Leong E N T Limited

Skellow Hall

Inspection report

Cross Hill
Old Skellow
Doncaster
South Yorkshire
DN6 8JW

Tel: 01302354977

Date of inspection visit:
24 June 2020

Date of publication:
24 July 2020

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
Skellow Hall is a residential care home providing personal care, it can accommodate up to 29 people aged 65 and over. There were nine people using the service at the time of the inspection.

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

The service had no registered manager and systems and processes used to ensure the service was running safely were not robust or effective.

Risks to people were not always managed and reduced. Accidents and incidents were not analysed.

There were shortfalls in the way medicines were administered and staff were not suitably trained to administer medicines safely.

Records were not accurate and up to date to show what care people had received. Staff were not suitably trained or supervised to be able to effectively carry out their roles and responsibilities.

There were systems in place to safeguard people from abuse. However, a number of safeguarding concerns had been referred to the local authority. There were safe recruitment processes in place which were followed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published October 2019).

Why we inspected
We received concerns in relation to care needs not being met and risks not being managed. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not include them in this inspection. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has not changed.

We have found evidence the provider needs to make improvements. We identified continued breaches in regulation.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, medicines, person centred care and governance at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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.

Skellow Hall

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and an assistant inspector.

Service and service type
Skellow Hall 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the provider 48 hours' notice of the inspection. This was due to the Covid-19 pandemic to ensure we had prior information to promote safety.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and five relatives about their experience of the care

provided. We spoke with ten members of staff including the provider, finance manager, senior care workers, care workers and ancillary staff. We also spoke with a visiting district nurse. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with four professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people were not suitably assessed or managed. For example, we found the risk of weight loss was not addressed. People had lost weight, and this was not monitored or reviewed to ensure staff were following advice from health care professionals.
- Peoples records were not up to date. We identified food and fluid charts were not properly completed and did not accurately reflect what people had eaten or drunk. This meant they could not be effectively reviewed. Care staff told us they did not have access to the electronic care records so were not always aware of any changes to people's needs. For example, a health care professional told us they observed a member of staff moving and handling a person on their own. The assessment completed by the occupational therapist clearly recorded they should be moved with two staff for their safety. When the health professional asked the staff member, they told them they were not aware they had to be moved with two staff. This put the person at risk of harm.
- Accidents and incidents were not analysed; therefore, any themes or trends were not identified to mitigate risk and ensure lessons learned.
- Environmental risks had been assessed and monitored and environmental safety checks were being carried out.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People were not protected from the unsafe management of medicines. It was not clear if people received their medicines as prescribed. For example, one person was prescribed two different types of aperients, however, neither had been given to the person. Staff had not monitored the persons bowel movements to determine if they were required and had not reviewed the time of the prescribed medicine.
- The provider's monitoring systems had failed to identify errors or missed medicines. The last audit was completed in January 2019 and identified no issues. However, we found a number of issues that were not picked up by the providers quality monitoring.
- There was no clear guidance for staff on when to administer medicines that were prescribed 'when required.' Protocols were in place but did not give adequate information. For example, where people lacked capacity to communicate with staff, the protocols did not explain how the person presented when they were in pain. Therefore, people may have been in pain and not received their medication.

- Staff did not follow policies and procedures relating to the management of medicines. Not all staff had a

recent competency check and staff who were undertaking the administration of medicines had not all received training in the safe management of medicines.

The provider had failed to ensure the proper and safe management of medicines which is a continued breach of Regulation 12 (Medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Sufficient numbers of staff were available to meet people's needs. However, the lack of leadership and direction meant the deployment of staff was ineffective in meeting people's needs. For example, we observed staff sat around with no communication or interaction with people who used the service. One person told us, "There is nothing to do, we are bored." Relatives we spoke with gave mixed views. Some said the staff were good and they had no concerns, while others said there was a high turnover of staff and their relatives had to wait a long time for support when requested.

