Mr David John Dickson & Mrs Leanda Dickson

Elgin Rest Home

Inspection report

12-14 Manor Road
Westcliff On Sea
Essex
SS0 7SS

Tel: 01702340172

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17 May 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a focussed inspection of this service on 10 and 17 May 2017.

When we last inspected the service on the 6 and 10 February 2017 a criminal investigation was taking place following the death of a person who had died shortly after being admitted to the service following their discharge from hospital; therefore we did not fully report the circumstances of the incident. However information shared with CQC about the incident indicated potential concerns regarding the service's pre-admission/admission procedures, the management of medication, emergency procedures and ensuring staff were competent and skilled to effectively fulfil their role. This inspection examined those risks.

Elgin Rest Home is registered to provide accommodation with personal care for up to 17 older people, some of whom may be living with dementia. There were 16 people living at the service when we inspected.

The service had a registered manager who was also the registered provider 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.

Improvements were required to ensure robust pre-assessments were undertaken prior to people moving into the service to ensure people's needs could be met safely by appropriately trained, skilled and competent staff.

Improvements were required to the management of medicines to ensure people received their medicines safely and as prescribed.

Improvements were required to ensure all incidents were thoroughly investigated and lessons learned to mitigate the risk of re-occurrence.

Quality assurance systems had failed to identify a number of concerns we found during our inspection placing people at risk of harm.

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 safe.

Pre-admission and admission procedures were not robust.

Improvements were required to the management of medicines. People did not always receive their medicines as prescribed.

We have not changed our rating from the inspection in February 2017 for Safe from Requires Improvement.

Is the service well-led?

Inadequate

The service was not well-led.

There was no formal analysis of an incident in December 2016 to establish lessons learned or to prevent re-occurrence.

Quality assurance processes were not effective in assessing, monitoring and improving the quality of the service.

Elgin Rest 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 checked 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.

The inspection was prompted following an incident where a person using the service died in December 2016. At our last inspection on 6 and 10 February 2017 this incident was subject to a criminal investigation and our report did not contain detailed circumstances in relation to the incident.

Following information shared with the Care Quality Commission by the local authority and hospital safeguarding teams and the Police, a series of internal management meetings were held. A visit to the service was also undertaken by CQC on the 8 March 2017. Our findings indicated potential concerns about the management and risks associated with:

- Pre-assessment and admission procedures
- Procedures for dealing with emergency situations
- Medication administration
- Safe use of oxygen therapy
- Staff training and induction procedures

Following our comprehensive inspection as part of our ongoing investigation a further focussed inspection was undertaken to follow further lines of enquiry. The concerns raised form part of the following domains: Is the service safe? And Is the service well-Led? Our findings are reported under these two domains.

The inspection took place on 10 and 17 May 2017. The first day of the inspection was announced. We gave the registered provider notice of the inspection as we needed to be sure they would be at the service. The second day of our inspection was unannounced. On both days the inspection team consisted of two inspectors.

During our inspection we spoke with the registered manager and the deputy manager. We also spoke with

one member of staff by telephone on the 11 May 2017 and five members of staff on the 17 May 2017.

We looked at a range of records including seven people's care plans and records, staff training records, three staff supervision records, staff rotas, arrangements for the management of medicines including reviewing 16 medication administration records, a sample of policies and procedures and quality assurance information and investigation documentation specific to the person's death and their personal records were also taken into consideration.

Requires Improvement

Is the service safe?

Our findings

We looked at the registered provider's pre-admission and admission procedures. We checked whether these were robust and that the service completed a holistic assessment of people's care and support needs prior to them moving into the service which included ensuring staff were appropriately trained and had the skills and competencies to safely meet people's individual needs.

The sample of pre-assessment documentation we reviewed for people who had been admitted to the service since December 2016 had not been fully completed and, with the exception of one person, did not contain any information on people's past and current medical histories. This is contrary to the registered provider's admission policy which states, 'Prospective residents' care and support requirements are fully assessed and discussed before admission to the home.' We discussed this with the registered manager who could give no rationale as to why the pre-assessments had not been fully completed. Furthermore with regard to people's medication histories the registered manager's view was that 'the majority of people coming into a care home require medication which they would do'. We were not assured that the registered manager fully understood the need to undertake a thorough assessment of people's needs to ensure they had, at all times, appropriately trained and skilled staff who could safely meet people's needs, particularly those with complex needs.

