Songbird Hearing Limited

Charing Court Residential Home

Inspection report

Charing Court
Pluckley Road
Charing
Kent
TN27 0AQ

Tel: 01233712491

Date of inspection visit:
25 January 2018

Date of publication:
21 March 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 January 2018 and was unannounced.

Charing Court Residential Home 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. Charing Court Residential Home accommodates up to 33 older people in one adapted building. There were 25 people living there during our inspection. Some people lived with dementia and/or other conditions such as diabetes, epilepsy or impaired mobility.

There was a registered manager in post, however they were not available at the time of inspection and the day to day running of the service was being overseen by a consultant. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.
The service was last inspected in August 2017 when it was rated as 'Requires Improvement' overall. Five breaches of Regulation were identified during that inspection. These related to person-centred care planning, management of risks; including those associated with medicines, complaints handling, lack of efficient oversight and auditing and failure to notify CQC of certain events. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) Safe, Effective, Responsive and Well-led to at least good.

At this focused inspection, we looked at Safe and Well-led domains and found that standards had deteriorated since our last inspection; which meant people remained at risk of receiving unsafe care and treatment.

Risks to people had not been properly assessed or addressed; including those associated with epilepsy, medicines and the possible spread of infection. Processes designed to keep people safe from harm and neglect had not been consistently followed by the registered manager to make sure people remained safe and well cared for. Staff knew their responsibilities in this regard. Some staff had raised concerns and these had been addressed by the provider. However, the concerns were not shared with the local authority.

Audits to monitor the quality of care had not been completed and the provider did not have oversight of the service, relying solely on feedback from the registered manager. Audits relating to medicines had not highlighted the concerns found at this inspection. Information provided to CQC in the provider's action plan following the previous inspection about changes made to resolve breaches of regulation was inaccurate. People's records had not always been completed fully or updated when required.

The registered manager had not informed CQC of particular events such as deaths, in a timely fashion. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a

rating has been given. A previous rating from 2105 was on display in the service when we arrived.

There were enough staff to meet people's needs during the inspection and changes had been recently made to respect people's rights and choices about getting up in the mornings. Staff worked closely with other professionals such as district nurses to meet people's needs.

The premises and equipment were routinely checked and servicing had been regularly carried out where necessary. The risks to people in case of fire had been assessed and documented within individual evacuation plans.
After the inspection the provider sent us evidence of the changes made to improve the service and address, some of the concerns raised at this inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

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.

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.

Risks to people had not been properly assessed and reduced; including those associated with medicines and infection.

Safeguarding processes had not been followed to ensure people were kept safe.

Recruitment processes were not suitably robust.

There were enough staff to meet people's needs during the inspection.

The premises and equipment were properly maintained.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have oversight of the service.

The provider and registered manager had not completed audits to monitor the quality of the service and medicines audits had not highlighted issues found on inspection.

Staff had not felt supported or able to give their views, this had recently improved.

People's records were not completed fully and were not updated when required.

There was no culture of learning or drive for improvement.

Charing Court Residential 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection focused on whether the service was safe and well-led. It took place on 25 January 2018 and was unannounced. The inspection was carried out by two inspectors and was prompted by information of concern received from a number of sources. We were also aware of an incident which had a serious impact on a person using the service and this indicated potential concerns about the management of risk at Charing Court Residential Home. The incident involved an allegation made by a person that they had been roughly handled by a staff member, resulting in bruising. The Police and local safeguarding authority were investigating this allegation at the time of our inspection. While we did not look at the circumstances of the specific incident, which may be subject to a criminal investigation, we did look at associated risks.

We did not ask the provider to complete a Provider Information Return (PIR), because the inspection was brought forward due to our concerns. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with five of the people who lived at Charing Court Residential Home and spoke with two people's relatives. We also spent time observing the support people received. We inspected the service, including the bathrooms and some people's bedrooms. We spoke with three of the care workers, the provider and the

consultant working in the service.

We 'pathway tracked' five of the 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 in the service where possible, and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

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

Inadequate

Is the service safe?

Our findings

People and relatives told us that the service was safe. A person told us "I'm alright, the girls [Staff] come to me if I need them" and a relative said "Mum has everything she needs and is very well looked after."

Despite these comments, we found that people were not safe at Charing Court Residential Home.

