Eldercare (Halifax) Limited

Cowlersley Court Care Home

Inspection report

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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 14, 15 and 19 October 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches of, Regulation 9 person centred care, Regulation 10 dignity and respect, Regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 13 Safeguarding people from abuse and improper treatment, Regulation 17 Good Governance, Regulation 18 staffing, this was in relation to there not being enough staff to meet people's needs, and staff not being adequately trained and skilled to carry out their duties.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cowlersley Court Care Home on our website at www.cqc.org.uk.
The service is required to have a registered manager; there was no registered manager at the time of our initial inspection or at this inspection. There was a manager who was responsible for the day to day running of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that safeguarding incidents had not been recognised or reported to the Care Quality Commission, although some of the concerns had been recognised by other health professionals who had visited the service.

The registered provider had done some work on the risk assessments which needed to be in place to reduce identified risks. These were in some cases not adequate and in other cases not completed.

Accidents and incidents were not being recorded adequately and in cases where these were referred to in daily care records no accident or incident forms were available, although the area manager told us they had been completed.

There were not enough staff on duty to meet people's needs. This was due to the people who used the service being spread out over the home which is large, which meant there were long periods where there were no staff in some areas.

We looked at the processes in place for the administration of medicines. We found that there had been some changes made, however these were not sufficient to ensure that people were receiving their medicines as prescribed.

The home was not always kept clean. We saw several examples of poor cleanliness which would contribute

to the risk of any infections within the home spreading.

There was little evidence of leadership in the home. The manager was on leave at the time of our inspection, however there was no manager covering for their absence. The area manager attended the service during our inspection but spent most of their time in the office which is away from the main areas of the home.

Staff told us that the manager asked them 'how they could support them' and 'did not tell staff what needed to be done'.

The registered provider was not meeting the requirements of their registration with the Care Quality Commission as they were not notifying CQC of events which they had a duty to do.

There was some evidence of oversight from the wider management team as there had been a visit made by the area manager to the service in January 2016 and we saw that there had been a report completed of this visit. However the action plan for the identified areas of concern was not completed and we saw no evidence that this information had been used to improve the service.

The records in the service were not of good quality and were not accessible. Records of accidents and incidents were not in the file marked as being for their storage and could not be located during the inspection or supplied afterwards. Daily records were loose in the medicines room and there was a care plan which was not in the file of the person it related to and was found to be loose in the medicines room.

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

We found action had not been taken to improve the safety of the service.

The service did not have sufficient staff on duty to safely care for people.

The service did not manage medicines safely and people were not always receiving their medication as it had been prescribed.

The service did not recognise when people were unwell, and did not act in a timely manner or report safeguarding incidents.

We could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during our net planned comprehensive inspection.

Is the service well-led?

Inadequate

The service was not well-led.

There was no effective leadership in the service.

The registered provider was not notifying the Care Quality Commission of notifiable events.

The oversight from the registered provider was not effective as the improvements which were required had not been made.

Cowlersley Court Care Home

Detailed findings

Background to this inspection

We undertook an unannounced inspection of Cowlersley Court Care Home on 4 and 5 February 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 14, 15 and 19 October 2015 inspection had been made. The team inspected the service against two of the five questions we ask about services, is the service safe, and is the service well-led. This is because the service was not meeting some legal requirements.
The inspection took place on 4 and 5 February 2016 and was unannounced. The inspection was focussed and looked at the safe and well-led key questions.

The inspection was carried out by an adult social care inspector on both days and a specialist advisor who had extensive knowledge of the safe handling of medicines on day one. Prior to our inspection we had received information of significant concern from the local authority safeguarding team. This was in relation to safeguarding matters which we had not been notified of and related to the safe care and treatment of people who used the service. The service was last inspected during October 2015, and was found to be inadequate in all of the five key questions at that time. There were multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to other agencies who worked with the service to gather further information; these included the district nursing service and the local authority contracting team.

During our inspection we looked at the care records of six service users, the medication administration records for all the people who used the service, weight records, bathing records, complaints file, incident and accident files, medicine competency checks, staff rotas and safeguarding records for the service since our last inspection.

