Care Quality Commission

Southend Care Limited

Ramsey manor

Inspection report

Ramsay Road
Ramsay
Harwich
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection took place on 13 and 17 April 2015. Ramsay Manor provides accommodation and personal care for up to 84 people, many of whom were living with dementia . There were 36 people living in the service when we inspected.

The overall rating for this provider is 'inadequate'. This means that it has been placed into 'special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin

Summary of findings

the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove the location or cancel the provider's registration.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

After an inspection in July 2014 we asked the provider to take action to make improvements to the environment, care and welfare ,staffing, and how the quality of the service was monitored. Following this inspection the provider sent us an action plan to tell us the improvements they were going to make, which they would complete by September 2014. During this inspection we looked to see if these improvements had been made, but they had not all been completed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People's safety was being compromised in a number of areas. This included how well the environment was being maintained and how well equipment was cleaned and maintained as well as how well medicine's were administered.

People's health care needs were assessed. However, people's care was not planned or delivered consistently. Although people told us they felt their privacy and dignity was respected and made positive comments about staff, we saw that care was mainly based around completing tasks and did not take account of people's preferences, it was not individualised and did not promote independence where possible.

The provider did not have a system to assess staffing levels and make changes when people's needs changed. This meant they could not be sure that there were enough staff to meet people's needs. Furthermore, everyone we spoke with raised concerns about low staffing levels. There were not enough staff to meet people's needs.

The process for monitoring the quality of care was still not effective; it had not picked up some of the significant problems we found so had not led to the necessary improvements.

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?

Inadequate

The service was not safe.

People who used the service were being put at risk because the environment was not being well maintained and equipment was not cleaned or maintained properly.

Arrangements for the administration of people's medicines were not managed safely and effectively.

There was no way of assessing staffing levels against people's needs, this meant that there were not always enough staff on duty at certain times.

Recruitment processes were not sufficiently robust to ensure that risks to people were minimised.

Is the service effective?

Requires Improvement

The service was not effective.

We found that people's health needs were not being appropriately met.

People enjoyed the food and had a choice about what and where to eat, but information about what was available was not always shared in a way people could understand.

Is the service caring?

Inadequate

The service was not caring.

People were generally positive about the care they received, but this was not supported by our observations. Care mainly focused on tasks did not always take account of people's individual and personal preferences.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

People's concerns and complaints were investigated and responded to but lessons were not shared to limit the possibility of reoccurrence and improve practice.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well- led.

People were put at risk because systems for monitoring quality were not effective or robust.

Safeguarding concerns, accidents and injuries were monitored and investigated, however they were not analysed to enable any trends to be identified and improvements to be made.

Management and staff did not have a clear vision of the service they were providing and the culture was not focused on improving for the benefit of those living there.

Ramsey manor

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 took place on 13 and 17 April 2015 and was unannounced. The inspection team consisted of three Inspectors, two specialist advisors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. To help us plan what areas we were going to focus on during our inspection, we looked at the PIR and reviewed information we had received about the service such as notifications. This is information about important events which the service is required to send us by law. Information sent to us from other stakeholders for example the local authority and members of the public were also reviewed. We spoke with people who were able to express their views about the service and relatives.

We spoke with 10 people who were using the service, three relatives seven staff, including the deputy manager and five care staff. We also spoke with the registered manager. We looked at records relating to people's care and welfare, the management of the service, staff recruitment, training records, and systems for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

We found significant concerns with the safety and suitability of the premises, care and welfare of people and staffing. A number of areas of the service posed a health and safety risk to people's welfare. There was also records showing that there were a significant number of people who had experienced falls related to unsuitable equipment and the poor environment.

Risks to individuals were not always managed consistently to ensure people's safety. People who had bed rails in place had not been assessed for them. This is important to ensure that people are safe where there is a risk they may fall from bed. There were a number of people who were cared for in bed who had rails fitted. Without the assessment we could not determine their suitability or safety. For one person the rails were fitted to a low divan bed and were not secure. When the rail was raised one part detached from the other. The design and position created a hazard and risk for the person becoming trapped.

