142 Petts Hill Care Home

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Inspection report

142 Petts Hill
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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
142 Petts Hill Care Home is a care home without nursing that provides accommodation, support and care for up to three people with mental health needs. At the time of our inspection, three people were living in the home.

People's experience of using this service and what we found
Staff did not always follow the provider's procedure for recording and administration of medicines and we could not be assured people received their medicines safely and as prescribed. Similar issues were found at the last inspection.

Risks to people's wellbeing and safety had not always been assessed. One person did not have a care plan in place, and, where there were risks to this person's safety and wellbeing, the provider had not taken appropriate action to mitigate these. Although there were risk assessments in place for other people, these were not always reviewed and updated regularly.

The provider did not always carry out regular fire safety checks. Fire risk assessments had not been reviewed regularly. People's emergency evacuation plans (PEEPS) were in place for two people, however, one person did not have this in place. This placed them at risk of harm should there be a fire or an emergency.

The provider's monitoring systems were not always regular or effective and had failed to identify the shortfalls we found during the inspection. Furthermore, there was no evidence of lessons learned as issues we had found at previous inspections were repeated at this inspection.

The staff told us they had regular staff meetings and met with people who used the service. However, there were no records of these, so we could not be sure they took place. We saw evidence the staff did not always communicate effectively with each other about the running of the service.

The provider had processes in place for the recording and investigation of incidents and accidents and none had been recorded since our last inspection.

There were enough staff on duty at all times to meet people's needs in a timely manner. Nobody had been recruited since the last inspection.

There were systems in place to protect people from the risk of infection although further improvements were required. Staff had received appropriate training in infection prevention and control. There hads been no cases of COVID-19 at the home. The home was clean.

People felt safe when staff were providing support. Staff had received training in safeguarding adults and

demonstrated a good knowledge of this and what they would do if they thought someone was at risk of 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 requires improvement (published 3 October 2020). At this inspection enough improvement had not been made/sustained and the provider was still in breach of regulations. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We carried out an announced inspection of this service on 10 September 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed and remains requires improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 142 Petts Hill on our website at www.cqc.org.uk.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 safe care and treatment 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 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.

142 Petts Hill Care Home

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

Service and service type
142 Petts Hill 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 had a manager registered with the Care Quality Commission. This means that 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
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 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.

During the inspection
We met with one person who used the service and observed interactions between people and the staff members. We spoke with all three staff members, including the owner, registered manager and a senior support worker.

We reviewed a range of records. This included all three people's care records and medicines records. We reviewed a variety of records relating to the management of the service, including policies and procedures and safety checks.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and 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 requires improvement. At this inspection this key question has remained the same.

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

At our last inspection we found people did not always receive their medicines safely and as prescribed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People did not always receive their medicines safely. One person's medicines administration record (MAR) showed 28 tablets had been prescribed and there were 18 staff signatures to show they had supported the person to take this daily. However, where there should have been 10 tablets left, 11 remained. Similarly, for another person, 56 tablets had been prescribed and there were 35 staff signatures. There should have been 21 tablets left but 26 remained. The senior support worker was unable to offer an explanation for these discrepancies.
● At our last inspection we found it was not always possible to audit if the number of tablets in packs tallied with the staff signatures indicating the person had taken their tablets. This was because staff did not keep records of the total amount of prescribed medicines when they carried forward medicines from the previous month, and did not record the date of opening on packs. At this inspection, we found this had not improved. This meant that we could not be sure people received their medicines as prescribed.
● The provider had a medicines policy and procedures in place. The policy included 'as required' (PRN) medicines, and required the provider to have 'clear and precise instructions when service users require PRN medication'. It also required the provider to 'ensure there is a specific care plan for PRN medication and this is written in the service user's care plan'. However, for people who were prescribed PRN medicines, there was no PRN protocols in place or particular instructions about these in people's care plans.
● The provider's medicines policy required them to monitor the daily temperature of the room where medicines were kept and the medicines cupboard where they were stored. We saw staff had not done this regularly. The last recording for the medicines cupboard was 1 July 2021 and the room 12 November 2020. The effectiveness of medicines can be reduced if these are stored at the wrong temperature.
● There were medicines audits in place, but these did not include counting medicines and ensuring the number of tablets corresponded to the staff signatures. This meant audits had failed to identify the concerns we found. MAR chart audits were carried out, and did not highlight any issues. This was because the provider

did not check if the signatures matched the amount of tablets in packs.

The provider had not ensured they followed their policy and procedures in relation to medicines management. This placed people at risk of not receiving their medicines as prescribed. This was a repeated breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● The safety and wellbeing of people was not always assessed, monitored and managed. A person had been admitted to the service on 28 July 2021, but did not have a care plan in place. We discussed this with the staff who could not offer an explanation for this. Additionally, they had not assessed, managed or mitigated any risk for this person. For example, although the person's hospital record stated they were cognitively impaired, the registered manager told us they were able to go out locally on their own and occasionally did this. However, there were no measures in place to help ensure they did this safely or identify where their safety could be compromised.

● Another person was a risk of malnutrition. The care plan stated staff educated the person about the benefits of a healthy diet, involving them in shopping, choosing their ingredients and helping with cooking. However, there was no recent record of the person's weight, so we could not be sure this was adequately monitored. The last entry was 7 September 2017. We discussed this with the staff who said the person always refused to be weighed. However, this was not recorded on their care plan or on the chart. We observed the staff asking the person if they wanted to be weighed and they said they would when they got up. The staff said they would come back later, but this did not happen.

● Most of the risk assessments for people had not been regularly reviewed and updated, some not since May 2021. When we raised this with the staff, they were unable to provide a reason for this.