We spoke with six of the people living at the service, three of care staff, a senior care workers and the area manager.

Inadequate

Is the service safe?

Our findings

At our last inspection on 14, 15 and 19 October 2015 we found that there were multiple breaches of the Health and Social Care Act 2008 (regulated Activities() Regulations 2014. Regulation 9 person centred care, people's needs were not being met as there were not up to date care plans in place. People were not receiving care which met their needs and the care was not person centred. Regulation 10 dignity and respect, staff were not recognising when people's dignity was not being protected .People were not having their care needs met in a timely or dignified manner. Regulation 11 Need for consent, the registered provider was failing to gain people's consent for the care they were receiving, and not ensuring that Deprivation of Liberty Safeguards were in place where needed. This meant that people's human rights were not being protected and maintained. Regulation 12 Safe care and treatment, medicines were not being managed safely and there was a lack of effective risk assessments. People were not receiving their medicines in line with the prescriber's instructions and risks were not being identified and reduced. Regulation 13 Safeguarding people from abuse and improper treatment, staff were not recognising and reporting safeguarding referrals to the local authority and Care Quality Commission. People were not being protected from harm as there were no investigations taking place or actions taken to prevent future incidents of the same nature. Regulation 18 staffing, there were not enough staff to meet people's needs, and staff were not being adequately trained and skilled to carry out their duties. People's needs were not met in a timely manner and staff did not have the necessary knowledge to care for people.
People who used the service told us "It's no better than last time you came, I can't remember when I last had a bath or a shower," and "There is nothing going on and very few staff around."

We looked at the care files of and asked to look at the incident and accident forms for people we had concerns about in relation to the concerns raised to us by the local authority safeguarding team. We found that there was evidence in people's daily notes that there had been incidents which should have been reported as safeguarding incidents, but which had not been recognised by staff and there were no incident forms for us to review. The area manager told us the incident forms had been completed but was not able to produce them. This meant that significant incidents were not being recorded and there had been no action taken to investigate them. This meant that people were not being protected from harm.

There was one instance where a person who used the service had been assaulted by another person who used the service; this had involved the police being called. This incident had not been reported to the local authority or the Care Quality Commission. There were also records showing multiple assaults by a person who used the service against staff, visitors to the service and on one occasion another person who used the service. These matters had not been recognised or reported as safeguarding.

This was a continuing breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that whilst some work had been carried out on risk assessments, there were still five out of the six files we reviewed where there were blank copies of risk assessment forms, falls risk assessments and incomplete forms for choking risks and no risk assessments in place for the use of bedrails when these were

recorded elsewhere in the records as being in use. This meant that the registered provider was not putting measures in place to reduce the risks to people who used the service.

We found there were no personal emergency evacuation plans (PEEPS) in place for any of the people who used the service. The area manager gave us a blank copy of the form they were intending to use; this process had not started at the time of the inspection. There was a 'fire risk management' form in one of the files we looked at. This was not dated or signed to say when it had been completed and did not give the information care staff would need to know in order to safely assist the person from the home if there was a fire.

This was a continuing breach of Regulation 12 (2) (a) and (b) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The file which was marked as containing accident and incident forms which was presented to us contained records which ended in November 2015. This was raised with the area manager, who said there must be another file. This was found not to be the case, and a small number of accident and incident forms were found around the service. This meant that processes in the home were not being followed which resulted in important records not being available.

We spoke with a member of staff who told us 'there are two carers and a senior on all the time now.' The area manager told us that there were 16 people using the service, however we found that there were in fact 13 as there were people in hospital. The home is a large building which is set out in a square which does not connect at the final corner. Therefore the only way to get from one end, where the conservatory is located to the entrance is to walk through the length of the building. Most of the people who used the service were sat in the conservatory as this is the largest lounge; there were people who remained in their rooms on both the ground and first floor. People's bedrooms were spread throughout the whole building, which meant staff had long distances to walk in order to assist some people.

