Ark Specialist Healthcare LLP

Advent House

Inspection report

125 Bottom Boat Road
Stanley
Wakefield
West Yorkshire
WF3 4AR

Tel: 01924826868

Date of inspection visit:
20 January 2017
07 February 2017

Date of publication:
20 June 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection of Advent House took place on 20 January and 7 February 2017

This inspection was prompted by an incident whereby a person who used the service sustained a serious injury. As this incident may be subject to an investigation the inspection did not examine the circumstances of the incident. However, we did examine how the service managed risk to people in general.

Advent House is a two storey purpose built facility which is registered to provide 24 hour accommodation and nursing care for up to 10 people who have a learning disability. The service is accessible for people with a learning disability and who may need to use a wheelchair. The service is located within a quiet residential area with open views to fields. At the time of our visit there were four people who used the service permanently and one person who was using the service for respite care on the day. At the time of this inspection eight people regularly used the service for respite care.

The service is required to have a registered manager. 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 service did not have a registered manager at the time of this inspection. The registered manager had de-registered in August 2016; however they continued to work at the service as a registered nurse. The registered provider had deployed an interim manager at the service. A new manager had been appointed in December 2016, but was no longer in post and the interim manager remained in post.

We previously inspected the service on 30 November and 12 December 2016 and at that time we found the registered provider was not meeting the regulations relating to safe care and treatment, person centred care, consent and good governance. We asked the registered provider to make improvements.

At our last two inspections we found risk assessments were not always up to date to reflect current risks to people. This meant staff did not have the written guidance they needed to help people to remain safe. At this inspection we found improvements had not been made.

We found the registered provider had not done all that was reasonably practical to mitigate risks to people and suitable policies were not in place to keep people safe from harm.

We found incidents were recorded but not always analysed for trends, and the registered provider did not maintain an effective overview of incidents to minimise future risks to people.

Emergency plans were not in place in the event of a fire because fire drills had not been regularly completed with all staff to reduce the risks to people.

The above issues were a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the first day of this inspection CQC issues urgent action to require the service to make improvements. On the second day of this inspection we found the registered provider was taking the required action.

At this inspection we found there were enough suitably trained staff to meet the assessed needs of people who used the service, however nurses didn't always have time to complete management tasks due to supporting hands on with people with nursing needs.

Staff had a good understanding of safeguarding adults from abuse and knew who to contact if they suspected any form of abuse.

Medicines were managed in a safe way for people.

The provider had not done all that was reasonably practicable to assess, monitor and mitigate risks to people. This was a continuing breach of Regulation 12 and 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Effective systems were not in place to assess monitor and improve the quality and safety of the service. We found continuing breaches of regulation 12 and 17 which had not been addressed. This was a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 21 July 2016 this provider was placed into special measures by CQC. Our inspection on 30 November and 12 December found that there was not enough improvement to take the provider out of special measures and the service remains in special measures following our inspection on 20 January and 7 February 2017.

Following the first day of this inspection CQC issued urgent action to require the service to make improvements. On the second day of this inspection we found the registered provider was taking the required action.

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.

Risk assessments had not been completed to prevent the risk of harm to people who lacked capacity to keep themselves safe.

Incidents were not always analysed to reduce future risks to people.

Suitable policies were not in place to prevent and manage risks to people.

Fire drills were not regularly completed to reduce risks to people in the event of a fire.

Suitable staffing was in place to meet the assessed needs of people using the service.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider had not done all that was reasonably practicable to assess, monitor and mitigate risks to people.

Accurate and up to date records were not always maintained.

People were not protected by effective quality monitoring systems.

The registered provider had not taken robust action to improve the quality and safety of the service to people and address the previous breaches of the regulations we found.

Advent House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014

This inspection of Advent House took place on 20 January 2017 and 7 February 2017 and both visits were unannounced. One adult social care inspector inspected the service on both days.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding and commissioners. Before this visit we had received information of concern about an incident where a person using the service was harmed.

We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We used a number of different methods to help us understand the experiences of people who used the service, including observations and speaking with people. We spoke with three people who used the service, however as we were not familiar with their communication style, we used additional methods to understand their experience. as we had spoken with eight relatives in December 2016 we did not speak with them again. We spoke with two nurses, two support workers, the interim manager, the operations manager and the director of operations. We spoke with two community professionals. We looked at documents and records that related to five people's care, medicines records, incident reports, audits and records related to the management of the service.

