Care Quality Commission

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Speke Care Home (Residential)

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**

Overall summary

We carried out an unannounced comprehensive inspection of this service on the 20 and 24 April 2015. At this inspection breaches of legal requirements were found.

We are taking enforcement action against the provider because of continuing breaches in the care provided. We will report on this action when it is completed.

We undertook this focused inspection on the 23 June 2015 due to receiving concerning information. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection on the 20 and 24 April 2015, by selecting the 'all reports' link for ' Speke care Home (Residential)' on our website at www.cqc.org.uk'

Speke Care Home (Residential) provides accommodation for persons who do not require nursing care. It is a privately owned service which provides accommodation for up to 49 adults. There are currently 27 people living there. The service is located in the Speke area of Merseyside.

There was no registered manager of the home at the time of our inspection. 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.'

Summary of findings

We found a number of continued breaches of regulations relating to safeguarding people, administration of medicines, nutrition management, poor staffing levels and the need for consent.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe

Inadequate

People were not protected from potential abuse as the provider and their staff had not appropriately monitored people's care. The provider had not followed the safeguarding policy that included notifying the local authority and the CQC when required.

People's finances were not being appropriately managed by the provider.

People, relatives and staff told us the home was short staffed. We saw from the provider's rota arrangements and observing this was more evident for the people living with dementia.

The medication procedures and practices were not sufficient to maintain the safe giving of medicines. Pain relief medicines were not being administered appropriately.

People's individual risks in the planning and delivery of care were not adequate to identify, assess or manage people's nutritional care needs. The lack of appropriate assessments and plans placed people at risk of inappropriate and unsafe care.

Is the service effective?
The service was not effective.

Inadequate

The provider had not complied with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure people received appropriate support and were enabled to participate in and consent to decisions about their care and support. The financial transactions procedure used by the provider for people was not appropriate as people had not given their consent.

The understanding of staff for people's nutritional needs was inadequate and did not ensure where people had special nutritional needs these were met.

Care plans lacked sufficient up to date information about people's health related illnesses, such as weight loss. Records informed of the deterioration of the person's health, however staff had not actioned the findings.

Care Quality Commission

Speke Care Home (Residential)

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.

We undertook a focused inspection of Speke Care Home (Residential) on 23 June 2015, due to receiving concerning information. We inspected the service against two of the five questions we ask about services: is the service safe and is the service effective. This is because the service was also not meeting legal requirements in relation to these questions at our last inspection in April 2015.

The inspection was undertaken by two Adult Social Care (ASC) Inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During our visit to the home we spoke with five people who lived there, the provider, the acting manager, the administration officer and three staff. We looked at four people's nutritional care plan records, all 27 people's financial transaction records, safeguarding records, staff duty rotas and medication administration records. We requested monitoring records to check the safety of the environment, none were available.

Inadequate

Is the service safe?

Our findings

We looked at the safeguarding information with the acting manager. We were notified by the local authority that there had been two identified safeguarding incidents that should have been reported to them as well as the CQC. We discussed the identified information with the acting manager who informed us that she had omitted to refer and would do so immediately.

All of the 27 People living at the home had their money (personal allowance) directly paid into one account. The account was not in the name of the people living there or the provider. There were no receipts for any of the people. We discussed the procedure with the provider who informed us that this had been the procedure for a long period of time "years". We requested that local authority be notified under safeguarding for all 27 people living at Speke Care Home (Residential) as their monies were being managed without the correct procedures in place to protect them. The acting manager said that they had not looked at the financial transactions for people living at the home. There was no system in place to protect people from financial abuse as monitoring was not being completed.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spent time in the dementia unit where there were five people being cared for, two cared for full time in bed requiring two staff at all times for their personal care needs, repositioning and comfort.

We spent time talking to the acting manager and two staff working on the dementia unit about the level of staffing required to meet the needs of the five people. We were told that there were two staff rostered to work on the day shifts. Staff were required to contact staff from main residential to support them when they were attending to people's personal care. We were informed by staff that this did not happen when requested as there was not always sufficient staff on the residential unit to support. We were also told that when the two staff were with the people cared for in bed the other four people were left unsupervised at different times of the day.

We spent time looking at the staff rotas for the dementia unit from May 2015 and June 2015. The rotas informed that at times there was only 1 member of staff on duty. The acting manager said this was due to sickness and no cover could be sought. The acting manager told us was that they were aware of the staff ratios not being sufficient to meet the needs of the people however the provider had implemented budget restraints.

