Saffronland Homes 2 Limited

Glen Rose

Inspection report

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Date of inspection visit:
04 March 2019

Date of publication:
16 May 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Glen Rose is a residential care home that was providing personal and nursing care to 15 older people at the time of the inspection. The majority of people living in the home were living with dementia as well as physical health needs. Early into the inspection, the inspection team were informed by members of the senior management team for the provider, that the provider had made the decision to close the care provision at Glen Rose and that they would be working with the Local authority to ensure a 28 day closure programme was arranged.

People's experience of using this service:
• At this inspection we found the service was not well led. It lacked a person-centred focus, managers lacked a clear understanding of regulatory requirements and governance systems were not operated effectively so concerns were not always identified and acted upon. This meant people were not always safe.
• We found people were not always protected against the risk of abuse or avoidable harm because the registered persons had not ensured concerns were always reported to the local authority and had failed to complete prompt and through investigations into unexplained injuries.
• People were put at risk of receiving unsafe care and treatment because risks associated with people's care were either not assessed, lacked effective plans to reduce risks and when they were in place staff failed to always follow these.
• People were put at risk of receiving unsafe care and treatment because a high number of agency staff were being used and the registered persons had failed to ensure they had received sufficient information to be confident they were safe and trained sufficiently to work with adults at risk. In addition, registered persons had failed to ensure all agency staff had access to information they needed to understand and support people living in the home. At times we could not be confident that sufficiently skilled staff were available. We have made a recommendation about the assessment of staffing levels and skill mix, as well as the deployment of staff.
• The service met the characteristics of inadequate in the areas we looked at; more information is in the full report.

Rating at last inspection:
This was the first inspection of the service since the provider changed in January 2019.

Why we inspected:
In January 2019 the provider of this service changed, however no changes were made in terms of the individuals running and managing the organisation. The Commission had been made aware before the inspection of a number of concerns about the safety and quality of this service.

Follow up: Following the inspection we shared our concerns with the local authority. The provider also submitted a notification to advise us that they planned to close the home as of 12 April 2019 and were working with the local authority to ensure people moved safely to alternative and appropriate accommodation. We continued to liaise with the provider and local authority throughout this process.

Enforcement: We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

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.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Glen Rose

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 in part by concerns we had received about the management of the home and so we focussed on the key questions, Safe and Well led.

Inspection team:
The inspection consisted of two 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. This person had personal experience of caring for people with dementia.

Service and service type:
Glen Rose is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection:
The inspection was unannounced.

What we did:
Before the inspection we reviewed information, we had received about the service since the last inspection. This included details about incidents the provider must notify us about, for example, injuries that occur in the service and any allegations of abuse. We also requested feedback from two health care professionals.

Some people using the service were not able to verbally express their views about the service. Therefore, we spent time observing interactions between staff and people within the communal areas of the home. We spoke to four people, five relatives/friends, 11 members of staff, the registered manager, general manager and nominated individual. We looked at the care records for seven people and the medicines records for nine people. We also looked at four staff recruitment records; five agency staff records and records relating to the quality and management of the service.

Following the inspection, we requested further information regarding agency workers training, policies and some measures of support for people. We didn't receive everything we asked for.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People and their relatives told us they felt safe at Glen Rose. One person told us, "Yes. People keep an eye on you" and a relative said, "Yes, she's safe and warm and comfortable". However, we found people were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse:
• Appropriate systems were not operated to protect people from the risk of abuse.
• Incidents had occurred which may be of a safeguarding nature, for example an unexplained serious injury. However, the registered manager had failed to report this to the local authority responsible for safeguarding and to CQC. They had also failed to promptly and thoroughly investigate unexplained injuries. This meant people were at risk because appropriate external authorities were not always notified of what was happening in the service.
• Staff had received training and we saw evidence that some allegations of abuse were reported to the local authority and risk assessments implemented. The registered manager had not ensured the risk assessments were readily available and there was a lack of oversight to ensure risk assessments were adhered to. This meant we could not be confident that appropriate measures were operated to keep people safe from avoidable harm and abuse.

