Whisselwell Care Limited

The Priory Residential Care Home

Inspection report

10 Paternoster Row
Ottery St Mary
Devon
EX11 1DP

Tel: 01404812939
Website: www.prioryresidentialcarehome.co.uk

Date of inspection visit:
10 August 2016
18 August 2016

Date of publication:
13 October 2016

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of The Priory in May 2016. Eight breaches of regulations were found. We took enforcement action about staffing levels. We also took enforcement action about the overall quality assurance at the home. The enforcement action required the provider to be meeting the requirement regarding staffing levels and training by 29 July 2016.

We undertook this focussed inspection on 10 and 18 August 2016 to check they had followed their plan and to confirm they now met legal requirements. We had also received concerns regarding the safety of people at the home. This report only covers our findings in relation to the staffing levels and the safety of people living at the home. You can read the report from our last comprehensive inspection by selecting the all reports link for the Priory Residential Home on our website at www.cqc.org.uk.

The Priory Residential Care Home provides accommodation and 24 hour care for up to 21 older people, some of whom have dementia and some who have physical frailties. At the time of this inspection there were 15 people living at the home.

The home is located in Ottery St Mary, a small town in East Devon. The Priory had been adapted from a large three storey house set around a small courtyard with bedrooms on all three floors. Communal areas include two sitting rooms and a dining room were located on the ground floor. A day service for six people is also provided in the home by three staff who use one of the lounges and the dining room for activities. These staff also support people who live at The Priory if they wish to join in the activities.

The home has a registered manager, who is also the provider. 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.

The registered manager was supported by two assistant managers who oversaw the work of three shift leader care workers. Shift leader care workers were responsible for managing the work of the care workers who were on duty.

We found on the first day of inspection that there were insufficient staff to keep people safe and meet their needs during the evening. We also found that staff did not ensure they prioritised their work to ensure vulnerable people were kept safe while in communal areas. Staff had not undertaken all the checks they were supposed to do, for example on pressure mats and door alarms. This had meant that incidents, such as a person falling or leaving their bedroom, which staff had not been immediately alerted to.

By the second day of inspection, rotas showed additional staff were on duty during the evening. We spoke to staff who confirmed that there were now three members of staff on duty between 19:00 and 21:30 each evening.

Risk assessments and care plans had not been updated after incidents had occurred. For example where people had shown aggression to other people, there was no evidence that staff had updated care plans to reduce the risks of reoccurrence. Safeguarding referrals had not been made where there had been altercations between people who lived at the home. The deployment of staff had not been arranged to ensure people at risk were observed in order to ensure harm to themselves or others was prevented.

By the second day of the inspections, there had been some improvements but there were still times where people were not observed by staff.

We found breaches of the Health and Social Care Act (2008) Regulations 2014. CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

There were insufficient staff at all times to support people safely.

Risk management was not robust and put people at risk of harm.

The Priory Residential Care 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 of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18 requires the provider to ensure that sufficient numbers of suitably qualified, competent and experienced staff are deployed in the service. The inspection also provides a rating of the Safe domain which is one of five domains (Safe; Effective; Caring; Responsive and Well-led) under the Care Act 2014.

We undertook an unannounced, focussed inspection on 10 and 18 August 2016. The first inspection visit started at 6.45pm and ended at 9.45pm. The second visit was during the afternoon. This inspection was to make sure that improvements to meet legal requirements, planned by the provider after our comprehensive inspection in May 2016, had been made. The team inspected against one of the key questions we ask about services: Is the service safe? The inspection was carried out by one adult social care inspector and one adult social care inspection manager.

Prior to the inspection we reviewed information about the service. This included information we held about the service and any notifications received. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection, we met most of the people living at The Priory and talked with seven of them at various times. We met and talked with the provider, an assistant manager, 12 care staff and a cook. We looked at four people's care records and two staff records. We also looked at staff rotas.

During the inspection we met and talked with one relative. We also spoke with a health and safety consultant who was working at the home. We also had feedback from a health and social care professional.

Inadequate

Is the service safe?

Our findings

At the last inspection in May 2016 we found that the service did not have sufficient numbers of suitable trained and skilled staff on duty and we served a warning notice. The warning notice stated that the provider was required to meet the legal requirements by 29 July 2016.

During this inspection we found that although staffing arrangements had improved for some parts of the day, there were not enough staff in the evening which put people at risk of harm to themselves or others.

When we first arrived at 6:45pm, the day staff were on duty. Their shift was due to end at 7.00pm. These included a senior care worker, two care workers and a trainee care worker who was shadowing more experienced staff. Rota sheets confirmed this had been the staffing during the afternoon. Staff were busy but were meeting people's needs in a timely way. For example, one member of staff was helping a person overcome pain in their legs, by gently massaging them with some cream.

The registered manager was not at the home, but called us during the inspection, when we explained why we were inspecting at that time.