When we arrived at the home there was no manager on duty, a senior carer informed us that the manager was working at another of the provider's care homes due to a nursing staff shortage. The acting manager told us that the provider had instructed that they go to the other home the day before. We discussed the staffing levels with the acting manager who told us that the senior carer was left in charge. The rotas we looked at informed that the senior carer had been rostered to work on the dementia unit.

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

When we arrived at the home we accessed the building without challenge as both doors were unlocked. We spent time walking through the home checking the safety of the environment. We observed in the conservatory that a parasol was blocking open a wedged open fire exit door, which could prevent evacuation if it had been necessary. Staff told us it had been that way since the previous afternoon.

We asked the acting manager about checks on the safety of the environment; we were informed that none had been recorded. The acting manager informed us that allocation lists should be completed each day. The records being completed were on dementia unit but not on main residential. We were given two copies of the allocation lists that did not include the safety of the environment.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care records for one person that informed on the 22 June 2015 they had sustained an injury in bed whilst being cared for, full time in bed. The record was regarding a GP consultation. Nothing was recorded in the daily records, or the accident records, there was no updated care plan to inform about the injury. We discussed the findings with the acting manager who informed us they were unaware of the injury.

One person who had been identified at previous inspections regarding their pain relief medication was monitored as they were observed requesting pain relief medication in the morning. The person was given

Inadequate

Is the service safe?

paracetamol for their pain relief. The person said to a member of staff that they were still in pain, a member of staff said "You've just had your pain killers". We monitored the person and saw that they were still in pain. There was no monitoring of the persons pain by staff. We looked at the medication administration records for June 2015; the person was prescribed Oramorph but was not offered any and has not had any for a long period of time. This meant that this person was left in pain when appropriate pain relief was available. We discussed this with the acting manager who told us that she would deal with the issue straight away.

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

Inadequate

Is the service effective?

Our findings

We spent time in the lounge/dining area of the residential unit. A SOFI showed staff moving people without consent and they were not explaining what was happening. Staff were observed to walk up to people, did not communicate in any way and moved them in wheelchairs. For example, a gentleman who was moved away from a dining table by wheelchair had staff discussing them without including him. The discussion was that he needed to have a hair cut by the visiting hairdresser. A staff member took him to the hairdressers without once discussing it with him.

We had also found that people's finances were being managed without their consent or the Mental Capacity Act procedures correctly applied.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four people's nutrition care plans; two had incorrectly calculated MUST scores. One persons' record informed that there was no risk when the calculation showed that there was a moderate to high risk that required a dietician referral for the person. The other person's had informed that staff had contacted a dietician but had not taken any action other than that. There was no care plan or information for staff to follow, such as the person requiring a fortified diet due to their weight loss.

We checked all four people's records for diet and fluid monitoring, records were not always completed. Staff were not recording appropriately; records did not always include what they had eaten. The monitoring records were not checked by the acting manager or seniors to ensure an appropriate nutritional intake was in place.

We were made aware of one person who was steadily losing weight and they were buying their own food with their own money as they did not like the food on offer in the home. We could not see that any appropriate action had been taken to support this person.

We monitored the lounge/dining area for over one and half hours on a hot day "hottest day of year so far" no drinks were given to the people sitting in there. A hot drink was offered at 11:30am with lunch being provided at 12pm. We observed snacks were offered but these were not suitable for all people. The plain biscuits were appropriate for diabetics only. We discussed the menu with the cook who told us the budget was £2 per person a day. The Cook said "It's a struggle as this includes all drinks etc too". The Cook writes the menu on a Monday for the week. There was no nutritional assessments as to the suitability of the nutrition of the food for a range of diets as, three people were diet controlled diabetics , four people on fortified diets, two people on a soft diet and one person on a reduced potassium diet. The Cook told us that she did not know how to produce a low potassium diet.

The two people that had been referred to safeguarding had issues due to their food and fluid intakes, one person was admitted to hospital with potential dehydration. The other person was identified at the last inspection as being at risk of poor nutrition. We asked the acting manager to contact the dietician at the inspection on the 24 April 2015, this was not done and no referral was sent to a dietician. The acting manager stated that she asked the deputy manager to do, however they went off on long term sick so no referral was made.

These issues are breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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