The failure to operate effective systems and processes to prevent abuse or investigate concerns of a potential safeguarding nature was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management:
• People were not always protected against risks associated with their care and support because risk assessments were either not in place, appropriate or adhered to.
• Prior to the inspection, the registered manager had informed us about a person who had been losing weight and told us that the practice nurse had requested the 'GP to come and review and set up contingency plan for further treatment as patient was refusing diet and fluids and medication'. Although the GP had visited this person, the registered manager had failed to ensure the person's care plans and risk assessments reflected a contingency plan. Although their weight was starting to stabilise, their care plan contained no information to ensure staff were aware of the risk of not eating or what to do to manage this. In addition, there was no guidance to encourage staff to offer a high calorie diet or regular snacks. A member of staff told us this person was not on a fortified diet and said they entice them to eat anything they want to, for example chocolate. They also said they leave food with her (i.e. do not remove their plate) as they may eat later. However, this was not in the care plan or on the handover sheet. On occasions unfamiliar agency staff were working in the home and one told us they had not received a verbal handover from staff about people. A permanent member of staff told us how there had been incidents where they had had to intervene because agency staff had provided people with the wrong food.
• Similar concerns were identified for another person who had lost approximately 10kgs in weight and there

was no evidence to show that any action had been taken to address this. The registered manager was not able to provide any evidence. The clinical lead told us that this person had been previously very unwell and so they were not concerned about the weight loss. They said this person's health had improved in December 2018. However, there was a failure to recognise their ongoing weight loss act upon this. Following the inspection, we received information that told us the persons GP had since been made aware.
• One person had been assessed as needing raised seating. The use of raised seat helps people with mobility issues to stand up easily as well as helping to prevent complications following hip surgery. We observed that this person was not seated in a raised chair when in the communal areas of the home and a raised seat was not available in their bathroom. The registered manager told us the staff had forgotten to move the raised seat for the bathroom when the person changed bedrooms. However, this person had moved bedrooms five days prior. A failure to ensure appropriate seating for this person could place them at risk of falls or injury.
• A third person required support with their mobility and using a hoist caused them significant distress. We observed this person being supported to move using a hoist. This was carried out inappropriately and unprofessionally. The support provided to the person by staff failed to reduce their anxiety, which placed them at risk of becoming injured. Their care plan was unclear and provided inaccurate and unsafe information to staff. For example, it stated that the person may prefer to use a 'rotunda' (a piece of equipment that a person who is able to can use to help them turn). However, this had been assessed as unsafe by an external professional. In addition, it failed to address how to manage this person's anxiety. The lack of effective assessment and mitigation planning around this person's moving and handling needs placed them at risk. Records that were held in the home for agency staff were not always present and those that we viewed, suggested that training such as moving and handling was not up to date and we could not be confident the registered manager or provider had assured themselves that these staff were trained and competent. Following the inspection we were sent some evidence of training but not of competency assessments.
• In addition, this person remained seated in a hoist sling throughout the day. The care records demonstrated that this person had been assessed at high risk of skin breakdown as a result of pressure damage and although the registered manager told us this sling was appropriate to be seated in, they were unable to provide us evidence to confirm this. In addition to this, there was nothing in the person's care records to explain the rationale for the sling to be kept in place, which could increase the risk of skin breakdown. Staff told us this was because it was difficult to put back in place due to behaviours which presented challenges.
• This person was also living with a number of health conditions, including diabetes and was known to become unresponsive on occasions. We found two recent entries in their records showing that this had occurred. The registered manager told us the unresponsive episodes occurred when the persons anxiety was high. Despite this no risk assessment had been undertaken and no plan of care developed. Although a communication care plan stated that staff would try and divert the persons attention when they were agitated, we did not observe staff doing.
• Despite registered nurses being present on these occasions we found they did not always undertaken this persons clinical observations, when they were found unresponsive, before calling emergency services. Clinical observations help nurses and other medical professionals to identify early, a deterioration in a person's health. If a person was unresponsive it would be expected that a registered nurse undertakes these observations to inform their clinical assessment and decision making.