Equipment being used was in a poor state of repair for example safety rails in toilets were loose and poorly fitted. Armchairs in some areas of the service were unstable or too low to meet the needs of people who were unsteady. This again placed them at risk of falling.

The building was also in a poor state of repair and equipment was not being maintained safely.

Many areas of the service had differing floor levels which we saw made it difficult for people with dementia or poor mobility to negotiate. In addition we saw people using areas where there were soiled items including bed sheets which had not been removed or cleaned. There was inconsistency in the documentation to show when an area had last been cleaned or checked for safety.

The layout of the service meant that communal areas were a long way from some people's private rooms. For people whose mobility was reduced this resulted in fatigue when walking and thereby an increased risk of falling. There may also be a risk that people's mobility will not be maintained and they will become unnecessarily dependent upon staff or wheelchairs. There may also be a risk that people could become socially isolated as they may remain in their rooms due to the effort involved in walking the distances to the communal areas.

The call bell and intercom arrangements were not working effectively for people with impaired hearing, communication difficulties or dementia because they were either unable to use it or unable to communicate effectively with staff through it. This meant people were not always able to call staff when they needed them with the equipment available.

One person was having significant respiratory difficulties and needed a way to call for staff. We observed this person press their call bell twice for assistance it was answered via the intercom system but that each time it was answered by a different member of staff who were unable to understand what the person required. We intervened and explained that the person required assistance and a member of staff then came and attended to their needs.

It was not always obvious that a call bell was ringing as no sound was heard only a flashing light in the person's room. Staff told us that they answered call bells by mobile phones and were able to speak directly with the person who called. Staff could not explain how people who were unable to communicate or were unwell were enabled to alert staff that they needed help.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where there were fall risk assessments/plans in place for people they were not personalised and did not clearly identify the assessed hazards, risks and control measures necessary to eliminate, avoid or reduce the individual's risk of falls. This included people not being individually assessed for appropriate mobility equipment which met their needs. Moving and handling risk management tools did not reflect people's needs accurately or tell staff how their needs effected the support they required. For example we found that there were twelve different types of sling being used with a variety of hoists. They were not labelled and staff could not tell us who they were for and confirmed they were being used for everyone. Slings should be measured and assessed for individuals to avoid accidents (due to being too large, small or inappropriate for the support needed) and risk of cross infection.

The service had an 'Equipment Store' which staff used to provide people with walking frames, sticks and other items. We observed (and a relative shared their experience of) people using inappropriate equipment when their own had

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Is the service safe?

broken or was faulty. In the two cases we observed the replacement items had not been assessed for the individual and/or a referral to appropriate professionals had not been made. One person was no longer able to access a toilet independently because their replacement frame from the store was too large. Their attempt to do so meant they were at a further risk of falls. Another person had had a stroke and had a history of falls and so needed assistance with standing. However the service failed to refer them to a professional to help assess their needs and instead provided a toilet frame which was not suitable and placed them at further risk.

There were not enough staff to meet the needs of the people. A relative said, "The staff do a good job, but the staff are stretched, they go beyond the call". Another told us, "Sometimes there is definitely not enough staff". Another relative told us, "Some staff are tired as they are working a 12-14 hour day, from 7am till 9pm". We saw that people were not getting the care they needed at the time they wanted. People told us that they felt there should be more staff. One person told us, "They [the staff] are often slow to respond when I call them." They went onto tell us that their call bell had not been functioning for sometime, despite being reported.

Throughout the inspection we saw that people needed staff but staff were not available as they were busy helping others. Staff told us they were under pressure and sometimes worked 12 – 14 hour shifts. One told us "You can sometimes feed two [people] at a time. Some of our residents are slow at eating so you can manage it". We intervened to call staff on a number of occasions to support people. This included when a person had to shout for assistance to go to the toilet because their call bell was not in their reach and when another person got their hand trapped between their wheelchair and a radiator.

