Top Care Homes Limited

Southminster Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out a responsive focused inspection at Southminster Residential home on the 4 September 2017 as a result of safeguarding concerns received by the Commission that peoples medications were not being managed safely.

We reviewed the outcome from this inspection and due to concerns found we expanded this inspection across all the key areas. We have not reviewed all the key lines of enquiry but we will be returning to the service within three months of this reports publication and provide a comprehensive overview of each key question at this time.

The home had previously been inspected in July 2016 following Inadequate and Requires Improvement's ratings in 2015. At this time the service had been found to have made improvements achieving an overall rating of Good, with Requires Improvement in the safe domain.

Southminster residential home can provide accommodation for to up to 40 older people who may or may not be living with dementia. At the time of inspection 33 people were living at the service.

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.

A long standing registered manager was in place at the home. 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.

Medicines were not managed safely and when errors had occurred they had not investigated these transparently. In most cases they had not identified errors or discrepancies through the services own quality assurance audits.

When lessons from errors had been identified, the service did not ensure that these actions were implemented in a timely way to mitigate future risk of the error reoccurring.

Entries in people's daily records by care workers demonstrated that they did not have the skills or knowledge to support people safely. Discussions we had with the provider and registered manager also reflected their inability to manage complex risks appropriately with a person centred approach.

Language used to describe people presenting with behaviours that challenged was disrespectful and uncaring.

People who had complex mental and physical health care needs did not have care plans that reflected how these needs impacted on their daily life. They did not provide staff with sufficient information to care for people responsively.

We found concerns about how the provider was ensuring that they were open and transparent about mistakes made in line with their legal obligations of duty of candour. Investigations into incidents did not result in lessons learnt and improving the service.

Audits in place to monitor the quality of the service did not identify what the service needs were who was responsible and when actions would be reviewed.

We found multiple breaches in the Health and Social care Act. You can see what action we told the provider to take at the back of the full version of the report.
We were so concerned about our findings that we had a meeting with the provider and the local authority to discuss the shortfalls. The provider has responded to the urgent action we asked them to take and provided us with a clear action plan with timescales to improve the service. Will monitor these improvements and inspect again within the next three months.

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

Medicines were not managed safely

Dependency tools did not accurately reflect risks identified for people and the level of support they required to remain safe.

Is the service effective?

Inadequate

The service was always effective.

Staff at all levels did not have the appropriate knowledge to support people with behaviours that challenged.

Staff training needs in medicine competency was not identified and acted on.

The service did not appropriately liaise with other organisation's to explore how to support people at risk of falls.

Is the service caring?

Inadequate

The service was not always caring.

Language used in some written entries was disrespectful and uncaring.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans for people with physical and mental health needs had insufficient information for staff about how to best support individuals.

Care plans were not person centred.

Is the service well-led?

Inadequate

Quality audits were inadequate. Oversight of the service was poor. Investigation's into incidents was not always transparent Lessons learnt were not acted on quickly to mitigate future risks.	

Southminster 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 responsive following concerns around the safe management of medicines, to check whether the provider meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. The inspection found additional concerns and consequently this report had been widened to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 4 September 2017 and was unannounced.

The inspection team consisted of two inspectors.

Prior to our visit we looked at all the information we held about the service, including all notifications and enquiries submitted to us by the service as required under the Health and Social Care Act 2008. We also reviewed all the information that had been sent to us from members of the public and staff working at the home for the last 12 months.

We contacted local NHS commissioning teams, and Local Authority contract, quality improvement and safeguarding department's prior to and following the inspection to share information held about the service.

We reviewed all 33 medication records for people living at the home. We also reviewed care plans and all risk assessments for eight people with complex health needs. We carried out a thorough review of all quality and governance processes to monitor the quality and safety of the care provided. This included medicine audits, falls analysis, manager and area manager audits and service action plans.