● Safety checks were not always carried out regularly. Weekly fire checks had not been carried out since 8 June 2021. We raised this with the registered manager who told us they thought another member of staff had done these. However they could not give us a reasonable explanation for the lack of testing. The fire equipment policy and procedure had not been reviewed and updated since 8 October 2019. There was no recent fire risk assessment in place. The last one on record was completed in February 2019.

● There were individual fire risk assessments in place for people who used the service but these had not been reviewed recently. In addition to these, there were individual personal emergency evacuation plans (PEEPS) in place which took into account people's individual needs and how to ensure they could evacuate safely in the event of a fire. However, the person who had been admitted in July 2021 did not have this in place. This placed them at risk of harm should there be a fire or other emergency.

The provider did not always have robust systems in place to protect people from the risk of avoidable harm. This was a repeated breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection, we made a recommendation in relation to infection prevention and control. At this inspection, improvements had been made, although further improvements were required.

● Following the last inspection, the provider had made improvements to the management of infection prevention and control, and relevant documents were in place. This included a COVID-19 quality audit. We saw evidence the staff all received adequate training in infection control and the use of PPE. There were numerous guidelines in place for staff to follow in relation to the risk associated with COVID-19.

● The provider was accessing testing for people using the service and staff and we saw evidence of this.
● The provider's infection prevention and control policy was up to date.
● Two out of three people who used the service had a COVID-19 risk assessment in place. These were usually reviewed monthly although we saw there had not been a review in July or August 2021.
● There were regular infection control audits undertaken. These looked into all areas of the home such hand hygiene, laundry, environment, training and staff knowledge and outbreak management. There had not been any cases of COVID-19 at the service.

Learning lessons when things go wrong
● The provider did not always learn lessons when things went wrong. They told us they discussed concerns as a team to make improvements. However, we found at this inspection that the provider had not followed their improvement plan, therefore they had not made the necessary improvements. We found concerns which we identified at previous inspections, in relation to risk management and medicines management. This meant the provider did not consistently learn from mistakes and make improvements to the service based on these. This is covered further in the Well Led domain.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse. The provider had a safeguarding policy and procedure in place. All staff received training in safeguarding adults and training records confirmed this. Two of the people who used the service had lived at the home for a long time and were settled and happy. One person told us, "I like living here. They look after you here." There had not been any safeguarding concerns raised since our last inspection.

Staffing and recruitment
● The service was a family run business and the family group covered all shifts on a 24 hour rota. The provider told us they had not needed to use agency staff and there was no staff shortage. The rota we viewed confirmed this. The provider had not recruited new staff since our last inspection.

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 requires improvement. At this inspection this key question has remained the same.

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

At our last inspection, we found the provider did not have effective arrangements to assess, monitor and improve the quality of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider had processes for auditing and monitoring the quality and safety of the service. However, these had not been effective as they had failed to identify the issues we found during our inspection. Furthermore, audits and checks were irregular and some of these had not been carried out for several months.
- The provider's processes for the management of medicines had not been effective and we found issues with the recording and administration of people's medicines.
- The provider's processes had failed to identify a person who used the service did not have a care plan in place, and no risk assessment had been put in place to keep the person safe from avoidable harm.
- Although improvements had been made to the prevention and control of infection, the provider did not ask us to show a negative COVID-19 test and did not take our temperature on arrival.
- We found issues noted at previous inspections during our visit, such as concerns regarding the safe management of medicines, care planning and risk management. This meant the provider did not consistently learn lessons from mistakes and did not consistently embed any improvements they had made to the service as a result.

The provider did not have effective arrangements to assess, monitor and improve the quality of the service. This was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People were happy at the home and felt well cared for. There was continuity of staff and a family atmosphere which helped make people feel safe and secure.
● Staff told us they supported each other and worked as a team. They told us they cared about the people who lived at the home. Our observations confirmed this. However, they did not always communicate effectively between them, and some tasks were not completed in a timely manner, which put people at risk. For example nobody had taken the responsibility to put in place a care plan for a person who had been admitted a month earlier, taking into consideration their needs and wishes and nobody had identified any risk to their wellbeing and safety and put in place systems to mitigate these.

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 understood their legal responsibility and were open and honest where we identified shortfalls during our inspection. However, because their monitoring systems were ineffective, they did not always identify shortfalls themselves, therefore they failed to take appropriate action, notify the relevant agencies and make the necessary improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The senior support worker told us there were regular staff meetings where relevant issues were discussed, for example COVID-19, health and safety, appointments and issues concerning people who used the service. However, there were no recent records of these. They also told us people who used the service were able to voice their thoughts and opinions through individual discussions. Again, there were no records of these discussions, so we could not verify if and when these took place.
● At our last inspection, we viewed a sample of quality questionnaires which had been sent to people's relatives and returned to the service and these showed an overall satisfaction of the care received. The provider told us they were due to carry out a new survey before the end of the year.

Continuous learning and improving care; Working in partnership with others
● The provider told us they had felt well supported by the local authority during the pandemic. They said they had received advice and guidance which had been helpful.
● The staff worked with healthcare and social care professionals who provided support, training and advice so staff could support people safely at the service, such as the GP, pharmacist, mental health professionals and social workers. The staff had undertaken online training to keep their skills up to date and records evidenced this.

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 Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure the proper and safe management of medicines. Regulation 12 The registered person did not always assess the risk of, preventing, detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 good governance The registered person did not have effective arrangements to assess, monitor and improve the quality of the service. Regulation 17

The enforcement action we took:

Warning notice