The failure to ensure risks for people were appropriately assessed, plans developed to mitigate the risks and these plans were adhered to, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:
• Three of five relatives told us they felt there was not always sufficient staff. One told us, "There's never

enough staff anywhere. But they're always busy, you never see anyone just standing about". A second said, "Not always. They rely on agency staff, especially at weekends and then it's quiet, nothing happens, there's no activities". A third relative said, "No, there aren't. They're not always available. They're busy. If there were more, they'd get things done quicker. They come and say they'll be there in a minute. I know they're busy, but [person] doesn't. She thinks they're not coming".
• A staff dependency tool was used and the registered manager told us this was completed by the general manager and sent to them. Whilst this reflected more staff to provide direct care were in place than needed, we noted a significant number of these staff were agency workers. The registered manager told us some of these were seconded from agency providers and worked consistent hours in the home.
• Although the number of staff on paper suggested that this was appropriate to meet people's needs there were occasions when we observed appropriate staff were not available for people.
• For example, we were told about one person who turned off a sensor alarm in their room that would alert staff to their movement. This person's mobility had deteriorated, they were at risk of falls and had recently suffered a serious injury. Care plans stated they should be checked hourly at night and half hourly during the day, however the daily records did not confirm this was happening During handover, staff were made that the alarm may not be working and told to attend to this person immediately they stood up. We found this person, alone in the corridor without footwear on. Their sensor alarm had not sounded and staff had not noticed their movement. We were required to find staff.
• On another occasion, whilst on the first floor we noted that no care or nursing staff were present to support those in their rooms. The floor was being manned by a cleaner who then asked the maintenance worker to cover the floor. A member of staff told us this took place to enable the two members of staff allocated to the first floor to provide personal care to some people living on the ground floor and that the non-care staff would pull the emergency alarm if they were concerned.

We recommend the provider seek guidance from a reputable source about the assessment of staffing levels and skill mix, as well as the deployment of staff.

• Safe recruitment practices were operated for permanent staff, however the registered manager had failed to ensure there were records provided from the agency for all of these workers, confirming their appropriateness to work in the home.

Learning lessons when things go wrong:
• Prior to our inspection we were alerted to two medicines errors that had occurred. The registered manager provided us with information which suggested agency nurses were involved in one significant medicines error and permanent staff in the other. They told us about the action they were planning to take to reduce the likelihood of reoccurrence. Although we saw the checks of medicines had been implemented, the investigation had failed to recognise that an area of learning was to ensure that the agency nurses were competent in medicines management. The registered manager provided no evidence of agency nurses competency having been checked when we requested this. Although we did receive four of five that we requested following the inspection. These demonstrated that nurse involved in the error, competence had not been reassessed following the incident.
• In addition, whilst it was known that a person was at high risk of injury as a result of falls, was known to be turning off their sensor alarm mat used to alert staff to their movement. No learning had been taken and no alternative measures implemented.
• Investigation into injuries did not support learning from incidents. We had been made aware of injuries sustained in the home and noted the investigations were a timeline of events rather than identifying why this had happened and how it could be prevented. Although we saw some measures had been implemented for one person, such as the use of a crash mat. The risks associated with the use of the crash mat had not been assessed. For example, to ensure it would prevent injury and not increase the risk of falls

further.
•A failure to effectively evaluate and improve practice to ensure the safety of people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:
• The management of medicines was safe and people told us they were given their medicines when they needed them.
• Storage of medicines was safe. Locked trolleys and a medicines fridge were stored in a locked room and the temperature of medicines storage was monitored daily to ensure it was within safe limits.
• Where needed the opening dates of medicines was recorded and monitored to ensure they were not used outside of their expiry times.
• Records were maintained to show when medicines had been administered and for medicines that were prescribed on a PRN basis, guidance for staff on when to administer or escalate the use of these to a GP were in place.
• A number of auditing systems were in place and operated effectively to monitor the administration of medicines.

Preventing and controlling infection:
• Staff received infection control training.
• Staff had access to and used appropriate personal protective equipment.