At our last inspection, not all known risks to people had been effectively minimised. This included risks associated with epilepsy, medicines and the spread of infection. Regulation 12 was breached in relation to these areas and had not been sufficiently met at this inspection.

At our last inspection staff told us that two people had been diagnosed with epilepsy. At this inspection staff said there was now only one person with this condition. However, in our review of care plans we discovered that there were two people with epilepsy. It was concerning that staff were not aware of this, as they may not recognise seizure activity and take appropriate action. Following our last inspection there was now some information in care plans about the condition, but this was not individual to each person and advice about how to deal with a seizure had been printed off the internet. Epilepsy can take different forms and care plans did not detail how seizures may present or specific information about each person's seizure history.

At our last inspection, staff had not received training about epilepsy. Following that inspection the registered manager had contacted CQC to tell us that all staff had received training. However, we found that only half the staff had been trained about the condition, with the remainder booked on courses in February 2018. The deputy manager and some senior care staff had not received epilepsy training at the time of our inspection. The consultant working in the service told us that there were enough staff trained to ensure that one was on each shift, but the lack of proper care plan guidance continued to create a risk that people may not receive appropriate care and treatment.

At our last inspection, medicines had not been safely managed. At this inspection, the areas we highlighted previously had not been addressed, leaving people exposed to risk.

Handwritten entries continued to be made on medicines administration records (MAR) without these being checked and signed by two staff to ensure their accuracy. There were still no detailed protocols about medicines people could take as and when they needed them (PRN). PRN protocols help to prevent the risk of people being given too much of their medicine by documenting the maximum and minimum doses, gaps between doses and the limit to be taken in any 24 hour period.

Liquid medicines had not been dated on initial opening so staff knew when they should be disposed of. This was an issue at our last inspection and had not been resolved. Although the temperature of the medicines room had been recorded daily and had not exceeded the recommended maximum of 25 degrees in the last month, no action had been taken to remedy the problems that had caused the temperature to rise beyond acceptable limits in warmer weather. The registered manager had told us that they would look at purchasing a cooler unit following our last inspection, but this had not happened. In addition to the

unaddressed issues from our last inspection, the medicines fridge needed to be defrosted as there was a large build- up of ice inside it; which could make it less effective over time. Following the inspection the provider sent us evidence of a new air conditioning unit and a new medicines fridge in place in the service. Not all people's medicines had been appropriately signed as administered on the MAR. One person had not received one dose of their prescribed medicine two days before our inspection. Staff had not picked up on this, even though the missed tablet remained in the blister pack and could be seen there by staff giving subsequent doses. Another person had not received their heart medicine on five days in January 2018. There was no explanation for this recorded on the MAR but staff said that they believed this was because the person had experienced swallowing difficulties. After the inspection we were informed by the provider that the medicine had been stopped due to the person being unwell. However, there was no documentation available to evidence this change. Other people's MAR had not been signed by staff on some dates but our checks showed they had received the medicine.

Medicines about which there are specific legal requirements were not being correctly stored. The cabinet designated for holding these medicines also contained items such as head lice treatment, crepe bandages and jewellery items. The register for administration of the medicines had however been properly completed and signed by two staff each time people were given these medicines. Following the inspection the provider sent us evidence that the cabinet for medicines with special legal requirements was only in use for those items.

Prescribed creams were not stored safely. These were seen on shelves in people's bedrooms and one bathroom had different people's creams on the windowsill. Some of the labels on these creams had worn off so it was not possible to see who they had been prescribed for, or the application directions. Other creams found were prescribed for people who were now deceased. Staff told us that at least half of the people using the service were living with dementia. No assessments had been made about the potential risks to individual people of being able to access these creams. There was a risk that some people might apply more creams that they should or to the wrong areas, or to ingest them. Records about cream applications showed that some people had not received consistent benefits from their prescribed creams. For example, one person who was being cared for in bed, had creams to be applied to their sacrum twice daily. At the time of our inspection on 25 January 2018, the last record of cream application was dated 20 January 2018.

At our last inspection we highlighted infection risks. At this inspection some of these remained and others had emerged. While the service appeared to be clean and smelled fresh, open waste bins were still in use in toilets and bathrooms. Used sanitary items were seen in some bins and could be easily accessed by people living with dementia. During the inspection the provider placed an order for suitable bins throughout the service. Used latex gloves were seen on the drainer in the sluice room and records showed that this room had not been cleaned since 20 January 2018.