The admission policy also stated that, 'the home will organise an induction programme for the resident. This programme will be written down'. The policy goes on to say that 'the induction period will last until completed, usually two to four weeks'. With the exception of two 'new service user admission checklists which had been partially completed, we did not see any documentation within people's care records to support that this had taken place. On both the admission checklists we noted the 'Introductions and Orientation' sections had not been completed to show, for example, that people had been informed how to access help and use the call bell system and given information on fire safety procedures and emergency exits. We discussed this with the registered manager who advised the service user admission checklist was a relatively new document however we noted one of the documents we looked at related to a person who had been living at the service since January 2017. We could not be assured that people moving into the service received an induction which included what to do in the event of an emergency to help them keep safe.

At this inspection the registered manager told us the admissions policy was being reviewed imminently and would be updated to include that no hospital discharges or admissions to the service would be accepted after 8pm. They went on to say that this was already in place however this was not reflected in any of the service's policies and procedures and there were no clear protocols in place with regards to late hospital discharges and admissions into the service, or clear information available to staff regarding people with complex needs such as for a senior member of staff to remain on site until it is appropriate and safe to leave.

Senior staff were trained to administer medication and had their competency checked regularly. At the time of the incident in December 2016 there were no staff on duty during the night shift who had been trained to administer medication. At our visit to the service on the 8 March 2017 the registered manager advised this was due to a senior member of staff calling in sick shortly before they were due to start work and there had

been no trained staff available to cover their shift. We discussed with the registered manager the arrangements in place for administering medication during the night, for example PRN (as and when required) medication if a senior member of staff was not working. They told us that people living at the service rarely woke up in the night and, in the event that no senior was on shift, staff could contact a senior member of staff or the deputy manager who both lived nearby and they would come to the service to assist with the administration of medication; there were no written procedures in place for staff to follow in this eventuality. At this inspection the registered manager told us that they were encouraging other staff to complete medication training to circumvent a situation whereby there were no staff available to administer medication. They assured us that there had always been a member of staff working the night shift since December 2016 who had been trained to administer medication.

We requested copies of staff rotas for April and May 2017. The registered manager confirmed these were accurate with the exception of 10 May 2017. On reviewing the rotas we noted two occasions in April when two members of staff had been rostered to work the night shift; no records were available to confirm they were trained to administer medication. We also saw that one of the members of staff had been rostered to work the night shift in May with another member of staff who was not trained to administer medication. When we discussed this with the registered manager they informed us the member of staff no longer worked at the service and had been taken off the rota from May 2017. We asked to see evidence of their medication training however the registered manager was unable to provide this information. We therefore could not be assured that competent staff who were trained to administer medication had worked on these night shifts. Furthermore, the registered provider did not have a formal contingency plan in place in the event that no trained staff were available. We discussed this with the registered manager who advised they had spoken with the deputy manager and that they had agreed one of them would ensure they were at the service should no trained staff be available.

During our inspection we reviewed the Medication Administration Records (MARs) for all the people living at the service. The service used an electronic medication system which recorded and tracked ordering, dispensing, receipt and administration of medicines. We identified that one person had received their prescribed Alendronic Acid medication incorrectly. The prescriber's instructions stated the medication should be given once a week, 30 minutes before all other medications and that the person should be sat upright after the medication had been administered. The electronic records showed that the medication was being given at the same time as the person's other medication. The registered manager and deputy manager could provide no rationale as to why the prescriber's instructions were not being followed and were not aware of the implications of not following the prescriber's instructions correctly.

We found the medication records for one person who had been prescribed aspirin showing 'out of stock' for the period 30 March 2017 to 4 April 2017. Both the registered and deputy managers looked at the electronic medication notes for the person and could give no rationale as to why the person had not received their medication as prescribed. The deputy manager later informed us that according to the dispensing pharmacy five tablets were still available and said that 'the tablets must have fallen when staff popped the box'.

The electronic medication system generated daily management reports which were printed, checked and stored in a dedicated folder. The last report which had been printed was for 24 April 2017. The purpose of the daily management reports was to provide a snapshot of key medicine management measures each day. We reviewed a sample of the printed reports. We saw examples where the reports were showing that 'no stock was available' or 'low stock levels' and, although medication audits were completed we could not be assured that a thorough analysis of the daily management reports was being undertaken to ensure the safe management of medicines.

We saw that topical medicines application records sheets which documented the name of people's creams, site of application, how to apply and frequency of application had been poorly recorded. For example, we looked at topical medicines charts for four people for the month of May. We found no entries had been recorded for two people, for another person entries had only been recorded on 6, 7 and 8 May 2017 and for another for 5, 6, 7 and 9 May 2017. We also found a number of missing entries for another person for the month of April 2017.

