Mr A Agarwal

Leiston Old Abbey Residential Home

Inspection report

Leiston
Suffolk
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Date of inspection visit: 18 and 22 January 2016
Date of publication: 08/03/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The Care Quality Commission (CQC) carried out a full comprehensive inspection on 29 September 2015 and rated the service overall as Inadequate, with the service being Inadequate in Safe, Effective and Well-led, and Requires Improvement in Caring and Responsive. This resulted in the service being put into special measures.

There was not a registered manager in post. 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.

On the 23 October 2015 we met with the provider who accepted a failure within the service which had led to the rating. Despite this acceptance, we found a lack of insight into how they would address the shortfalls and what was required to do this. They were unable to provide us with any reassurance on how they would address the issues. We were so concerned that we took enforcement action to impose conditions to try to lead improvement by making specific requirements regarding oversight, leadership and quality assurance of the service.

At this focused inspection we found no improvements have been made to the overall quality of the service. While some action had been taken the oversight of management was still failing.

Summary of findings

Improvements were needed in the way that the service assessed and monitored people's safety in the environment. The premises were not well maintained and safe.

People were being put at risk because there were not enough staff numbers in the service to meet people's needs safely and effectively.

The service's quality assurance systems were not robust. They failed to identify shortfalls in the care provided. Audits were not used to improve the quality of the service. Outcomes from safeguarding investigations had not been used to improve the service. Improvements were required to ensure the quality of the service continued to improve.

Improvements were needed in how the provider communicated information to staff to ensure that staff were given clear guidance on their roles and responsibilities.

This report only covers our findings in relation to the areas we focused on; Safe and Well-led, during our inspection of 18 and 22 January 2016. You can read the report from our comprehensive inspection of 29 September 2015, by selecting the 'all reports' link for 'Leiston Old Abbey Residential Home' on our website at www.cqc.org.uk

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

You can see what action we have told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

The environment was not safe. Improvements were needed to ensure any risk to people's safety and welfare were identified and acted on.

There were not sufficient numbers of staff to meet people's needs safely.

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Is the service well-led?
The service was not well-led.

Quality insurance and leadership within the service was not robust enough to independently pick up shortfalls and act on them. Where improvements had been made, lack of monitoring led to re-occurrences.

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Leiston Old Abbey 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 unannounced focused inspection took place over two days, 18 and 22 January 2016. The inspection team consisted of two inspectors on the first day, and one inspector on the second day. The team inspected the service against two of the five questions we ask about services: is the service safe, and is the service well-led. This is because the service was not meeting legal requirements in relation to these questions asked.

Before our inspection we reviewed the information we held about the service, this included the provider's action plan.

We spoke with the local authority safeguarding team and social care professionals. We also reviewed all other information sent to us from other stakeholders such as commissioners, environmental health and feedback received through the CQC website.

We spoke with three people who use the service and four people's relatives. We spoke with seven members of staff, including care staff, senior care staff, domestic staff, maintenance person, clerical staff and the provider. We looked at records relating to three people's care, management of medicines, staff training and systems for monitoring the quality and safety of the service.

Prior to our inspection we had received concerns about the service provided; this had been reported to and investigated by the local authority. The local authority kept us updated with the support that they were providing to the service to assist them to improve the care and support provided to people. During our inspection we looked to see what action had been taken as a result of these concerns.

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Is the service safe?

Our findings

Prior to the inspection we had received information of concern from social care professionals that the service were not maintaining adequate staffing levels, which directly affected the safety and quality of care people were receiving. This warranted them putting a system in place to carry out daily checks of the service. The provider was unable to demonstrate consistent and safe staffing levels during these daily visits. For example on the 5 January 2016 they found only two of the four rostered care staff on duty, and no effective management strategy in place to fill the shortfall. This impacted on the quality of care provided. A visitor arrived to find a person had been left in a soiled bed as staff had been too busy to monitor and provide assistance.

Relatives told us that they were happy with the care provided, but felt more staff were needed. One relative commented that staff, "Work like hell…really kind and caring but staff need more help." A care professional told us that there was a reliance on the television to provide stimulation as staff did not have the time to sit with people. For example the interactions we saw with a person who remained in their bedroom was caring, but task led. This put the person at risk of social isolation. This had not been considered or planned for by staff.

We found no systems in place to regularly assess that the staffing levels were based on the needs of people. Neither had they considered the impact of the layout of the home, which was large, spread across two floors and several corridors. Because these considerations had not been taken into account staff were unable to provide people with consistent and effective care. For example, where four people required the support of two staff, during the night, there was no third member of staff to respond to call bells or monitor the safety of people who were awake. In one example there were not enough staff available to answer the front door to an out of hours Doctor which had been called to visit a person who was in pain. They were unable to gain access to the home, because the night staff had not heard the doorbell. This delayed the person receiving treatment until the next day.