We spent time with the registered manager and provider to discuss concerns and overall quality governance

at the home and spoke to a senior member of care staff around issues found with medicines management and recording.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2016 we found that the service had improved. However, at this inspection those improvements had not been sustained and people were not being protected against the risk of unsafe care, particularly in relation to medication and risk management
When risk assessments indicated that individuals were at high risk, for example the risk of falling, dependency tools used to assess people's overall dependency needs did not reflect this information. In three cases, people had been categorised as medium or low dependency need, but on exploring their risk assessments, the registered manager informed us they needed constant oversight due to high risks of falls.

Systems in place to share information of risk with other agencies in the event of routine or emergency appointments and treatment were poor. Following a concern when a person was admitted to hospital without the correct information about allergy status, the registered manager had produced a new transfer form to include allergy status. However, over a month since the incident had occurred, new transfer forms had not been completed for all people at the service, including those who had identified allergies. The registered manager and provider informed us that they relied on staff to complete these at the time of emergency incident. They had not considered the risk of staff missing this information when in the middle of dealing with an emergency.

Medicines management oversight was not robust enough to ensure that medication was stored and kept safely. Pharmacy audits carried in in 2015 and on 01 September 2017 highlighted that clinical room temperatures should be monitored daily due to the room temperature being above recommended guidelines. Staff had previously been leaving the clinical room door open to allow cold air to circulate, which meant that equipment and medicines stored in the room were accessible to all staff, visitors and people living there. This presented as both a security risk and a hazard to vulnerable people living with dementia. The Commission had highlighted the need to monitor the room temperature as concern in July 2016 when the clinical room door was found open during inspection. We found on this inspection that a thermometer had been placed in the room, but staff were not recording temperatures. If medicines are not stored correctly they may not work in the way they were intended, and so exposing service users to risk. This failure has been lengthy and ongoing.

Controlled medicines in the clinical room cupboard had not been logged into the controlled drug book. We also found that on two occasions staff had not a signed for controlled drugs given to people. Controlled drugs (CDs) are prescribed medicines that are usually used to treat severe pain and have additional safety precautions and requirements. We discussed this with the registered manager who felt there was no urgency to log the controlled drugs received until they were in use. However, this is contrary to legal requirements for the storage, administration, records, and disposal of CDs, set out in the Misuse of Drugs Act Regulations 2001. The system for booking in and recording controlled drugs did not follow the 2001 Regulations and was unsafe. Without measures in place to record medications received and given, service users may be placed at risk of not receiving their medication prescribed. In addition the service could miss the opportunity to identify if medicines were kept securely in line with national guidance. We could not be confident that when people had run out of medications that staff were following this up with general practitioners and pharmacy

services to ensure that people received their prescribed medicine's in a timely way.

Record keeping was not accurate or robust. We found one case were someone had been recorded as being without their antidepressant medication for 16 days. Staff informed us they had chased this up but were unable to provide us with documents or records to demonstrate it. In addition, no records could be provided to demonstrate appropriate reporting had been considered or made for example safeguarding alerts and notifications to the Commission. Missed or interrupted treatment can harm a service user or put them at risk of harm or delayed recovery.

Additional areas of concern around medication were found. For those people who received regular pain analgesic there was a lack of assessment to monitor pain and need. Staff did not record how many tablets had been administered where people were prescribed variable doses, for example one or two tablets. When PRN medication had been administered (as required medicines) staff did not record the reason, or the affect. Consequently, staff could not demonstrate that PRN medications were regularly reviewed in line with National Institute for Health and Care Excellence (NICE) guidance.

Transdermal patch charts, and cream charts were not in place with medicine records to provide appropriate information for staff. These charts were not in care plans either. These had not been in place since July 2017. Medicine administration records did not include information about how to administer medication in line with people's preferences and needs. A medication audit carried out on the 22 August 2017 by the registered manager did not identify these issues.

A falls analysis tool used by staff only provided information of how many times people fell. The information did not result in staff looking at why people where falling and how to mitigate falls. Some people had fallen 11 times in one month and there were a total of 149 falls in the home over a period of 8 months. The registered manager did not know whether this was an excessive number. This was important because the dependency tools supported the service to ensure that appropriate numbers of staff were on duty to mitigate risks identified to people. Consequently, the registered manager was unable to demonstrate that the right amount of staff were deployed to manage people's identified needs and protect them from potential injury or harm.