● Staff did not receive effective training. There was not always the right mix of skills and competencies of staff on duty. For example, we found a number of staff who administered medicines had not received training or competency assessments.

● There was no stimulation or social activity for people. Staff told us, "The residents are lonely, we try to do things, but not always able, there is no activity person."

The provider had failed to ensure there were skilled and experienced staff deployed to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a staff recruitment system in place. Pre-employment checks were obtained prior to staff commencing employment. This helped to ensure people employed were of good character and had been assessed as suitable to work at the service.

Preventing and controlling infection

● People were protected from the risk of infection. We found staff wore suitable personal protective equipment (PPE) when supporting people. Staff were following the new guidance regarding PPE in relation to the COVID-19 pandemic. For example, one member of staff told another to wash their hands before and after removing their mask.

● The areas of the building we visited were generally clean. However, we found some areas we not properly maintained so could not be thoroughly cleaned. The provider had identified this and had plans to improve the environment.

Systems and processes to safeguard people from the risk of abuse

● There were systems and processes in place to safeguard people from abuse.

● Staff told if they had concerns that a person was being abused, they would report it to their line manager. However, staff told us they were not always listened to, but had not taken the issue further. This meant people were not always safeguarded. We found a number of concerns had not been reported to the local authority or CQC. The provider was addressing this.

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.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service did not have a registered manager. The provider had employed a new manager, but they had not commenced at the time of our site visit. They commenced in post on 29 June 2020.
- Staff were not clear about their roles and responsibilities and did not understand the regulatory requirements. Staff told us they did not feel supported and felt there had been lack of leadership and guidance.
- There was a lack of provider oversight, they were not able to tell us what the management in the home had completed while at the service, however, the provider acknowledged they needed to have more oversight by visiting the service more frequently.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider did not ensure that people received person centred care. Support we observed was task focused and institutionalised. For example, staff did not engage with people to ask their preferences or choices.
- Outcomes for people were not met. For example, people's mental health needs were not met, one person had one to one support that was meant to be activity based to improve their well-being. We observed the care worker just sat with no communication or interaction.
- Staff did not work together as a team. Staff told us there was no clear leadership and they didn't work together. One care worker told us, "We don't work as a team, in fact we try to discredit each other." This had a negative impact on people they were supporting.

People did not receive care that was person centred. This is a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The service did not always show honesty and transparency from all levels of staff and leadership. The provider had identified this and taken action. However, we identified issues that had not been reported. For example, unexplained bruising and safeguarding concerns, which had been reported to the local authority but had not been reported to CQC. The provider hadn't fulfilled their duty to inform the relevant bodies. The provider agreed to do this retrospectively, once they were made aware of their duties to report it.

Continuous learning and improving care

● Systems in place to monitor the service were not effective. Some quality monitoring had taken place but had not always identified the issues we found.

● We looked at the audit in relation to managing weight loss. We saw people's weight was recorded and the amount lost or gained but no other review was carried out. Therefore, the audit was not effective in driving improvements and ensuring the corrective action necessary was taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives we spoke with told us communication was poor. They felt they were not always kept informed or involved in the care and support of their loved ones. One person said, "You ring, and you can't get through, it just rings and is not answered. I rang 12 times the other day before it was answered." Due to the current COVID-19 pandemic there were restrictions on visiting yet no other methods of communication had been put in place. Staff told us the internet was not available in all the building so depending on where people's bedrooms where you could not access the internet to be able to face time relatives. We discussed this with the provider, who told us they would look to resolve the issue.

Working in partnership with others

● The provider did not always ensure good working relationships with healthcare professionals. Due to the concerns raised and safeguarding referrals made, the local authority was supporting the home and health care professionals were visiting daily to offer support and guidance. However, we found their advice was not embedded into practice and followed consistently. For example, professionals identified the risk of poor hydration and weigh loss two months prior to our inspection. There was no robust monitoring systems in place to monitor and evaluate this to ensure people's needs were met.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.