The provider told us that they had set staffing levels to, "Assume the worst case scenario." Staff said they had been informed that they were, "Over staffed," but did not feel this was the case. A relative commented even on the days they were told the service was fully staffed, they, "Needed more staff." We looked at the rotas to see how many staff were deployed across the home. The information did not match what we observed, or been told. For example the records still showed a member of staff working who was off long-term sick, and another who had left on Christmas Eve as still working. There were no clerical assistant, chef/cook and supper cook hours recorded on the rota. We looked at the staff signing in sheets to try to get a clearer picture as to which staff were on duty and when, however this was also inaccurate and unreliable because some staff had not signed in.

The provider confirmed that the staffing rotas we were shown were not accurate. Also that they had not written in the shifts which they themselves had covered as manager, or where necessary, as a carer due to shortfalls. They confirmed that they had a part time clerical assistant, and further support was given by care staff who worked a day in the office. There were no effective contingency plans in place to cover annual leave, vacancies and long-term sickness whilst recruiting. This resulted in staff being deployed to cover another role, which then impacted on the work they normally did. For example where the evening kitchen hours had not been covered, the supper tasks were carried out by the care staff. This meant when people required the support of two staff to assist, it impacted on their ability to monitor the safety and welfare of others using the service.

This was s a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed in the management of risk to ensure the premises and equipment provided by the service were maintained, safe and fit for purpose. The 'personal emergency evacuation plans,' which provided fire service and staff information on which bedrooms were occupied and the level of support required with people's mobility during an evacuation, were not being kept updated.

We found no effective action had been taken since our inspection of 29 September 2015 to prevent people living with dementia or who were otherwise vulnerable and frail from accessing areas of the home which were unsafe. This included the stairs which had threadbare carpets, a potential trip hazard, leading up to vacant bedrooms which were unlocked and did not provide a clean and safe environment. When we went to use the stairs, we found the

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Is the service safe?

light was not working, therefore the area was very dark and we could not see the stairs, when we grabbed the hand rail it wobbled because it was not secured properly. Records showed at night a person living with dementia had been found walking around the service. We were concerned that given the shortfalls in staff that people could access these areas unnoticed and place themselves at risk of harm.

The quality of the environmental risk assessments the provider was completing were not effective to ensure that all parts of the home were as far as possible safe for people living in the service, staff and others.This was because potential risks that could contribute to accidents or injuries were not being picked up. Staff carrying out risk assessments had not received training and told us they took guidance from the provider. The provider told us that they had not received training in carrying out risk assessments for any area of their work. They were unable to provide documentation that confirmed their competency to risk assess or train staff who carried out risk assessments in the areas they were working.

Where risks were identified, adequate control measures were not put in place to minimise the risk of people coming to harm. At the inspection on 18 January 2016 we observed that the previous risks we had identified during the 29 September 2015 inspection had not been fully addressed and despite these already being areas identified as requiring action they continued to present a risk. This included the small utility room, which people had access to. We found the light in this room still did not work, and a lamp which had previously been identified as a potential fire hazard had been placed back in the room. The risk was heightened because staff had started using it to store hazardous cleaning fluids again, a risk identified during the 27 October 2014 inspection. The door to this room had no fitted lock so remained fully accessible.

When we returned on the 22 January 2016, an electrician had just fixed the faulty light switch. This meant it had taken nearly four months to address. Records and feedback from social care professionals showed that one of the assisted baths had been out of action for some months. The provider told us it had recently come to their attention and a new one was on order.

We identified where a person living with dementia was identified as high risk of falls. Their care records said they were unable to use a call bell and that a sensor mat had been put in place to alert staff if they moved from bed independently. When we visited the person in their bedroom we observed that the mat was not in place. The provider was unable to clearly tell us when the mat was removed or when it would be replaced. The absence of the mat had not been risk assessed and had not been identified as a risk to the person's safety and wellbeing. This person spent the majority of time in their bed, so this was critical to monitoring their well-being. This raised concerns over how long it took to address maintenance issues to ensure people's safety and comfort.

The provider showed us the new risk assessments introduced as part of people's care plans. A member of staff told us the new format was much more detailed, which meant new staff would know how to care for someone. We looked at the mobility assessment for a person who required full support from staff. The information given, "Unable to mobilise without support from the hoist, slide sheet and wheelchair," was very basic and did not provide staff with clear safe guidance on how to move the person safely. To ensure the person's safety, there was no information on which was the correct size of hoist sling to use. The provider told us they were responsible for these risk assessments but had not been trained to asses which type/size of hoist sling to use for each person. Using the wrong size sling is potentially very dangerous because people can slip through, fall or be injured if used incorrectly. No information could be provided to show if professional advice or assessment had been sought.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Is the service well-led?

Our findings

We found that the provider did not understand the principles of good quality assurance and oversight to drive improvement within the service.