Some of the people who used the service required assistance from two care staff to help them to transfer from their bed to a wheelchair for instance. This meant that during the times where both care staff were in a person's room there was only the senior care worker available. We noted that the senior care worker spent long periods in the medicines room during the inspection. This meant that people's needs were not always met in a timely manner, for instance a person who was calling for help for a period of ten minutes and there was an instance where one person had been in the same chair from 10pm in the morning until approximately 5pm in the evening, we asked staff to assist this person on two separate occasions.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the area manager about their recruitment of new staff. They told us that they were currently recruiting new staff but that they were waiting for their pre-employment checks to be completed. This meant that there would be a delay in the new staff being available to start work.

We found that there was no consent to care gained in the care files we reviewed. The only consent which had been gained was in relation to photography and the administration of medicines. The lack of consent was discussed with the provider at the previous inspection. This meant that there was no evidence that people had been asked if they had consented to the care which was being given and had given their consent. We did not see staff asking people before they approached them to assist them, for instance when assisting a person from their chair to move to the dining room.

This was a continuing breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as there was no consent requested or gained. The care plans we reviewed were not signed by the person they related to or their representative.

We saw that where people were in bed their bedroom doors were left wide open on to the corridor which was the thoroughfare through the home. This meant that visitors to the home passed these doors and could see people asleep in their beds. Some of the people we saw were not well covered by their bed clothes. We saw that there was a person who was unable to move themselves who was assisted to a chair in the main conservatory at approximately 10am on the first day of inspection. We raised with staff twice through the day that we had not seen this person being assisted to the toilet. Staff on both occasions said they would assist the person and the person was assisted just prior to us leaving.

This was a continuing breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been concerns raised in relation to the management of medicines on several occasions. We asked to see the investigation into one of one of these concerns and this was not available at the inspection as the area manager was unable to locate it. We asked that this information be sent to us and this was not received before the inspection was concluded. The records showed that the matter investigated did not match the information which had been received by the whistle blowing alert which had raised concern. This meant that we were unable to evidence that a thorough investigation had taken place or that any action had been taken. We asked to see the medicines competency checks which had been carried out to ensure that the staff who were administering medicines were competent to do so. The two competency checks we were shown were completed by a senior care worker. We were unable to confirm their competence at inspection as the area manager could not produce their competency records; these were received after the inspection had been completed and showed that there were areas of weakness identified which needed to be further clarified by the manager. There were no competency checks available at the time of inspection for any of the staff who administered medication through the night; we received a record for one member of night staff after the inspection had ended. This meant that staff were being assessed as being competent by a senior care worker whose own competence was not clear.

We looked at all the records in relation to the handling of medicines by staff. There had been significant issues identified at our last inspection and during a recent visit by the local authority contract monitoring team. We found that there were still issues with the ordering and storage of medicines despite staff telling us this had improved. We found that there were medicines in the controlled drug cupboard which should not have been stored there. We spoke with the senior care worker about the incorrect storage of warfarin in the controlled drug cupboard, they told us this was because 'there have been a number of errors of dose with warfarin'. They explained they had decided to store the warfarin in the locked cupboard so that there would need to be two staff signatures for each dose to reduce the errors. We found when we looked at the records that 13 of 20 doses had only been signed by one member of staff. This meant that medicines were still not being ordered or stored correctly and that processes which had been put in place to reduce the risk of a person being given the wrong dose of a drug were not being followed.

We found that there were medicines still in stock for people who had died; these should have been returned to the pharmacy. We saw that there were medicines in stock which were labelled as being for people who were no longer prescribed those medicines. We looked at the process for applying creams and ointments to people. There should have been a body map with the areas for application marked and instructions of when application should be carried out. These documents were no longer in place. We asked the senior care worker why this was the case. They told us 'we removed them because the carers can't be trusted to sign for

the creams. I go and check if creams have been applied by looking at people, and then I sign for the cream. This meant that people may be at risk of not having their creams and ointments applied correctly or consistently.

We noted that there was a tube of cream in the fridge which had been prescribed the previous day. The cream had been signed as being applied by the senior care worker; however the tube of cream was sealed and unopened. This was reported to the area manager who told us they would investigate the matter personally. This meant that the person had not received the prescribed medicine in a timely manner and the medication administration record (MAR) had been falsely completed.