We had received a number of complaints about the service since the last inspection which highlighted lack of staff presence in communal areas at times, and relatives having to search the building for staff to support people in need. One person reported to us, "The staff were nowhere; we always have trouble finding them."

Risk management plans did not give staff sufficient information about how to support people who had severe anxiety. In some cases, behaviour monitoring charts were in place but these were not filled in properly. These charts are used to identify triggers to people's behaviour, what the behaviour was and how staff managed behaviour and supported the person. When filled in effectively they provide essential information about what is happening for that person and explains how to support them. However, these charts did not do this and included inappropriate recording, for example "rude behaviour," without any exploration of the cause or understanding about how the person was feeling. There was no monitoring of trends to establish if there were patterns for people, for example times of the day when they were more anxious, staff who they respond to more positively etc. We discussed this with the provider and registered manager who did not have sufficient understanding of how to monitor and support people with these complex needs. This meant that the service did not adequately mitigate or reduce the potential risk to people and to others resulting from these situations. .

This was a breach of Regulation 12, of the Health and Social Care Act 2008.

Inadequate

Is the service effective?

Our findings

The service was not effective

We have not reviewed all aspects of this Key Question but we will be returning to the service within three months of this report and will provide a comprehensive overview of it at this time.

The registered manager and nominated individual were unable to demonstrate understanding and knowledge around how to best support people with behaviours that challenged. They had not looked at current best practice guidance, nor had they consulted other agencies for a review of person's needs. For example, psychology input, talking therapies, and other such services. We also observed that staff did not understand how to approach people who were anxious, scared or angry. In one case the nominated individual told us they provided reassurance to a person but stating to inspectors that they (the person) would be angry when they found out that what they had said to ease their anger was not true. This did not give staff an appropriate example of how to approach the situation and raises serious concerns about leaderships contribution to the poor culture within the service through unacceptable practice. Colluding with the person may have also contributed to the existing negative relationships between the person and staff caring for them.

The services system to recognise risks to people did not always result in referrals to outside agencies. The home did not use the information to make referrals to the falls prevention team or inform the care plan as to how staff should manage and mitigate risk. The registered manager dismissed the use of assistive technology for one person stating it would not work. They had not considered the need for formally assessed the potential of additional support from other agencies or from additional equipment, such as sensory mats that would alert staff when the person got out of bed. We were not assured that people were receiving the best possible care for their conditions as the service had not explored all alternatives to support them.
This lack of staff knowledge is a breach of Regulation 18 Staffing, of the Health and Social Care Act, 2008; 2015.

Inadequate

Is the service caring?

Our findings

The service was not always caring.

We have not reviewed all aspects of this Key Question but we will be returning to the service within three months of this report and will provide a comprehensive overview of it at this time..

People were not always treated with care, dignity and kindness. We were concerned about the culture at the service and examples of poor practice, understanding and oversight displayed by the senior leadership.

Complaints received by the Commission informed us that people, relatives and staff were scared to speak out. One person wrote, "Staff can be really rude if you raise a concern. I am scared to say anything now." Another said, "They told me my [relative] knew what they were doing and knew how to pull the right strings."

A concurrent theme to complaints made to the Commission was that staff often took breaks together and were not available to people when they needed it. One visitor wrote, "[Name of person] wanted to go to the toilet, I couldn't find staff but eventually found them in the staff room together, they told me [person] would have to wait until they had finished their tea." Another person wrote, "I've seen [confused] people walking around in a state, I told staff but they said the person would just have to wait until they had finished their break."

We saw daily notes and behaviour monitoring charts for people with behaviours that challenged and found the language used in records as disrespectful. For example "[Name] has been misbehaving."; "[name] been badmouthing the home to people,"; "I told [person's name] to stop being rude and that she knows what she is doing."