At this inspection on 18 January 2016 the provider told us that the acting manager had not worked in the service since 23 December 2015 and had not been given a date for their return. During that time, no action had been taken to appoint an experienced, skilled, temporary manager in their absence. There has not been a registered manager in post since 1 August 2015 and the provider had not employed a deputy manager or another suitable person to support the service management.

At the time of the inspection on 18 January 2016 the provider informed us that they alone were undertaking the management role. Feedback from visiting professionals showed that the management of the service to be chaotic, with no clear leadership or oversight. We saw rather than being proactive in identifying areas that could impact on quality of service people received, and taking preventive action, a culture of 'crisis' management had developed. Where the provider stepped in himself to cover as a carer, this took time away from the management and oversight of the service. This meant we found that the leadership and support needed to run the service was not effective and resulted in us not seeing any significant improvement since our last inspection.

Following our inspection on 29 September 2015, the provider told us of the action they had taken to address the shortfalls identified and what they were doing to prevent them happening again. However, during this inspection we found the action had not been effective to ensure improvements were understood by all, made, sustained and embedded. For example feedback from social care professionals, care records and our own observations, identified the systems the provider put in place to support people of low weight who refused, or ate small amounts of food, to maintain, or increase their weight was not effective enough. The provider's action plan stated that people of low weight would be encouraged to eat more, that they all would be left within reach a 'snack bowl' to promote them to eat extra calories between meals. Although these were in place the provider had failed to consider best practice guidance as the contents did not demonstrate an awareness of suitable fingers foods. For example a person who required assistance had been given an unpeeled banana and a cake in a sealed container, which remained untouched because they were unable to peel or open them independently. Nobody had recognised that this approach was not working.

The auditing and management of medicines were not effective to identify and reduce the risk of people not receiving their medicines as prescribed, or in an effective manner. For example where the amount of repeat medicines booked in the service showed that they would not have enough to cover the expected period of time, action was not being taken quickly enough to ensure the person did not run out. The auditing systems in place had not picked an error on a person's medicine administration records. This meant instead of giving the person their as and when required medicines, referred to as PRN, when they required it, they were given it at set times. This reduced the flexibility of the person receiving pain relief when they needed it.

Improvements were required to ensure staff were adequately supervised and supported to understand their roles and responsibilities. There was no system in place to assess the quality of training staff received to ensure that they had the skills, confidence and knowledge to support people in a safe manner. Where a staff member's records showed that they had not felt confidant to use the hoist, we asked for their training records. We were given one sheet which showed 26 topics had been covered in one day as part of their induction, which included manual handling. The provider confirmed that the staff member had not received supervision, or had their competency checked. Due to the quality of the record keeping, it could not be confirmed what further shadow shifts and training the staff member had undertaken to help their confidence and improve their practice.

During our inspection the provider was unable to demonstrate how the shortfalls we had identified would be robustly addressed in a proactive way. We were also concerned where improvements had been made following reports from other external agencies, were not being maintained. For example where work had been undertaken to improve the service's previous food hygiene rating from a one to five, a review of their rating on the 19 January 2016 showed that their rating had slipped back to a two. The significant concerns raised by the food safety officer included; risks associated with food being prepared and

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Is the service well-led?

left out for unspecified amounts of time, staff training and competency to handle food safely, the dishwasher not working for several days but no contingency for disinfecting utensils used for raw meat/soiled vegetables, showed where previous improvements had been made they were not being maintained.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed to promote a positive staff culture through effective communication systems. Throughout the inspection during discussions with the provider, staff and relatives we identified where lack of effective communication systems impacted on the improvement and running of the service. One relative told us, "Staff are really working 100 percent, would help them to have more guidance." They felt having an, "Effective administration mechanism [in place] so everyone knows what they are doing," would help. For example, "Having a dedicated carer," who ensured that people always had a drink in front of them.

We found the lack of communication both verbal and written, between management and staff regarding the day-to-day tasks impacted on service delivery. This had resulted in 'blame' culture developing. The provider acknowledged that this was an area they needed to work on, that too much reliance was given on verbal communication. They provided an example of where this had happened, which had resulted in action not being taken to address shortfalls in the staffing levels.

The provider told us that if they kept a record of decisions and action taken, which staff could access, this would prevent miscommunication.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 People were at risk because they were not provided with safe care and treatment. Regulation 12 (1) (2) (a) (b) (c) (e) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People were at risk because the premises were not kept clean, well maintained, and fit for purpose. Regulation 15 (1) (a) (c) (e) (f) (2)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes are not robust, established and operated effectively to ensure risks to people are mitigated and to provide a good quality service to people. Regulation 17 (1) (2) (a) (b) (e)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People are at risk because there are not sufficient numbers of suitably trained, competent, skilled and experienced persons deployed in the service to meet people's needs Regulation 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took: