Romney Cottage Residential Care Home

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Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 17 May 2016 and was unannounced.

Romney Cottage Residential Care Home provides care and support for up to 22 older people. There were 14 people living at the service at the time of our inspection. People cared for were all older people; some of whom were living with dementia and some who could show behaviours which may challenge others. People were living with a range of care needs, including diabetes and epilepsy. Some people needed support with all of their personal care, and some with eating, drinking and mobility needs. Other people were more independent and needed less support from staff.

Accommodation is provided over two floors with communal lounges and dining areas. People had their own bedroom, shower and bath facilities were shared. Access to the first floor is gained by stairs, making some areas of the service inaccessible to people with limited mobility.

The service did not have a registered manager in post at the time of our visit and had not had one since February 2016. 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. The provider had appointed a manager to manage the service who had taken up the position in March 2016. They confirmed their intention to register with the Care Quality Commission (CQC). The new manager was present throughout our inspection.

At the last comprehensive inspection on 25 and 26 January 2016 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. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Action plans submitted by the provider following the last inspection had not been fully met, or we identified continued concerns in areas where the provider had taken action to address them.

People remained at risk of harm as incidents and accidents lacked investigation and oversight; management of the risk of falls was poor and people continued to experience falls as the provider had not ensured known risks to people were mitigated.

People with diabetes remained at significant risk of harm as they did not have their healthcare needs met or regularly reviewed. Staff did not have the knowledge or resources to accurately measure blood sugar levels; a device used regularly for the measurement of blood sugar levels could not be calibrated and placed people at risk of receiving the wrong dosage of insulin. Diabetes reviews were only recognised as overdue following prompting by health care professionals.

Staff shortages meant the service had operated below the numbers of staff it said it needed; no method was in place to establish if the numbers of staff on duty could safely meet people's needs. Prominent information indicating a lack of staff was not recognised or considered.

People were not safeguarded from abuse because action was not taken to minimise the risks of preventable injuries.

New staff were undergoing final recruitment procedures.

Aspects of the service that were previously poorly maintained or presented a risk to people had been addressed.

Fire safety checks had been routinely undertaken and equipment serviced regularly.

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.

Insufficient priority was given to Incidents and accidents; they did not receive suitable oversight or promote learning to reduce the risk of them happening again.

Risk assessments did not always record suitable measures required to keep people safe and were not always reviewed when needed.

Blood sugar level measuring equipment could not be calibrated as needed; and diabetes management reviews were only arranged following prompting by health care professionals.

The service had operated below its staffing requirement, however, staff shortages had been addressed with new staff being recruited.

Appropriate water temperature and fire safety checks were undertaken and action completed to address any concerns identified.

Romney Cottage Residential Care Home

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.

We undertook a focused inspection of Romney Cottage Residential Care Home on 17 May 2016. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 25 and 26 January 2016 had been made. We inspected the service against one of the five questions we ask about services: is the service safe. This is because it presented the greatest concern and would help us to consider our regulatory response to some of the shortfalls previously identified.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. The provider had also sent us regular action plans following the last inspection.

We met and spoke with seven people who lived at the service and observed their care, including the lunchtime meal, medicines administration and activities. We inspected areas of the environment and equipment used at the service. We spoke with four of the care workers, two visiting health care professionals, the acting manager and the provider.

We 'pathway tracked' two people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for three

other people.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, some quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

At the last inspection on 25 and 26 January 2016, we reported on a number of areas where people's safety at Romney Cottage was not ensured. At this inspection we found not enough improvement been made and people were still not receiving safe care. This had a major impact on people.