Inadequate

Is the service safe?

Our findings

People who used the service were unable to tell us if they felt safe due to cognitive and sensory impairments. In December 2016 relatives we spoke with told us they felt their relation was safe at Advent House.

At our previous two inspections we found accidents and incidents were recorded but not always analysed to prevent future risks to people for trends. The registered provider did not maintain an overview of incidents to minimise future risks to people. This constituted breaches of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we checked to see if improvements had been made.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. The interim manager and staff members were able to describe the procedure to follow and explain what action had been taken following accidents and incidents. Incidents were recorded on a behavioural occurrence sheet and following this an incident report was completed.

We looked at the arrangements in place for managing incidents and preventing the risk of reoccurrence. We sampled six incident reports. One person had 3 incidents of self-harm recorded on one day in December 2016. Staff had described the incident and written triggers to each incident on the report. However the space for action taken and management overview was blank and the incident reports were signed by a nurse on 12 January 2017, four weeks after the incidents had occurred. There was no evidence the incidents had been analysed or discussed at the time or since to help prevent future incidents. The interim manager told us this was because they were normal incidents that occurred regularly and the plans in place were managing them well, however there was no evidence the incidents had been analysed to look for a way to prevent reoccurrence or reduce the potential harm. A further incident report recorded self-harm occurred on 30 January 2017 and no record of triggers or management signature was recorded.

A medicines error was recorded on 17 January 2017 for one person, as well as an incident of self-harm. A further incident where the person dented the wall with their knee running into it was recorded on 23 January 2017. We asked to see these incident reports and the interim manager could not locate them. They told us incident reports were usually left on their desk for them to review. The registered provider forwarded the reports following our inspection. The medicines error involved a medicine missing from one person's medicines box and the interim manager had recorded that they had looked into this and it had been broken and discarded, however there was no evidence the lack of recording had been followed up with the staff responsible.

The second incident report from 23 January recorded the triggers to the incident and the management action said, "No injury. PC to repair the wall." There was no analysis of how this behaviour might have been prevented for example by distracting the person with activities at busy times. This showed people were not always protected from the risk of harm because incidents and accidents were not always analysed to

prevent future risks to people.

At our inspection on 21 July 2016 we found risk assessments for people who used the service were insufficiently detailed. This meant that staff did not have the written guidance they needed to help people to remain safe. We told the registered provider to make improvements and they sent us a response outlining the improvements they would make. At our inspection on 30 November and 12 December we found some improvements had been made however risk assessments for one person using the service for respite care had not been updated. Their risk assessments did not include or reflect current risks caused by significant deterioration in their health related needs. The interim manager told us they had prioritised long term residents care records. Following the inspection we telephoned the interim manager to check the persons care plans and risk assessments had been completed and updated to reflect current risk. They said the key nurse had completed the updated care plans and risk assessments. At this inspection we checked three respite care records to see if improvements had been made.

On 20 January 2017 we saw the above person's risk assessments and care plans had been audited, to record which care plans and risk assessments required updating but the action had not been completed. There were still no up to date care plans and risk assessments in place regarding the persons complex health care needs.). An emergency care plan was in place in the care records provided by the community palliative care team. We told the registered provider to make improvements and on the second day of our inspection we found a nurse was in the process of updating the person's risk assessments and care plans. The person attended the service for respite care on the second day of this inspection and the nurse on duty told us the person attended the service most weeks. We saw a new nurse was being shown how to support the person and meet their complex needs, as the person's key nurse was leaving the service.

The above issues were a continuing breach of regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the first day of this inspection we told the registered provider to take urgent action to reduce risks to people. On the second day of this inspection we saw the required action was being taken and the interim manager, operations manager and operations director were present at the service completing the required actions.

The interim manager gave us an example where they felt the risks to one person's health had been managed well recently and the way in which staff always ensured the person was seated in the correct posture to minimise their health risks.