The senior care worker said that two staff were due to come on duty at 7.00pm and the day staff were due to finish their shift at this time. Both night care staff arrived shortly before 7.00pm and the senior day care worker had a hand-over meeting with them. This meeting described how each person living at The Priory had been during the day and where they were presently situated. The senior care worker said, of the 15 people living at The Priory, eight had already chosen to go to bed. Of the people who had already gone to bed, the senior care worker explained that four required some particular attention in addition to the usual care and checks undertaken during the night. This included one person who needed turning every two hours; one person who needed to be encouraged to take additional fluids if possible, one person who was waiting for their medicine and another person who needed regular assistance until they went to bed.

We checked people who were already in bed. One person told us they had everything they needed, and they had chosen to go to bed. They had a call bell, TV remote control and a glass of water on their bedside table. Care records and charts in people's rooms showed that staff recorded how often people were turned and how much they had to drink. These had improved in terms of accuracy and completeness from the last inspection.

The senior care worker said the seven people who had chosen not to go to bed before 7.00pm were in communal areas, including both the lounges on the ground floor. We checked with the senior care worker what the needs of these seven people were during the evening. They said that two people required two care workers to support them to bed which took around 30 minutes each. This meant there would be times when there were no staff available to ensure the remaining people in the communal areas were safe. The other five people needed one care worker to support them for between 10 and 20 minutes each when they chose to go to bed, which would normally be before 10pm, although it could be later.

Staff described how two people living at The Priory could at times display challenging behaviour which included being aggressive to other people. They added that staff needed to monitor them more closely when they were in communal areas, to ensure people were kept safe. One of the people who sometimes had challenging behaviour, had not gone to bed when we arrived on the first day of inspection.

There were times when no staff were present in either lounge when issues arose. For example, at one point one person got cross with another and left the lounge in an angry manner. At another time, one person was crying and asking for help, but there were no staff to observe this or take action to address the person's needs. When asked about this person, staff said they needed a lot of encouragement and distraction to help them and staff needed to spend time with them.

One person, who was described in their care records as at risk of falling, left the lounge area on four separate occasions in the space of 20 minutes. Staff were not observing them during this time, although one care worker came into the lounge to offer tea and coffee to people, whilst the person was in the room. A door in a corridor outside the lounge which led to the basement area had been left unlocked. The basement was an area which staff only accessed and therefore the door should have been locked at all times. At one point, the person walked to the corridor, opened the door and then closed it again. Staff were not present to witness this or try to prevent it happening. The lights in the stairwell leading to the basement were unlit and potentially this created a risk for this person who was prone to wander and at risk of falls.

We informed the senior care worker from the day shift and staff looked for the keys to the padlock for the door. The night staff found the keys 40 minutes later and made the area safe by locking the door. On the second day of our inspection, a new chain had been attached to the door with the key and a large yellow laminated sign reminding staff to lock the door.

During the evening, the two care workers spent some time supporting people to go to bed. However they also spent time working in the kitchen area with the door open. At these times, people in the lounges were not observed or heard by staff unless they were very loud. We discussed with the staff, what they understood their priorities to be when people were still in communal areas. For example, we asked whether they were able to do the kitchen duties once everyone had gone to bed for the night. The care workers responded that they needed to ensure the kitchen was clean and ready for the morning. This meant that at times, their priorities were not focussed on people's needs as they were unaware of what was happening in the communal areas. Therefore people were not always being supported safely.

There was evidence in a resident and family meeting in June 2016, that relatives had raised concerns about the lack of support for people in communal areas. The minutes also stated that the registered manager had promised "more support on the floor."

We discussed our concerns about staffing levels with the registered manager the morning after the inspection. We explained that we had not felt it safe to leave The Priory on the evening of the 10 August 2016, until everyone had gone to bed. We explained that this was because staff had been unable to support people safely in communal areas as there had been significant amounts of time, when both staff had been doing other duties, including helping some people get to bed. At these times, there had been occasions when people were unsafe. The registered manager agreed to ensure that an additional member of staff would be on duty in the evening immediately. We received copies of rotas which showed an additional member of staff had been deployed in the evenings.

During our inspection in May 2016, we asked how the registered manager assessed staffing levels and whether this took into account people's needs and the layout of the home, rather than just the number of

people living there. The registered manager had said they did not use a dependency tool, but were able to gauge how many staff were needed through experience. The registered manager had said she had recognised the need for more than two staff to be on duty during the evening whilst people were up. At that time she had said she would appoint staff to work a 'twilight' shift. We asked her during this inspection why this had not continued. She said that since there had been a reduced number of people living at The Priory she had decided not to have a third member of staff on during the evening. The lack of appropriate numbers of staff in the evenings is a continued breach of regulations.

This is a continued breach of Regulation 18 of the Health and Social Care Act (2008), Regulations 2014

Our second day of the inspection took place in the afternoon. Eight people were sitting in the main lounge enjoying some karaoke music with an activities worker. There was a good level of engagement and people were enjoying themselves, tapping their feet or hands to music and singing along.

Since our previous inspection in May 2016, the cooks now worked in the afternoon and early evening to prepare the suppers and also at weekends. Staff told us they had noticed a big difference with the increased staffing levels and the deployment of staff. Comments included "Cooks now on makes a big difference, we are all over the moon"; "We don't have to do the cooking, it really helps out" and "It takes a lot of pressure off me." However, one staff member still felt it could be a rush.