During this inspection we received mixed feedback; no one told us they did not feel safe, but some people and staff expressed their concerns about shortfalls in staffing which they felt impacted upon the safe running of the service. One person told us, "So long as we have enough staff it's okay, when staff don't turn up I think the ones here (staff) find it hard to cope" another person told us, "One minute they're cooking, the next minute they're trying to support us, are they cooks or carers?" Other comments included, "The staff work hard, they all do their best" and "I'm happy, there's the odd grumble, but on the whole I am happy". A member of staff told us, "There had been problems with some staff ringing in or texting to say they couldn't come in; they did this at short notice and of course it's difficult to get cover". Visiting health care professionals told us on one occasion colleagues were kept waiting for 16 minutes before a member of staff let them into the service. This had delayed the administration of medication for two people at the service.

Following our last inspection, the provider submitted weekly action plans setting out what they had done and proposed to do to address the breaches identified. The provider told us staff responsible for medication had received further training and audits would be completed weekly; a more comprehensive system was being introduced to support care planning and assessing risks; a proactive approach was being taken in relation to incidents and accidents to highlight areas of risk and ensure lessons were learnt. The measures introduced were inadequate; breaches of regulations were identified in each of these areas. People remained at risk of continuing injury and poor care.

Insufficient priority had been afforded to accidents and incidents; they were not investigated and did not reflect any learning to minimise the risk to people of incidents happening again. This concern had been highlighted to the service following our last inspection. Incidents and accidents were recorded, however, with the exception of one accident, no analysis or overview had taken place. In March 2016 one person had fallen because they had tripped on a floor mounted door stopper designed to release the door in the event of an emergency. During our inspection a different person tripped over the same stopper causing them injuries that required the emergency attendance of an ambulance. In the interim two months since the first accident, no action had been taken to look at the cause, the possibility of further accidents or to mitigate the risk of this happening again. Procedures the provider had told us were in place were not.

Three people had suffered frequent falls. In the period from 4 February to 13 May 2016, two people had fallen eight times and another person seven times. Again incident and accident forms were completed; however, risk assessments had not always been reviewed. One person had fallen getting out of their bed; the accident form noted consideration should be given to the use of bed rails, two days later they fell again getting out of their bed. Although a referral was made to the GP and a prescription given for the treatment of a urinary tract infection which can contribute to disorientation, unsteadiness and confusion, no other measures were taken. These could have included further consideration of bed rails, the use of a padded mat

placed at the side of the bed or a pressure mat to alert staff if the person was out of bed. This did not demonstrate learning from previous events.

Some risk assessments intended to safeguard people from falling relied upon people asking staff for help when they mobilised. Most of the accidents had occurred when unwitnessed by staff; some in people's bedrooms and some in communal areas. This indicated staff were not present when people needed support or were not perceptive of people's needs. One person wore hip guards to afford some protection in the event of a fall. A review of their falls and mobility risk assessments did not inform staff of this; no system was in place to ensure they were used. Where people had fallen in their bedrooms, staff were often alerted by their shouts for help. Risk assessment reviews had not taken place to establish why people fell or were unable to use the call bell system. Proactive measures, such as providing pendant or wrist band alarms had not been considered, nor had the provision of pressure mats. This equipment may have alerted staff to provide a more timely intervention, offered some contingency of help if the person was not conscious as well as reducing the risks of incidents happening and the time a person may lay undiscovered. This did not reflect a more comprehensive system to support care planning and assessing risks.

Medicines continued not to be managed safely. This placed people at risk of major harm. Two people required the use of insulin to manage their diabetes. While staff monitored blood sugar levels and knew what to do if the levels observed were outside of a prescribed range; the equipment used to measure blood sugar levels could not be calibrated with complete confidence. This was because the fluid needed to calibrate the blood sugar meter had been opened and in use for longer than the manufacturer recommended. There was no spare supply of calibrating fluid. Visiting health care professionals, who administered insulin, commented the meter ideally should be calibrated daily or weekly as a minimum to ensure its accuracy.