This was a breach of Regulation 10 (1) Privacy and Dignity, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we saw serious shortfalls in the approach of some staff there were some who did clearly care about those in their care. For example, on the day of inspection a person had passed away at the home and staff had ensured that the family were contacted and cared for with kindness and empathy. The senior leadership team did not have good enough oversight or systems in place to ensure that staff had a consistent approach, poor practice was recognised, and appropriate action was taken to irradiate it

Inadequate

Is the service responsive?

Our findings

The service was not responsive

We have not reviewed all aspects of this Key Question but we will be returning to the service within three months of this report and will provide a comprehensive overview of it at this time.
Care plans were not person centred. They did not provide staff with information about people's preferences, what was important to them and how staff could support these. People who had complex mental and physical health care needs did not have care plans that reflected their preferences, how these needs impacted on their daily life, what worked well for that person in meeting their needs, for example when experiencing heightened anxiety. There were no explorations with people and their loved ones about things that worked well.

Care plans did not provide staff with sufficient information to care for people's needs identified in risk assessments. For example, care plans for people living with Parkinson's did not contain information about how it affected their ability to carry out daily tasks. It did not inform staff how to promote people's independence, whether additional equipment could be considered and how people's symptoms might fluctuate day to day. Without this information staff would be unable to act responsively to people's needs and this could impact on people's quality of life.

Important information was omitted from care plans, for example when a person had a history of epilepsy. No information was available for staff about what type of epilepsy they had, potential symptoms specific to them and what they should do in event of the person experiencing symptoms. The registered manager informed inspectors this was because the person had not experienced symptoms for some time, however we could not be certain that staff would not pick up on potential symptoms and act according to access support the person needed.

There was a lack of an activity coordinator at the home. Whilst the service was attempting to recruit into this role, staff were trying to do activities with people. Staff had discussed with people what they wanted to do and would try and fit things in whilst also managing care responsibilities. No further hours had been provided for them to do this alongside their other responsibilities. People sat in various different areas around the home so was difficult to ensure that all people had access to meaningful activity, particularly when some people required constant oversight due to their identified falls risk. Activities, when offered, were group orientated with little variation or ability to look at individual's activities needs.

The provider could not be assured that people would receive the correct care due to lack of accurate care records that reflected their needs and the identified potential staff culture issues which we identified in the CARING key question.

This was a breach of Regulation 9 Person Centred Care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was lacked adequate effective leadership and systems to monitor and improve the service for people were inadequate.

Quality assurance systems did not consider the impact of inadequate resourcing and deployment of staff. Whilst the registered manager and Nominated Individual advised that recruitment was on going, we saw that the registered manager was also completing both night and day shifts as a care worker. They also had been covering as a cook. No risk assessments or related actions had been taken into consider the impact of this on the registered manager and their role and responsibilities. This would also account for the lack of apparent oversight over areas of the service that were failing. The nominated individual confirmed the manager was contracted to work 40 hours a week, but through choice worked up to 60 hours. Despite the amount of hours worked the impact was not showing as improvements and the root cause of the poor quality had not been fully addressed or identified by the provider. Our inspection demonstrated a failure in the infrastructure of the service to ensure the registered manager had effective oversight over deployment, numbers and skill mix of staff along-side robust quality assurance systems that identify issues prior to them becoming a potential risk to those in their care.

The service had been without a deputy manager since July 2017. Their roles and responsibilities had not been delegated to anyone and the registered manager had to ensure these were covered in addition to their own responsibilities. The service had recruited to the role, but the new deputy manager had not been able to fully take up the position. The registered manager told inspectors that the failures in quality assurance processes was because there had been no deputy manager since July 2017. They told us that they were 6 weeks behind in looking at quality and risks of the environment. We found that some audits were over due by two months, and audits previous to this did not identify what needed to be done, timescales and whose responsibility it was to carry through actions. The provider had not considered looking at alternative support such as supporting existing senior care staff to take on some of these roles. As a consequence we saw that routine quality assurance processes had not been completed since the beginning of July 2017. This meant that there was no proper oversight of the quality of the service.