There were some eye drops in the fridge which had been prescribed for a person who used the service and the eye drops had been opened. The records for the administration of the eye drops showed a cross through each time when eye drops should have been administered. Staff were not able to explain why this was. This meant that it was impossible identify whether this person had received their eye drops in line with the prescribers instructions.

The recording of the temperatures for the medication fridge were not consistently carried out. The temperature of the fridge was zero degrees Celsius when we checked this. The correct temperature for a fridge used to store medicines is between 2 and 8 degrees Celsius. This meant medicines were not being stored in line with the manufacturer's instructions and the efficacy of the medicines was not assured. Eye drops which are stored at a lower than recommended temperature would also be unpleasant to the person who was receiving them.

Some people who used the service had been prescribed food supplements to fortify their diet and help them to maintain their weight. We looked at the stocks of these supplements and found that there in one case there was stock of these drinks for a person who was no longer prescribed to have them, which should have been returned to the pharmacy. There was a stock of 49 units for a person who had died and a further instance where records showed that 56 drinks had been delivered for a person who had been prescribed them, 36 were signed as being given yet there were still 48 in stock. This meant that people were not receiving their prescribed supplements in line with the prescriptions which had been given. These issues demonstrate that medicines were not being safely managed by the staff in the service.

This was a continuing breach of Regulation 12 (2) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that there had been an incident recorded where a person who used the service, who we knew from our previous inspection had a history of urinary tract infections (UTIs), had collapsed and been taken to hospital for treatment of a confirmed UTI. There was no care plan in place for this person other than a very basic short term care plan. There was nothing recorded in their daily records to suggest that staff had noticed this person was unwell, which would be expected in this circumstance. This demonstrated that staff were not recognising the signs of people being unwell and were not consulting health professionals in a timely manner.

There was evidence that unqualified care staff had undertaken the removal and application of dressings to a wound. Care staff are not trained or competent to undertake these duties. There was evidence that in one instance the care staff suspected the wound to be infected and still soaked off a dressing before seeking medical assistance. The care staff had documented re-dressing this wound multiple times per day; there was no evidence that they had requested a district nurse to attend which should have happened in every instance. This meant that untrained staff were acting outside of their trained competency and such

interventions risked infection and further deterioration of the wound.

We noted that in one of the bathrooms on the ground floor the toilet was stained with dried urine on the toilet seat. There was also a lack of personal protective equipment found in this bathroom, as there were five loose gloves in the drawer, an empty glove box in the cupboard under the sink and no other stocks present. We observed that on day two of the inspection the dining room floor was very dirty at approximately 2pm in the afternoon. A member of staff raised this and a member of the laundry staff came to clean the food up.

Inadequate

Is the service well-led?

Our findings

At the inspection which we carried out 14,15 and 19 October 2015, there was a breach of Regulation 17 Good Governance. The registered provider was failing to maintain accurate records which were accessible to show the care which had been delivered. There was a lack of leadership within the service and there was no evidence that the registered provider had oversight of the service and the failings which we identified within the home.

There was no registered manager in place at the time of the inspection. There was a manager in post who was responsible for the day to day running of the service; they were on leave at this inspection. There was an area manager who attended the service on both days of our inspection, who was responsible for supporting the manager and overseeing the service.

Staff we spoke with told us "This manager is much better than the last one, they have meetings with us and ask us how we want them to support us, they don't tell us what needs doing and when it needs doing by." On the days we visited the home the area manager was present, but spent long periods in the office which was away from the main service. This was partly as they were looking for records we had asked to see which they were unable to locate. There was a senior care worker on duty and we noted that they spent long periods in the medicines room which again is away from the main areas of the home. This meant that there was no leadership evident where care was being actively delivered where people were in the service. There had been no management cover arranged for the period of the manager's absence other than by the area manager themselves. This meant that despite the failings which had been previously identified and the current concerns about the quality of the care being provided the registered provider had not arranged for there to be a manager in the home.