The inspection was brought forward as we had received information about an incident which had led to a safeguarding vulnerable adults investigation. A safeguarding meeting had been held which the provider had attended. Because of this, during the focussed inspection, we not only reviewed staffing levels, but also looked at how the risks to people were managed.

We reviewed records of incidents that had occurred at The Priory. There was evidence that some incidents involved alleged aggression between people. For example, records showed there had been six incidents of alleged aggression in the last six months involving one person. There was no written information about this person's aggression. Risks associated with these behaviours had not been assessed and no written guidance had been provided to staff on how to reduce the risk of occurrence or how to manage them when they did. For example, ensuring the person was monitored at all times while in communal areas.

Staff were unable to describe what actions they took to keep the person and other people safe. One member of staff described how they needed to be vigilant when visitors left the home as the person sometimes tried to leave with them. They also described how the person sometimes was "verbally aggressive and unwitnessed reports of physical aggression."

The member of staff also described an incident where one person living at the home said the person who displayed aggression had "come to her room and hit her in the face." The staff member also said the person who had been hit was bruised. Care records showed the person had 'a bruise from being slapped (unwitnessed)' , and another entry said 'large bruise to arm', although the cause was recorded as 'unknown'. In the person's daily notes staff had recorded in the first person "I went to staff to say I have been slapped, I have a large bruise'. A bruise chart had been completed, but no safeguarding alerts had been made to the local authority. All incidents, whether witnessed or not, where a person is alleged to have been abused, should be reported to the local safeguarding team who will then decide what action needs to be taken. For example, whether an investigation in the incident should be carried out by staff at the home or by a designated member of the safeguarding team. This helps to ensure that alleged abuse is looked into and where appropriate actions taken to reduce the risk of it reoccurring.

The staff member said that when such incidents happened, an ABC chart was completed. An ABC chart describes what may have been contributory factors leading up to the incident (Antecedents); what happened (Behaviours) and what happened following the incident (Consequence), However, the staff member did not describe actions which would have reduced the risks of a recurrence, for example monitoring the person at particular times of the day or when they appeared agitated. This meant that risks were not being managed appropriately and people were not being kept safe at all times.

Staff had not always ensured that systems to alert them when a person left their bedroom were checked as frequently as required. For example staff said that pressure mats and door alarms on people's doors should be checked every night. However they said they sometimes forgot to do this. We reviewed a checklist sheet on one person's door, which showed that the pressure mat and door alarm had only been checked twice in the last two months. We also found incident records where the person had fallen in their bedroom. This meant that staff may not have been alerted when the person got out of bed or left their room.

By the second day of the inspection staff had received instructions about the observation of people who presented risk to themselves and others. This included observing where the people were on a regular basis when they had not retired to their bedroom.

One care worker said "We have to keep an eye on X at all times, record every two hours, but more if they are agitated". Also, they said the senior care workers made sure staff were completing these records. One person's notes had been updated in July 2016 and said "I have become a little more challenging lately possibly because I feel so tired". One day entry said "I have been awake all night and aggressive at times" and another "I refused personal care and became aggressive." A new monthly summary identified that this had been a difficult month for this person, and they had presented as having various health issues. The GP had been contacted and had seen them.

However, the care plans did not show how it had been assessed that the current level of observation was sufficient to mitigate risks associated with this person and their care needs. Health and social care professionals had not been asked for advice on how best to support this person to remain safe at the home and minimise risk to others. As we left the home on the second day of the inspection, this person was wandering unobserved near the office. Before we left, we raised this with staff, who took action to support the person.

Since the inspection we were informed that community healthcare professionals had some concerns whilst they were visiting the home. They witnessed an altercation between two people living at the home. There was no member of staff present to intervene, apart from a volunteer who was unable to manage the situation. There were no care workers at the time in the area who were able to witness or intervene between the people. Staff were involved in other people's care and were not readily available to be called.

This was a breach of Regulation 12 of the Health and Social Care Act (2008), Regulations 2014

Although the care record entries had been written in the first person, they did not reflect language that would have been used by the people themselves. Some entries were disrespectful to the person. Unless the person had given permission to the home to record information as if it were the person saying it, this should not be done.

By the second day of the inspection staff had been instructed to record when they had monitored two people living at the home who presented risk to themselves and others. There was a chart for each person which was completed at least every two hours. Care staff knew that they had to monitor these people and

also had a good understanding of their needs. One gave good examples of the skills they used to help keep this person calm. For example, they recognised the person became anxious when the football was on as they though their husband would want their tea. The care staff would talk to them about the husband and not needing his tea yet, and this would help calm them.

We also looked at records relating to people who needed regular turning in bed, and also records of people who needed their food and fluid intake recording. There were improvements from the inspection in May 2016, with records being clearer and better recorded. One person had been found to have a large yellow bruise on their bottom. The registered manager had been made aware and the District Nurse had visited.