The provider told us that they had recruited an area manager to oversee and support the running of the homes on their portfolio. However, it was unclear of what support the area manager had offered or oversight they had, for example, identifying the known staffing issues at the home and lack of quality assessments being carried out. This further demonstrated a lack of oversight by the provider who had not considered what additional resources and support the registered manager would need to ensure the adequate management of the home.

Lessons learnt were not acted on quickly to mitigate future risks. In one case changes needed to ensure that other services had vital information about people's allergies had been identified but not implemented in full four weeks after the incident.

Following the inspection the provider sent us additional information about how they were going to redress

our concerns; however we found that the new audit tool had not been used and did not include checking that people's allergy status had been recorded. This did not demonstrate that lessons had been learnt. And had it not been for the Commission's inspection of the service, we were not assured that any of the shortfalls would have been identified or addressed without our intervention.

This was a breach of Regulation 17 Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Investigations did not always demonstrate that they had been completed in an open and transparent way to examine why and how things went wrong and how information could be used to support organisational and personal learning to limit potential future risks. We spoke to the registered manager and provider about concerns found during the inspection. In each case they were unable to acknowledge any fault at the home, contributing blame elsewhere.

In one situation the provider had not issued an apology to relatives following an error as is their responsibility under the duty of candour.

This was a breach of Regulation 20 Duty of candour, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We were so concerned about our findings that we had a meeting with the provider and the local authority to discuss the shortfalls. The provider also responded to urgent action we asked them to take. They have provided us with a clear action plan with timescales to improve the service and will monitor these improvements and inspect again within the next three months.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and did not contain interventions to manage identified individual needs and preferences.

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 10 HSCA RA Regulations 2014 Dignity and respect Language used to document interactions with people that had behaviours that challenged were disrespectful and unkind. These entries demonstrated a general lack of knowledge and understanding of how to support people with these behaviours in a dignified and compassionate way.

The enforcement action we took:

We have made a recommendation to the service to improve the training for staff on how to support people with behaviours that challenge.

We enforced positive conditions on the service to send us monthly reports. These conditions include a review of every persons needs at the service and how the service will support them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service was not ensuring that medicines were managed safely. Staffing levels were based on dependency needs assessments for people that did not reflect people's actual identified needs. Where risks to people were identified there was insufficient information for staff to support that person to maintain their safety and ensure they received quality care.

The enforcement action we took:

We issued a notice of decision following the inspection to restrict admissions to the home until standards around peoples safety could be improved.

We placed positive conditions on the service to ensure that they sent the commission regular reports of progress in making the improvement's identified in the report. This included a complete review of all people living at the home, their individual needs and how the service would meet these needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Clinical audits and processes to identify risks to the service and the quality of care provided to people were inadequate. They had not been completed for two months. Previous audits did not identify what the issues were, how they issues would be managed, who was responsible and when actions would be completed by. Systems in place had not identified the concerns that we found.

The enforcement action we took:

We placed positive conditions on the service to ensure that they sent the commission regular reports of progress in making the improvement's identified in the report. This included a complete review of all people living at the home, their individual needs and how the service would meet these needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The service did not review incidents in accordance with the duty of candour requirements. They did not identify appropriately when the service had made errors and taken timely action to learn from these errors. They did not issue written apologies to following errors which detailed what the error was, and the result of investigations in the error and actions to mitigate future risk.

The enforcement action we took:

We issued a notice of decision following the inspection to restrict admissions to the home until standards around peoples safety could be improved.

We placed positive conditions on the service to ensure that they sent the commission regular reports of progress in making the improvement's identified in the report. This included a complete review of all people living at the home, their individual needs and how the service would meet these needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff all levels were not equipped with the knowledge and understanding necessary to ensure that people received safe, effective, caring and response care and support.

The enforcement action we took:

We issued a notice of decision following the inspection to restrict admissions to the home until standards around peoples safety could be improved.

We placed positive conditions on the service to ensure that they sent the commission regular reports of progress in making the improvement's identified in the report. This included a complete review of all people living at the home, their individual needs and how the service would meet these needs.