Regular diabetic reviews had not always taken place when needed. For example, a 'HbA1C' test is currently one of the best ways to check diabetes is properly managed; it is a blood test that is sent to a laboratory that shows the average level of blood sugar (glucose) over the previous 3 months. This is intended to show how well diabetes is being controlled. Discussion with visiting health care professionals found one person's review had fallen due in December 2015, there was no record that a test appointment had been booked or tests carried out. During our inspection, health care professionals reminded the manager such tests were best practice and were overdue. People were at risk of unsafe care because tests intended to support treatment of health conditions were not undertaken when required.

At the previous inspection people's medication administration records (MAR) had not always been completed by staff when prescribed medicines were administered. This failure presented a risk to people that medicine had not been administered and that medicine may have been incorrectly re-administered by another staff member. At this inspection a review of medicine administration records showed there were continuing instances of staff not signing or entering a code on the records to indicate if a medicine was administered or not. This is despite staff undergoing recent training, competency checks in the administration of people's medicines and management checks of administration records. Although the provider told us medication audits had taken place, other than the manager's amendment of some MAR charts, there were no records auditing had taken place. This continued failure and errors in recording administration of medicines placed people at risk of harm.

Some people may need help and assistance to leave the service in the event of an emergency evacuation. Individual plans to establish people's needs during these circumstances were not in place. Discussion with the manager found they had identified the need to complete personal emergency evacuation plans for people, however this had not been done. Staff were therefore not aware how people may respond to a fire

alarm or the support they need to leave the service safely. This placed people at risk.

Care and treatment was not provided in a safe way for people because the service had not done all that was reasonably practicable to mitigate any such risks. This was a breach of Regulation 12 (1)(2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoken with told us they understood about keeping people safe from harm and protecting them from abuse. However, the service did not recognise its failure to investigate and address incidents and accidents to reduce the risks of further occurrences represented neglect, a form of abuse. The failure of the service to take effective action or afford sufficient priority to the investigation and mitigation of accidents and incidents meant people were not safeguarded from abuse and improper treatment. Care was provided in a way that significantly disregarded people's needs resulting in preventable injuries and therefore neglect.

The provider had not ensured systems and processes were established and operated effectively to prevent abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing comprised of four care staff in the morning and three in the afternoon, in addition to the manager and a domestic housekeeper. Night support was provided by two waking staff. Shifts ran from 7am to 1 pm, 1pm to 7pm then 7pm until 7am for night staff, although staff rotas showed most day shifts for staff were 12 hours from 7am until 7pm. The service did not employ a cook, food preparation and cooking was undertaken by care staff. The manager proposed this arrangement would continue, although it effectively reduced the availability of care staff. No specific staffing tool was used to determine staff levels required and dependency assessments in care plans were incomplete or blank. Information, such as the high number of unwitnessed falls and accidents, was not used to factor into staffing numbers or their deployment around the service. Our last inspection found there were insufficient staff to safely provide the support people required. The frequency of unwitnessed incidents and accidents reasonably indicated this continued to be the case.

The manager confirmed there had been difficulties in ensuring required numbers of staff were present to cover each shift. Staff rotas showed a shortfall in staff at least once a week for the past five weeks, with on some occasions only two care staff present. This had caused the manager to frequently cover some shifts, taking his time away from the management of the service. In the absence of a structured system based upon people's needs and recognising prominent factors such as unwitnessed incidents, the service could not demonstrate with any degree of factual assessment that sufficient numbers of suitably competent staff were deployed. This continued to place people at risk of unsafe care and treatment.

The service had not ensured there were, at all times, sufficient numbers of staff to meet the needs of the people. This was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at most areas of the service, repaired areas of plaster that had required re-decoration had been completed. Other areas of the service such as a bathroom and treatment room were refurbished. Fire prevention and protection equipment had been tested and equipment used at the service inspected and certified as safe to use. New water mixer valves were fitted to ensure hot water did not exceed maximum safe temperatures; checks showed all water temperatures were within a safe range. All checks were up to date with the exception of the previous week, the manager acknowledged a system needed to be put in place when the members of staff responsible were on leave.