Seacole's Limited

Pelham House

Inspection report

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19 August 2021

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11 October 2021

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Pelham House is a residential care home providing personal care to 22 people at the time of the inspection. The service can support up to 22 people.

People's experience of using this service and what we found

People were not protected from the risks of avoidable harm. Risk assessments were not robust and did not give staff the required guidance to support people safely. People did not always receive their medicines as prescribed.

There were not enough staff to meet people's needs. An overview of personal emergency evacuation plans had not been updated for five months, despite the service now having a further eight people living at the service since it was last completed. Staff told us there were not enough staff on duty at night and that people's call bells were sometimes ignored.

There continued to be a lack of oversight and scrutiny. The new manager had not received a handover from the previous manager and the auditing systems was ineffective and not robust.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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 Inadequate (published 9 September 2021).
At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the management of risks to people's health, safety and welfare, staffing and management oversight of the service. A decision was made for us to inspect and examine those risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pelham House on our website at www.cqc.org.uk.

You can see what action we have asked the provider to take at the end of this full report.

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 continued breaches in relation to unsafe medicines management, poor assessing and mitigating of risk, inadequate staffing levels, and a lack of leadership and oversight.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Pelham House

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check on specific concerns we had about risks to people's health, safety and welfare, staffing and leadership.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Pelham House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with CQC. 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. A new manager had been employed since the inspection on 4 August 2021. They are referred to throughout the report as 'new manager'.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received since the last inspection. We reviewed correspondence from the provider about how they were planning to drive improvements. We used all of this information to plan our inspection.

During the inspection
We spoke with the new manager, independent care consultant, administrator, human resources staff and two care staff.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We reviewed further care plans and risk assessments. We contacted the provider on the day of the inspection to provide assurances around risk management of catheter care and choking, ensuring staff were competent to administer medicines and for a plan to ensure management oversight of the service.

Inspected but not rated

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 Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns we had about the management of risks to people's health, safety and welfare and staffing. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management; Using medicines safely

At the inspection on 4 August 2021 care and treatment was not provided in a safe way. Medicines were not managed safely. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection further concerns were identified regarding safe care and treatment. The provider remained in breach of Regulation 12.

● People continued to be at risk of harm. On 18 August 2021, a person had a health complication when their catheter bypassed. Bypassing is when the urine cannot drain down the catheter and causes it to leak around the outside of the catheter. Night staff did not contact health care professionals to seek medical attention. Instead, they handed this to the day staff, who then contacted the community nursing team on the morning of 19 August 2021. Timely action is needed when a catheter bypasses as bypassing may lead to skin damage. If action is not taken for longer periods of time this may cause serious infections. This delay to an urgent health complication put the person at risk of further harm.
● We reviewed catheter care records for two people. For one person, admitted to Pelham House in March 2021, there was no record their catheter had been changed by health care professionals since their admission. Staff could not provide any information regarding this. The independent care consultant immediately contacted the persons GP to seek advice. Following the inspection, the new manager contacted CQC and confirmed this person's catheter had been changed in June 2021, however this had not been recorded.
● At the last inspection, on 4 August 2021, we identified a person at risk of choking whose risk assessment noted they received their nutrition via a tube. It was confirmed by staff that no-one at Pelham House received their nutrition this way. During this inspection, a further person's care plan noted, 'Tube feeding should take place whilst [person] is sitting'. Therefore, staff were being provided with incorrect guidance on how to provide support. The new manager confirmed no-one was supported in this way and the risk assessments would be updated.
● Risk assessments relating to people's catheter care were not detailed to give staff the guidance they needed to provide people with the right support. Risk assessments relating to the risk of choking were not detailed. There was no information about what staff should do if a person began to choke. This left people

at risk of harm.
● People were not supported with their medicines by skilled, knowledgeable and competent staff.
● At the last inspection on 4 August 2021, we identified significant medication errors. Following the inspection on 4 August 2021, no immediate action was taken by the registered manager to address the significant medicines concerns identified. Medicines training and competency assessments had not been completed to make sure staff were safe to administer people's medicines. Since the last inspection we found a further serious medication error, by a member of staff who had previously made errors. This delay in taking action meant medicines errors continued and people were at risk of harm.
● When a new manager was employed, they stopped staff using the electronic medicines recording system and reverted back to paper records. They had implemented a daily medication check to make sure any errors could be identified and acted on quickly. Following these checks being implemented, one person was identified as not being administered their Parkinson's medication for five days. This serious error may have been identified earlier had immediate action to check medicines management been implemented following our inspection on 4 August 2021. Advice was sought from health care professionals and, on this occasion, the person did not suffer any adverse effects. Not administering this medicine put the person at risk of experiencing an increase in Parkinson's symptoms, such as tremors, rigidity and problems with balance.
● The new manager told us they had not been able to find any evidence of staff competency assessments. They said staff were not competent in administering medicines and that e-learning training was not enough to be assured of their competence. Following the inspection, the independent care consultant confirmed face to face medicines training had been arranged for staff.