A box of deodorants in one bathroom had no name labels on them and bath 'scrunchies' were found in other bathrooms. Staff were unable to say which people these belonged to, so there was a risk they could be shared between people; which could spread infection. We asked the consultant to remove a box of used disposable razors from this bathroom, some of which were rusty; and all were unlabelled so it was not possible to identify their owners. Aside from the risk of infection it was unsafe to store razors within reach of people living with dementia. There was also an unlabelled hairbrush in the shared bathroom and staff could not tell us who it belonged to. Staff told us later in the inspection that some people had had head lice recently; and there was a minor risk that this could be spread through shared use of hairbrushes.

At our last inspection catheter care plans were not sufficiently detailed to include guidance about cleaning

of equipment and the catheter site. At this inspection, generic information had been printed about catheter cleaning and was placed in people's care files. However this was not individualised, and one female person had guidance which related to the male body.

Foodstuffs, including meats, stored in the kitchen fridge had not been properly covered or labelled to show when they were cooked so that they could be used within reasonable timescales or disposed of. Some items such as yoghurt and a cucumber had exceeded their use by dates but remained in the fridge where there was a risk that people may be given them to eat. The cook told us they would go through the fridge and throw away any foods that should not be there.

The failure to safely manage risks to people is a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some people showed behaviours that could challenge. Individual care plans were in place about this, but had not always been updated to show recent events. There was no information about triggers to the behaviour but behaviour charts were maintained by staff and there was evidence that people received input from community mental health teams and medicine reviews. Other risk assessments about falls, communication and personal care were detailed and provided detailed guidance to staff about how to provide care safely.

At our last inspection, some recruitment processes were identified as an area requiring improvement. At this inspection we continued to have concerns about processes and records for some staff. We reviewed only files of staff who had been recruited since the last inspection. The provider and consultant were unable to locate any recruitment information for one staff member. This meant there was no evidence available to show this staff member had all necessary pre-employment checks; including criminal and background clearance in place. The provider assured us that this staff member would not work in the service until these checks were found or re-done. Another staff's recruitment file showed that a reference had not been sought from their most recent employer but a more historic one. The reference received was not a positive one, but this had not been followed up in any way. The provider told us that references would have been sought from this staff member's most recent employer, but there was no evidence on file to show this had happened.

The lack of a robust recruitment process is a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Other recruitment files held details of any gaps in employment history, identity information and a record of background checks and references.

All staff had received safeguarding training and were able to describe how they would recognise abuse or neglect. There was evidence that staff had raised concerns to the registered manager. One staff member had written to the registered manager to detail their concerns about three staff, who they alleged, had been neglectful of people's needs during the night shift. The registered manager and provider had carried out their own internal investigation about this, but the issues raised had not been discussed with the local safeguarding authority or CQC. They had not therefore been able to consider conducting their own independent inquiries into the allegations; to ensure people were being kept safe.

Accident and incident reports had been properly completed by staff appropriate action had not been taken to review known risks and people's safety: one recent record showed that a person had got out of bed, used the lift and left the building alone during the night shift. They were found by staff in the courtyard and the gates to this were locked. The local authority informed us this had happened before, yet there were no

records of the steps that had been taken to prevent a reoccurrence of the incident. Although the provider had fitted pin coded locks to minimise the risk of the person leaving unsupported, the second occurrence happened when the person ascertained the code. No risk assessment or guidance had been put in place to minimise the risk of this happening again.

The failure to operate a robust safeguarding process is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During this inspection there were enough care staff deployed to meet people's needs. The provider used agency staff to cover any sickness or annual leave. The provider's consultant told us how they had made changes to the way staff worked over the last week because previously people were being got up in the mornings at times to suit staff and not in line with their personal preferences. The consultant and staff said that the new system was working much better and meant that people's rights and choices were taken into account. One person told us "Staff come and get me when I'm ready and I can have my breakfast a bit sooner". Staff had received recent training about equality and diversity and the changes made by the consultant evidenced that people were being treated as individuals.