We looked at the emergency procedures in place. At our inspection on 30 November we found fire drills had not been completed since March 2016. The interim manager told us they would arrange a fire drill for the following day, however at this inspection we found a fire drill had been completed on 12 January 2017. We discussed the frequency of fire drills with the interim manager and operations manager, who told us drills should occur every 6 Months. The fire drill that had been completed involved 6 out of 23 staff. The interim manager and the operations manager told us they would ensure all staff had attended a fire drill in order to ensure they knew the procedure to follow in the event of a fire to keep people using the service safe from harm. This meant the registered provider was not doing all that was reasonably practical to reduce risks to people in the event of a fire.

This was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One staff member told us there were not enough staff at times and this could restrict activities outside the service for people, although they felt this had improved lately.

At our inspection on 21 July 2016 we found the registered provider had failed to ensure suitably qualified staff were on duty at all times because there was not always a nurse on duty. At our inspection on 30 November and 12 December we found improvements had been made and a qualified nurse was now on duty at all times.

At this inspection we looked at historic rotas and found there were enough suitably trained staff to meet the assessed needs of people who used the service and a nurse was on duty at all times in the weeks we sampled. However nurses found it difficult to complete management tasks such as updating care records, as they were needed to deliver nursing care.

At the time of this inspection one qualified nurse had resigned but agreed to stay on to help the service with updating records. There were two qualified permanent nurses in post to cover the service 24 hours a day. The service used agency nurses to cover all night shifts and some day shifts. The interim manager told us they used familiar agency staff wherever possible.

On the second day of this inspection we found medicines were administered in a safe way for people.

At the time of our inspection people who used the service were unable to administer their own medicines. We saw when medicines were administered the staff member spoke to the person and told them what the medicine was.

Blister packs were used for most medicines at the home, as well as some medicines in bottles and boxes. We looked at people's medication administration records (MAR). A MAR is a document showing the medicines a person has been prescribed and is used to record when they have been administered. We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered.

Some prescription medicines contained drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded.

Creams and ointments we saw were dated upon opening and found to be in date. Body maps were in place to guide staff as to how and where to administer creams.

People's medicines were stored safely in a locked room. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use and fridge and room temperatures were recorded daily. This meant people were protected against the risks associated with medicines because the registered provider had appropriate arrangements in place to manage medicines.

In the records we sampled we found people had individual 'as required' (or PRN) medication protocols. PRN protocols provide guidelines for staff to ensure these medicines are administered in a safe and consistent manner. However the PRN protocol format contained the signatures of staff, but the signature space for the person or their representative was not signed in the records we sampled. The nurse on duty told us if PRN medicine was administered they would inform the person's relative. We discussed signing consent forms at review meetings, however the nurse on duty told us they did not hold review meetings for people using the service for respite care, but did attend reviews held by other organisations, such as day care or social work

reviews. The interim manager told us they would ensure appropriate consent was gained in the future. We found there was no PRN protocol or body map in place for one person's cream for intermittent skin damage and the MAR sheet stated, 'As required.' The nurse on duty told us they would address this.

At our last inspection we saw no audits of medicines administration had been completed to ensure compliance with the registered provider's policies. At this inspection the nurse on duty showed us weekly audits, involving counting the number of medicines, had been completed. The audits did not include looking for any missed signatures on MAR charts. The nurse on duty told us that if they noticed a missed signature or inaccurate count they would complete an incident report for the manager to address and take the appropriate action to ensure the person using the service was safe.

We saw nurses and senior care workers administered medicines at the service and completed online training in relation to medicines administration. Medicines administration was witnessed by a second member of staff who had completed on-line training, although one staff member we spoke with told us they had not completed any training in medicines. They said the nurses had shown them what to look for when witnessing medicines administration. On the second day of our inspection we saw one member of staff witnessing medicines administration new what to look for to ensure medicines were administered safely.

At our last inspection we found there was no evidence competence assessments had been completed to ensure staff had the appropriate skills and knowledge to administer medicines safely. The manager told us this was an area to address and they planned to introduce three monthly competence assessments. On the second day of this inspection we saw some medicines competence assessments had been completed with staff.

On the second day of this inspection we saw the flooring in one person's flat had been replaced since our last inspection to reduce the odour and protect the person's dignity and well-being.

Inadequate

Is the service well-led?

Our findings

Relatives we spoke with in December 2016 told us the service was not always well led, but some improvements had been made.