When we visited the service on the 8 March 2017 the registered manager informed us they were in the process of drafting a policy on the safe use of oxygen. This policy was forwarded to CQC on the 10 March 2017. With the exception of one member of staff all the staff we spoke with were unaware of the policy. One member of staff told us they had received no instructions on the use and risks associated with oxygen nor had they been informed of the registered provider's safe use of oxygen policy or had been instructed to read it. This was contrary to the service's policy which stated: 'All new staff should be encouraged to read the policy on oxygen as part of their induction process and to be trained to remember that oxygen is potentially dangerous and will strongly support combustion. Existing staff will be offered training covering basic information about health and safety and oxygen. Care staff will be offered appropriate skills training or refresher courses in use of oxygen therapy as identified in appraisal or learning plans and as dictated by their need for continuous professional development.' Staff's supervision templates included a section on new policies which had been introduced since the staff member's previous supervision and confirmation as to whether they had read the policy. Records showed that supervisions held with senior members of staff in April 2017 had not referred to the new policy.

Furthermore, although staff we spoke with were able to tell us the risks associated with oxygen therapy and how to support the person who currently required oxygen therapy, the registered manager was unable to confirm what guidance or training had been provided to staff on the safe use and risks associated with oxygen therapy. Furthermore, they were unable to inform us which staff had received training from the supplier who had installed the oxygen equipment at the service in December 2016 and, more recently, when a person living at the service had been discharged from hospital with oxygen therapy, and how this information had been cascaded to other members of staff. We found no records to demonstrate that the safe use of oxygen therapy had formed part of the induction programme for new staff employed at the service since March 2017 or that other members of staff had been offered training covering the health and safety and use of oxygen.

When we visited the service on 8 March 2017 we noted that following the incident in December 2016 staff had received basic first aid training, had completed a questionnaire on what to do in the event of an emergency and posters were displayed showing the emergency numbers for staff to contact in the event of an emergency. However at this inspection the registered manager was unable to demonstrate that new staff employed since the 8 March 2017 had received this training, had completed the questionnaire or had received oxygen therapy training. We could not be assured that these areas had been completed as part of their induction into the service. Records also showed that one senior carer had not completed the questionnaire. We also saw that ten staff had completed basic life support training however seven staff, including the registered manager and one senior carer, had not completed this.

The above failures demonstrated a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our inspection some members of staff including the deputy manager and registered manager attended in-house end of life training facilitated by the NHS. Following our inspection we contacted the NHS training facilitator who advised they were delivering in-house training to staff such as breathlessness and

terminal agitation and end of life care.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager who was also the registered provider.

During this inspection we identified concerns relating to the governance of the service and how it was being effectively managed to ensure people received safe care and treatment. For example, the registered manager was unable to demonstrate that they had undertaken a comprehensive route cause analysis following the incident in December 2016. Although they had arranged for basic life support training in February 2017, displayed additional posters with information on emergency numbers to call in the event of an emergency and requested staff to complete questionnaires on what to do in the event of an emergency, not all staff had completed these. We could not be assured that lessons had been learnt following the incident or that the registered provider had reviewed and, where appropriate, put effective measures in place to mitigate the risk or potential risk of harm for people who used the service.

The service's pre-admission/admission procedures had also not been reviewed and updated to ensure they were thorough and systems in place to check whether staff had the skills and competencies to safely meet the individual needs of people living at the service prior to their admission.

Although the registered provider had implemented a new policy on the safe use of oxygen following the incident, they had not ensured all staff working at the service were aware of the new policy. Furthermore, we were not assured that new staff employed since December 2016 had received a comprehensive induction programme which included training on the safe use of oxygen.

The registered manager was able to demonstrate to us the arrangements in place to regularly assess and monitor the quality of the service, for example the management of medication; however these audits had not identified the issues we had found.

It was apparent from our inspection that the lack of robust quality assurance processes and the general lack of scrutiny and oversight of the service by the registered manager was a contributory factor to the failure of the provider to recognise potential breaches or risk of potential breaches with regulatory requirements sooner.

This demonstrated a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1) Providers must operation effective systems and processes to make sure they assess and monitor their service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015 (as amended). The provider must have a process in place to make sure this happens at all times and in response to the changing needs of people who use the service. 17(2)(a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) 17(2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.