite management and staff checking, we were not provided with evidence to illustrate the system in place to minimise this risk. We saw two incidents were tools had been found on the person when they should have been returned to storage. We asked the interim manager and regional manager about this and were told that records indicated that the counting of tools had not been completed by staff for a prolonged period.

This is a breach of Regulation 12 (2) (a) & (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the previous inspection we found a breach of regulation in relation to the safety of the physical environment. In particular we found that fire doors were missing or not fully functional. Prior to this inspection we received information of concern alleging that access to potentially harmful chemicals was not being safely managed. On each of the three days we walked around the home and checked the safety of fire doors and access to harmful chemicals/materials. On the 15 September 2016 we found fire doors wedged open or not fully operational in each of the three main buildings. We reported these concerns immediately to staff and managers. The wedges were removed and a contractor instructed to repair the damaged doors. We were told that staff had been reminded of the importance of not wedging fire doors open. On 16 September we saw that one of the fire doors previously wedged open was propped open by a dining chair. The door in question led directly to a kitchen and would be considered a high-risk area. Staff removed the chair as the inspector approached. The matter was discussed with the staff in the home and the interim and regional managers. They confirmed that staff had been instructed about the risk as soon as possible after the previous finding. The contractor repaired the damaged/ill-fitting fire doors before the end of the inspection.

On 16 September we saw that a protective fence around a building skip had been removed. This gave easy access to building materials including potentially harmful chemicals. The skip was directly opposite the

home of a person who presented a high risk of self-harm when accessing chemicals. We notified the interim and regional managers of the risk and the fence was reinstated. On the 19 August we saw that the fence had been removed again. We asked why this had happened and were told that it was needed to protect a newly identified area of risk in the garden. The interim manager and regional manager agreed to ensure that the building skip was adequately fenced-off as a priority.

This is a breach of Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the previous inspection we identified a breach of regulation in relation to the safe management of medicines. Prior to this inspection we received information of concern alleging unsafe practice in respect of a rescue medicine. A rescue medicine is used when a health condition reaches a stage where it becomes life-threatening. For example, during a prolonged seizure. We looked at a sample of medicines and Medicine Administration Records (MAR) sheets. We identified errors in relation to stock control, missed doses and recording. Each of these errors had occurred when the agency nurse/practitioner was not on-site. The provider's action plan from the previous inspection stated that nursing cover would be provided for all scheduled administration of medicines. We were told that the home had experienced difficulty in securing suitable trained staff and had been unable to complete this action. However, additional staff had received training from an external pharmacy and the overall level of medicine's errors had reduced.

We looked at arrangements for one person who had severe epilepsy and required access to a rescue medicine when seizures were prolonged. This medicine can only be administered by members of staff who have completed a specific programme of learning. If the rescue medicine is not administered correctly in a timely manner the person is placed at risk of serious harm. We checked the staff rotas and saw that on two occasions the person had left the home accompanied by staff who did not have the required training. We asked the interim manager about this and compared the rotas to the daily notes to establish if the person was engaged in activity away from the home. We found that the initials on the daily notes were not those of the staff originally allocated on the rota. This meant that the provider could not be certain if appropriately trained staff had been allocated to provide care and support when the person left the home.

This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the previous inspection we saw evidence that restraint was being used inappropriately by staff who were not trained in the relevant techniques. At this inspection we saw evidence that additional staff had been trained and that other training had been arranged. None of the records that we saw indicated that restraint had been used unsafely or inappropriately since the last inspection.

Inadequate

Is the service well-led?

Our findings

Following our inspection on 12 and 15 July and 1 August 2016, the provider produced an action plan which detailed actions that would be undertaken to improve safety and quality at the home. We used this as a point of reference in discussions with the interim manager and regional manager and looked at other sources of evidence to see what progress had been made towards the objectives.

The audit of staff skills and competencies was due to be completed by 31 August 2016. We were told by the interim manager and regional manager that they did not believe that the process had been started. No evidence of the completion of this action was provided during the inspection. This meant that the provider could not be certain that staff had the right skills and competencies to provide safe, effective support to people living at the home.

Staff training had been undertaken to improve the safety of physical interventions and the use of restraint. However, at the time of this inspection 17 staff still required the training. The specific training in use at the home requires physical restraint to be undertaken by two staff who are trained in the appropriate techniques. This meant that the home would have difficulty ensuring that sufficient, appropriately trained staff were available to cover each shift.

An experienced practitioner had been recruited from an external agency to oversee the safe administration of medicines. This person told us that they were not present in their capacity as a nurse. However, the home had not commissioned sufficient hours to cover the scheduled administration of all medicines. We were told that the practitioner regularly worked in excess of 60 hours per week and on at least one occasion had worked 84 hours. The interim manager and regional manager told us that they had experienced difficulty in recruiting an additional nurse/practitioner, but had now approached additional agencies.

The reinstatement of the personal alarm for staff use had not happened. We spoke with the interim manager and regional manager about this and were told that alternatives to the previous hardware were being evaluated. Neither person was able to explain why this action had not been completed. This meant that staff and people living at the home were unnecessarily vulnerable when incidents occurred. The provider subsequently agreed to complete this action by 23 September 2016.

The urgent external review of health and safety with specific reference to the control of hazardous substances had not been completed as planned. The interim manager told us that a previous inspection from May 2016 was being used. The document identified 18 'unmet major actions' relating to; documentation, risk assessment, training, environment and food safety. It was clear from other records that some of these actions had not been completed. For example, the report states, 'MVA (restraint) training to be brought up to date urgently'. We saw that this had not been completed for 17 staff by 1 August.

The weekly analysis of incidents had not been started. We spoke with the interim manager and regional manager about this. They offered reassurance that the processes would be completed as planned with effect from 23 September 2016.

The daily walk-around to monitor the safety of the environment had not been completed as planned. We saw records relating to the activity which clearly indicated that the process had not been completed between 22 August and 8 September 2016. This meant that the provider could not be certain that the physical environment was free from hazards which could cause harm to people living at the home and staff.

This is a breach of Regulation 17 (2) (a) & (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Prior to the inspection we received information of concern relating to the quality and effectiveness of management responses when issues were raised by staff. We were told that concerns had been raised relating to; the management of risk, failure to follow care plans and people's healthcare needs. We were told that in each case, the management response did not reflect the importance of the concern raised and did not result in timely and effective action. We looked at care records, incident forms and other records relating to individuals and discussed specific concerns with the interim manager and regional manager. They told us that they had not been made aware of all of the individual concerns, but acknowledged that records and care practice had not been reviewed and updated as required.

People living at the home and staff told us that they had noticed improvement following the last inspection. With reference to The Lodge (one of the main accommodation buildings) one person living at the home said, "It was three people, but one has gone. It's much quieter and we don't have as many staff in The Lodge." A member of staff said, "We've changed our regional manager. [Name] is a lot more hands-on."

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 Risk was not being effectively managed because risk assessments were not updated following some incidents and staff were not following people's care plans. Staff without the necessary training had been allocated to support a person with specific healthcare needs around their medication. The physical environment was not safely managed or effectively monitored which caused harm to people living at the location.

The enforcement action we took:

Urgent imposition of conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The action plan provided following the previous inspection had not been adhered to. Audit procedures had failed to identify significant risks associated with the physical environment.

The enforcement action we took:

Urgent imposition of conditions.