There were several occasions where we had asked for documents, in particular care plans for specific people. We were told that the area manager was 'just finishing them off' and that they would be available shortly. When we requested one care file we were told that they could not provide it as there had been a 'glitch'. The area manager showed us that the care planning paperwork which had been saved to a 'pen drive' were blank. We asked whether there were paper copies of the documents which would evidence that the care planning had been carried out. We were told there 'may' have been some basic notes made, but the care plans were created when they were typed up. There were no handwritten notes available when we asked to see them. This meant that the care plans were not written with the person, as they were created in the office upstairs. We were unable to evidence that the care plan for this person had been created, which was very concerning as they were one of the people we had highlighted as being particularly vulnerable at our last inspection.

The area manager did not inform us of the issue with this care plan, we only became aware of the issue after we had repeatedly asked to see the care file. We asked to see the version of the care plan which was in place for the person and were told it would be in the black care file which was kept downstairs. The care plan was not in the care file. This meant that there was no care plan available to staff for this person. This meant that staff had not access to information about the needs of this person, or the information they would need in an

emergency situation for instance whether the person had a do not attempt cardiopulmonary resuscitation order.

We spoke to the area manager about the issues we had found during the inspection on the second day. We discussed with them that the report which recorded their findings from a visit they had recently carried out to oversee the service had recorded issues which were both significant and had been raised by the Care Quality Commission at the previous inspection. There was no action plan created from the information they had recorded. The area manager told us it was the manager of the service who was responsible for creating the action plan. There was no action plan created by the manager which could be produced. We discussed with the area manager their responsibility to oversee the service and take action where issues were identified. They could produce no evidence that any action had been taken following their visit in January 2016. This meant that whilst a visit had been undertaken to review the service and identify any issues no action had been taken to rectify the areas which needed improvement.

We discussed with the area manager their inability to produce documentation across multiple areas of the service, and the manager's failures to ensure that processes had been followed and documentation stored securely. We also discussed our concerns about the area manager's disclosure that confidential information relating to both service users and staff were being taken out of the building by the manager.

We looked at daily care records and found that these were very basic and did not reflect the events which had taken place; this was particularly the case when incidents had taken place. This meant that there were no accurate detailed records of the care people had received or how they had presented over a period of time. There was no checking or auditing of daily records to identify these issues or to identify entries which may need further investigation. For instance in one person's care records we saw an entry which said 'been escaped a few times.' This meant that serious issues such as the person 'escaping' were not being picked up and there was no action taken to keep the person safe.

We reviewed the records which showed when people had a bath, shower or a wash. We found very little evidence that people who used the service were being offered baths or showers regularly and in some of the records we looked at there was no evidence of any showers or baths being undertaken over a three week period (30/11/2015 - 20/12/2015).

This was a continuing breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the service was not maintaining systems or processes to ensure accurate records were kept and accessible.

The registered provider is responsible for informing the Care Quality Commission of any events which are notifiable under the terms of their registration. The manager had informed CQC of deaths which had occurred in the home, however they had failed to notify CQC of other serious incidents which were being investigated by the local authority safeguarding team.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act (Regulated Activities) Regulations 2014, as the registered provider was failing to inform us (CQC) of notifiable events in line with their registration.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were incomplete or not in place. This meant that critical information was not available

The enforcement action we took:

Notice of proposal to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect doors open on main corridor when people asleep in bed. Not allowing people to access community and issues with DoLS conditions

The enforcement action we took:

Notice of proposal to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent No consent to care being gained, care plans are not signed by service user or their representatives

The enforcement action we took:

Notice of proposal to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments not in place or not adequate. Multiple issues with medicines management. Not calling medical opinion when needed. Issues with wound management and care staff dressing wounds

The enforcement action we took:

Notice of proposal to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding matters not being reported, provider not taking timely action to protect people from harm

The enforcement action we took:

Notice of proposal to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance records don't exist or are not able to be located. No action plans in place following AG visits and no evidence of follow up to ensure improvements are made.

The enforcement action we took:

Notice of proposal to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were only 2 care staff and 1 SCW on duty to meet the needs of all the people in the service.

The enforcement action we took:

Notice of proposal to remove the location