Care and treatment was not provided in a safe way. Medicines were not managed safely. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment

At the inspection on 4 August 2021 the provider failed to deploy sufficient numbers of suitably qualified, skilled and experienced staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider remained in breach of Regulation 18.

● At this inspection, the new manager had increased the numbers of staff by one on the day shifts. There were four staff on duty throughout the day. However, only two staff were deployed at night.
● We spoke with the new manager about our concerns as to how 22 people would be safely evacuated from the building in the event of an emergency, such as a fire. The new manager agreed with the concerns we raised and took immediate action for a member of agency staff to work on the night shifts. This was arranged for a month.
● The provider's overview of personal emergency evacuation plans had not been updated since March 2021. At that time, it noted there were 14 people living at the service. Six of these people were noted as immobile and a further two as needing assistance to leave the service safely. This should be kept up to date as people are admitted to the service and when people's needs change.
● Staff told us, when two staff were providing support to a person, if a call bell went off, it was ignored as they "Cannot be in two places at once". At least seven people living at Pelham House required the support of two staff to meet their needs. This meant people's needs were not consistently met in a timely way.

The provider failed to deploy sufficient numbers of suitably qualified, skilled and experienced staff. This is a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems and processes to safeguard people from the risk of abuse

At the last inspection on 4 August 2021 people could not be assured they were protected from the risks of abuse.

● At this inspection we reviewed an incident form dated 16 August 2021 which had been completed by a senior carer. This noted a person had slapped another person round the face. There was little detail about the actions taken and no information about how to prevent this happening again.
● We discussed this incident with the new manager. They told us they had not been informed of the incident, which they would usually review to make sure the right action and, if needed, relevant health care referrals had been made. This lack of reporting in line with the provider's processes meant the new manager had not informed the local authority safeguarding team or CQC.

The provider failed to establish and operate systems and processes to prevent the abuse of service users. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inspected but not rated

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 Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check specific concerns we had about the management oversight of the service. We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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

At the last inspection on 4 August 2021 the provider had failed to operate an effective system to assess, monitor and improve the quality and safety of all areas of the service. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection we found further concerns regarding the management and oversight of the service. The provider remained in breach of Regulation 17.

● The provider, who was also the registered manager, had not taken immediate action following the concerns raised at the inspection on 4 August 2021. Plans to make urgent improvements to address the identified shortfalls, to ensure people were safe, had not been implemented. For example, staff had not refreshed medicines management training and had not been competency assessed. Staff continued to make medicines administration errors which placed people at risk of harm.
● Since the last inspection on 4 August 2021 the manager had left, and a new manager had been employed. The provider did not ensure there was a comprehensive handover. Inspectors were informed there had been no handover at all. The new manager told us, "We cannot benchmark anything, as we cannot find anything".

● During this inspection we identified staff had not taken timely action to contact health care professionals with regard to people's catheter care. A further risk assessment about a person at risk of choking was found to contain incorrect guidance for staff which could put the person at risk of harm. Staff had not reported a safeguarding incident to the new manager, in line with the providers processes. This lack of action and incorrect guidance left people at risk of avoidable harm.
● An independent care consultant was working with the new manager to provide additional support with implementing a new auditing system. The new manager and independent care consultant told us they were having to start from scratch and put new checks and audits in place. They felt the current systems were 'a mess'. □
● The new manager told us, "Information needs to be accessible to staff and readable. We are working

through things that [staff that have left] started but did not finish. It is chaotic".

● The new manager and independent care consultant were providing on-call support to provide staff with advice and guidance outside normal hours. The new manager told us, staff were contacting them and had not felt they could do this with the previous manager.

● The new manager had begun to take action to improve processes and checks. For example, the management of medicines was now being reviewed daily. Staff competencies were to be checked to make sure people received their medicines safely. Although there were plans to improve auditing processes, these were not in place at the time of the inspection. This meant the provider could not be assured the quality and safety of the service were effectively monitored. We will continue to closely review this and check the effectiveness of this through reviews and at our next inspection.

The provider had failed to operate an effective system to assess, monitor and improve the quality and safety of all areas of the service. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014