At our last inspection, some corridors were found to be very dark because lights had not been switched on by staff. At this inspection the situation had been resolved and all passage ways and corridors were well-lit. Fire exits were clearly marked and safety checks on fire equipment and lighting had been routinely carried out. People had personal emergency evacuation plans (PEEPs) which identified any specific risk to them and how many staff would need to support them to leave the building. All other servicing of equipment and utilities had been regularly undertaken to ensure people lived in a safe environment.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found a number of issues relating to the oversight of the service, a lack of auditing and statutory notifications not been submitted.

At this inspection we found further issues. The provider told us they had not implemented any audits to gain oversight, but had continued to rely on information gain from phone calls with the registered manager. As a result they were unaware of a number of concerns identified at this inspection. The provider had seen an action plan provided by the registered manager following the inspection in August 2017, but had failed to address inaccuracies. For example, the document stated that activities for people were developed by a dedicated member of staff. The provider confirmed there had never been a member of staff employed in this role. Following concerns being raised by a number of staff the provider had recently employed a consultant to review the service and support improvements.

No audits of care had been completed by the registered manager since the last inspection. Medicine's audits had been completed, but had not identified the continuing issues found on inspection. Staff files had not been audited and it had not been identified that staff were working at the service without all the required checks being completed.

People's care plans were reviewed monthly, however this had not identified when people's needs had changed. For example, one person had become very unwell in December 2017 and now stayed in bed requiring full support with all personal care needs. The person's care plan had not been updated to show the change in needs or what support they now required. Risk assessments had not been reviewed or updated as a result of the person's changing needs.

Documents relating to people's support were held in a number of files, stored in a variety of locations throughout the service. Staff told us there was some information they could access freely but other files, including people's care plans were secured in the deputy manager's office which they could not access without the support of the deputy or consultant.

Each person had a 'falls' record in their care plan. However the subsequent falls audit was a chart of how many people had fallen on each day. No analysis had been completed and there were no records of any actions taken and their effectiveness. For example, one person had recently had a number of falls, we asked what action had been taken to minimise the risks of them falling. After some time the consultant told us, "Staff said they had put a crash mat in place." This information was not recorded in the person's care plan and there was no plan to see if this reduced the impact or occurrence of falls.

People were asked for feedback using a survey, however these were not dated and neither the provider nor their consultant could tell us when they were completed. The results of the surveys had not been analysed or shared for learning. We requested the minutes of any resident's meetings which had been held, no minutes could be found.

The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. The provider and registered manager had failed to make suitable arrangements to involve people and had failed to maintain accurate and complete records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables CQC to carry out checks to ensure that appropriate action has been taken. Although CQC had been informed of events by the service, one notification relating to the death of a person and one safeguarding had not been submitted and other notifications relating to deaths had not always been submitted in a timely fashion.

The registered manager had failed to notify CQC of the death of a person and other submissions were not completed in a timely manner. This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The current rating was not on display in the service when we arrived, a poster showing the rating from a previous inspection in 2015 was displayed.

The provider had not displayed their rating in the service. This is a breach of regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that until the consultant had been employed at the service a week prior to the inspection they had felt unable to express their views or raise concerns due to possible repercussions. One staff member said, "No one was interested in our ideas. We were told to just get on with our job and do as we were told." Occasional staff meetings had been held and the recorded minutes showed no input from the staff team, but rather a list of instructions for them. Relatives and people told us they could raise issues with the staff or registered manager, but there was no evidence of any concerns being recorded or actions taken.

Staff worked in partnership with other agencies such as district nurses and the local authority safeguarding team to meet people's needs. Referrals had been made to speech and language therapy, dieticians and the falls team when required. When advice had been received staff were aware of this and followed it when supporting people.
After the inspection the provider sent us evidence of the changes made to improve the service and address, some of the concerns raised at this inspection.

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 16 Registration Regulations 2009 Notification of death of a person who uses services failure to notify CQC about all deaths and within a timely fashion

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Failure to use robust recruitment procedures

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 12 HSCA RA Regulations 2014 Safe care and treatment failure to manage risks to people

The enforcement action we took:

We served a warning notice on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to operate a robust safeguarding procedure

The enforcement action we took:

We served a warning notice on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. The provider and registered manager had failed to make suitable arrangements to involve people and had failed to maintain accurate and complete records.

The enforcement action we took:

We served a warning notice on the provider