Inadequate

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness:
• Although elements of person centred care was contained in care records it was not always apparent that this was translated into care provided. For example, staff failed to offer reassurance and distraction while supporting a person in distress during a moving and handling procedure.
• Staff were observed to be bickering between themselves throughout this transfer.
• On another occasion, a staff member was seen to move a person in a wheelchair without discussing this with them or given them prior warning they would be moving. This had the potential to cause anxiety and confusion for the person who had not been made aware they would be moving.
• On a third occasion a staff member was observed using their personal mobile phone in a person's room who was trying to seek reassurance from the staff member.
• On a fourth occasion while discussing with a staff member why the head of a bed was raised, the member of staff told us that it distressed the person lying flat and then said they would demonstrate this. Consideration had not been given to the person who was lying in bed
• One member of staff told us, "I think we do have quite a high turnover of staff" and when communicating with agency staff, "getting the message across can be quite difficult, takes a while getting to know people (who live in the home)". The staff member told us, "Sometimes with agency we've had to jump in with them giving them the wrong food, so far they have been caught in time and we haven't had any incidents" but it "Could happen". Agency staff were regularly used in the home and not all of these were regular agency staff. One told us it was their second shift at Glen Rose and that they did not have access to people's care plans which were only available to staff on the computer and they also told us they had not received a handover.
• These incidents demonstrated that person centred care was not always at the forefront of the service's thinking and practice.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, and duty of candour:
• It was not evident managers understood their role in relation to regulation, safety and quality.
• Staff, including a senior member of staff were unable to tell us what Duty of Candour meant and how this applied to their day to day work.
• The registered manager told us there had been no incidents where Duty of Candour applied. However, two people had sustained a serious injury and a medicine error had been identified.
• The registered manager told us verbal apologies only had been given for the medicines error but did not provide any evidence to confirm this. Duty of candour requires providers to be open, honest and transparent about their service. We could not be assured that the provider consistently applied the principles of Duty of Candour.

Failing to apply duty of candour to these incidents was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Registered persons are required to notify CQC of incidents including allegations of or actual abuse and serious injuries. We found a serious unexplained injury had not been reported. The registered manager told us they hadn't reported the injury because it wasn't a broken bone. A failure to notify CQC means we did not have access to relevant information to enable us to accurately assess any risks in the service or ensure other authorities were aware.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

• Despite numerous audits being completed which covered safeguarding issues, incidents and accidents, these had failed to identify that an unexplained serious injury and an incident of physical aggression from one service user to another had not been appropriately reported to the local authority or to CQC. They had also failed to identify that an unexplained serious injury had not been investigated. A senior management audit in February 2019 had also failed to identify these issues of concerns and take action to ensure they were reported to the appropriate external authorities, investigated appropriately and acted upon appropriately.
• Although clinical audits were completed monthly the registered manager and senior management team had failed to identify that no action had been taken for one person with continual significant weight loss.
• Suction equipment stored on the first floor was kept in a dirty box and the catheters that would be used in the event this machine was needed were out of date. They had expired in September 2018. Despite being checked on a weekly basis, this had not been identified and acted upon.
• Despite care plan audits, there was a failure to identify the concerns we had found regarding assessing risk and development mitigation plans.
• The registered manager had failed to ensure that risk assessments were available to staff, as following an allegation of abuse made, the risk assessment remained in their office, six days after the event. In addition, they had failed to operate a system of checks to ensure risk assessments were adhered to.
• The registered manager and provider had failed to identify through a quality assurance framework, the lack of records confirming all agency workers appropriateness to work in the home and their current training. They had also failed to ensure that appropriate records were maintained for accidents or incidents that occurred in the home. For example, no accident or incident record had been completed for a person's serious injury.

A failure to operate effective systems and processes to ensure the safety, well-being and quality of the service, and ensure clear and accurate records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• It was not evident people were involved in the development of their care plans or in the service.
• No meetings with relatives or people had taken place since the provider had changed in January 2019 although the registered manager told us she had planned one for March 2019.
However, feedback had been sourced via surveys. The general manager had only received the feedback the day of our inspection and told us they planned to implement an action plan as a result of this. In addition, relatives and people told us they felt the registered manager listened to them and took action when they raised concerns.
• Staff feedback had also been sought and an action plan developed as a result, however no dates had been assigned for completion of the actions and no one had been assigned responsibility for ensuring the actions

were completed.
• Staff told us they felt listened to and supported. They said they could talk to the registered manager and general manager at any time.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered person had failed to notify CQC of all significant events that occurred in the home. Regulation 18.

The enforcement action we took:

We served a fixed penalty notice on the provider for failing to comply with the Care Quality Commission's (Registration) Regulations 2009. Fines totalling £1250 have been paid as an alternative to prosecution.