The service did not have a registered manager at the time of this inspection. The registered manager had de-registered in August 2016; however they continued to work at the service as a registered nurse. The registered provider had deployed an interim manager at the service. A new manager had been appointed in December 2016, but was no longer in post and the interim manager remained in post. On the 7 February 2017 the interim manager told us a new manager had been recruited and would commence employment at the service on 13 March 2017, subject to pre-employment checks.

Two staff members told us they felt the interim manager was doing a good job; however the registered provider did not always provide sufficient support. One staff member told us they felt the interim manager was left to deal with everything by the registered provider and they were overwhelmed by the work needed.

The staff we spoke with felt supported by the interim manager and told us the staff worked well as a team. One staff member we spoke with said, "(Name of manager) is doing her best to bring things up to date. Service users are great and families. Staff get on together. People will get stuck in."

On the second day of our inspection the new nurse we spoke with told us they had been prioritising risk management at the service and analyses of behavioural incidents, as well as getting people out in the community. They said, "Everything I have suggested has been supported. It's very positive to be here."

The interim manager told us they felt supported by the registered provider and they felt they provided good resources, such as funding for activities for people.

They said they would like to see the newly recruited permanent manager be able to come in and do the managers roll, with a deputy manager in place to support them. The deputy manager of the service was currently on maternity leave and their hours had not yet been replaced.

We found there was a lack of management input at the service. The interim manager was still responsible for the service where they were registered manager, although another manager had now applied to register as manager there and they had also been completing some work as an area manager for the registered provider, which meant they were not on site at Advent House full time.

At our inspection on 21 July 2016 we found the registered provider was failing to keep an overview of incidents and accidents to reduce risks to people. At our inspection on 30 November and 12 December we found improvements had not been made. On 30 November the interim manager told us they were intending to start an overview and analyses record in December 2016 and showed us the blank document. At this inspection on 7 February 2017 we asked the interim manager how trends and patterns in incidents were analysed and managed to reduce risks to people.

We saw an incident spread sheet had been started containing incidents that had occurred in December 2016. This included columns to record triggers to the incident, any injuries and action taken to prevent future risk. The nurse on duty told us they had been asked by the interim manager to enter December's incidents on the spread sheet after signing them on 12 January 2017. There was still no analyses of what the overall number of incidents meant or what patterns may be occurring to help plan risk reduction strategies. The interim manager told us this was due to time constraints and they aimed to complete this analysis at the beginning of each month in the future. They had completed an audit of physical interventions used during December 2016 on 28 January 2017, although there was no analysis of these figures for patterns to reduce recurrence. The interim manager said the new nurse would be helping in this area, as well as auditing use of PRN medicines for behavioural management in the coming months.

At our last inspection on 30 November and 12 December 2016 we found the number of incidents that occurred in any one month were sent to the registered provider as part of a monthly operations report. We saw from the monthly report in July 2016 23 incidents were recorded but there was no record of overview, analyses or action taken to reduce incidents by the registered provider. At that time no monthly operations reports had been completed since July 2016 and there was no evidence action had been taken by the registered provider to address this.

At this inspection we found the interim manager had completed a monthly operation report for November; however there was no report for December 2016 or January 2017. The interim manager told us this was due to time constraints and they would aim to complete each report in the first week of the following month.

As discussed earlier in this report we found appropriate and up to date records, such as risk assessments and care plans were not always kept to ensure staff had the information required to deliver safe person centred care. Records were not being regularly reviewed by senior staff at the service to ensure safe care and treatment was being provided.

In terms of being well led, the Registered provider had not demonstrated good governance, by way of assessing and mitigating the risks relating to health and safety of service users, nor had they assessed and improved the quality and safety of the service provided after a serious incident occurred. This was evidenced in relation to a specific incident for a service user, where they had suffered harm, whilst receiving care and treatment, by having the access to objects that placed their health and safety at risk of harm.

On 24 January 2017 we asked the operations manager what action was being taken to keep people at Advent House safe following the serious incident. They said the company health and safety department were compiling a policy. This meant the registered provider had not evaluated and improved their health and safety practice, until the Commission requested a policy. The Commission found there was no evidence any action had been taken by the registered provider of their own volition to review the incident and prevent it from happening again.

The operations manager told us they could not investigate the incident until the local authority safeguarding team had completed their investigation; however at our visit on 20 January 2017, the Commission found that no risk assessments had been updated or implemented to keep others safe.

No relatives or service user meetings were held to consult people and their representatives about how the service was managed. The registered provider had not requested any formal feedback from people using the service, relatives or professionals, despite some negative feedback contained in the last two CQC inspection reports. An annual questionnaire had been sent out to relatives in May 2016. The interim manager told us they and the nurses on duty spoke to family members regularly and tried to resolve any concerns they had,

but they felt the service may benefit from more formal feedback from and consultation with people using the service and their representatives.

On the first day of this inspection we found continuing breaches of the regulations relating to safe care and treatment and good governance, which had not been fully addressed. We found the registered provider was failing to keep an overview of the service and put effective measures in place to improve quality and safety.

The above issues evidenced a continuing breach of Regulation 12 (a) (b) (c) and (d) and 17 (1) and (2) (a) (b) and (c) (d) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued urgent action to require the registered provider to make improvements and on the second day of this inspection we found they were taking appropriate action.

On the second day of our inspection we saw a manager from another service was completing an investigation of a specific incident as required by CQC following our visit on 20 January 2017. We also found the operations director, operations manager and interim manager were present at the service completing the actions required to make the service safe, including updating risk assessments and policies.

A consultant had been appointed to advise the service on improvements. The operations director showed us the initial document they were planning to use to rate the urgency of actions to be completed and ensure action was taken to address any issues. This would be used as part of the overview by the operations manager on visits to the service in addition to supervision with the interim manager. Checking the maintenance report would also be included in the operations report.

Since the first day of this inspection the registered provider had also added a section to their operations report to include a recorded monthly walk around by the operations manager, including sampling two care records and two staff files to ensure compliance with the registered providers policies and procedures. This would include a summary of actions signed off by the operations manager on their visits. This was currently being developed and had not yet been completed.

The November 2016 operations report had been completed by the interim manager and included their supervision with the operations manager and any required actions. The operations manager showed us two supervisions they had completed with the interim manager since our last inspection, which included actions to be taken by whom. Issues discussed in supervision included fire safety checks and drills, complaints, records and care plans to be updated. Supervision had also been completed in February 2017.

On the second day of our inspection the interim manager showed us some audits that had recently been completed, for example an audit of physical intervention had been completed on 28 January 2017 and a medicines file audit on 27 January 2017. The actions required included adding photographs of some people to their medicine's records and the interim manager told us they had bought a camera for that purpose.

A competence matrix had been instigated on 3 February 2017 to keep an overview of staff competence assessments and some medicines competence assessments had been completed. On the second day of our inspection staff told us they had been observed using the hoist by the nurse on duty that day to ensure they were competent and safe to do so.

The interim manager said their aim for the service was positive outcomes for everyone who used the service and to see people out enjoying life and doing things. The interim manager attended regular managers meetings to discuss relevant issues and share good practice.

Staff told us they had regular meetings where they were encouraged to share their views. We saw regular staff meetings were held and one staff member told us ideas they suggested had been listened to and acted upon.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit statutory notifications to CQC when certain incidents happen. At this inspection we found notifications were being reported to CQC in line with legislation.

We found the most recent CQC ratings for the service were displayed at the service in line with Regulation 20A of Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015. This showed they were aware of their responsibilities to display the most recent performance assessment rating of their regulated activities.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not done all that was reasonably practicable to mitigate risks because incidents were not analysed to prevent the risk of re-occurrence and appropriate policies were not in place. (1) and (2) (a) (b) Fire drills had not been regularly completed. (1) and (2) (a) (b) (d) Risk assessments were not all up to date to reflect current risks (1) and (2) (a) (b)

The enforcement action we took:

A notice of decision to impose conditions on registration was issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not done all that was reasonably practicable to mitigate risks and appropriate policies were not in place. (1) and (2) (b) Accurate and up to date records were not always kept. (1) and (2) (c) Quality monitoring systems were minimal and ineffective. (1)and (2) (a) (b) (f) The registered provider did not seek and act on feedback from relevant persons (e)

The enforcement action we took:

A notice of decision to impose conditions on registration was issued