We observed a person in bed in a state of undress in the afternoon. A full uneaten meal was on their bedside table. The person said that they were "Still waiting for a wash" and "It is very difficult to get a wash here." In another case a person who had experienced a seizure earlier in the day had been supported to go to bed. No arrangements were in place to ensure they were monitored to ensure they were safe. We observed they pressed their call bell for assistance but no one came. We intervened and told a member of staff that the person needed help. However it was a further 12 minutes before staff attended them. We raised a safeguard to the local authority about our concerns as people with identified needs were not being supported or monitored to ensure they were safe.

Medicines were being appropriately and safely stored in a designated medication room. Appropriate arrangements were in place for the storage of controlled medicines, however the requirement for a second person to witness there administration had not been complied with. This is a specific requirement when administering medicines of a controlled nature.

We observed poor practice when observing a medicines round during the lunch time period. A staff member signed that medicines had been taken prior to a person taking it. The member of staff told us the person never refused their medicines. This is poor practice and also did not take account of the person's choice to change their mind, request having it later or if they were asleep. We also saw that the medicines cabinet was left open and unattended. This might potentially pose a significant risk to people using the service because people or others might be able to access medicines by accident or without the knowledge of staff.

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

All of the required checks had not been appropriately completed prior to staff commencing their employment including a Disclosure and Barring Service (DBS) check, previous employment references and a health check. We reviewed the recruitment records for three members of staff and in one could not find any evidence that a DBS check had been carried out. These checks are required to assist in minimising the risk of inappropriate staff being employed to work with vulnerable people. The manager was unable to explain this omission

The majority of people using the service needed support and care with daily living. In many cases they were unable to communicate independently with us. However we saw that the arrangements for their complex care was not keeping them safe from avoidable risks. However people who were more independent told us that they did feel safe,

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Is the service safe?

that staff understood their care needs well and were always kind and polite to them. A relative told us, " The staff here are exceptionally kind" and "I know that my relative is safe, secure and happy here".

Staff told us, and records confirmed that they had recently received training in safeguarding vulnerable adults. Staff were able to tell us how they would respond to allegations or incidents of abuse, and also knew the lines of reporting in the organisation. These were appropriate although we were concerned that staff had not considered that their concerns about the staffing levels and meeting people's needs could be a safeguarding matter. These concerns had not been identified or escalated within the service to ensure that people were kept safe as far as possible.

Requires Improvement

Is the service effective?

Our findings

Staff had not received effective training to ensure they could meet the specific needs of people to keep them safe. People using the service were at various stages of their dementia condition, ranging from early onset to advance stages; there was no plan about how the service kept up to date with developments in this area to ensure the care provided was effective and in keeping with best practice. Staff had a limited understanding of how dementia effected people in their day to day living, they did not know about best practice and did not always recognise poor practice; 17 of 43 staff had not received any training in this area since 2011.

We saw that at times staff were impatient with people who were anxious because they (people) were unable to remember where they were or what they wanted to do. Staff failed to explore ideas or recognise opportunities to help people be less anxious. For example a person who wanted to leave the building to go to the pub was not responded to by staff and they became increasingly anxious and disorientated. The service had access to a small bar area that might have been used to occupy the person and distract them. A relative told us, “The staff need better dementia training. Staff are not aware of dementia. They need to make the home far more dementia friendly.”

Overall staff training was inconsistent with significant gaps for staff in fire training, health and safety, Mental Capacity Act (2005) and Deprivation of Liberties (DOLs). Staff were unable to tell us about how they ensured people’s rights around consent were being respected and adhered to. Given that many people had needs which meant that at times they might lack capacity to make good decisions, we were concerned about this lack of understanding.

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

People had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists and had attended regular appointments about their health needs.

We observed lunch and saw that the menu consisted of two choices. All of the people were given a cold drink placed on the tables with the staff helping them to eat and encouraging those in a kind manner who seemed reluctant to eat. One person told us, "I eat when I want to eat, where I want to eat and what I want to eat.”

We observed a member of staff reading the menu for the following day from a sheet and ticking the boxes once the person had replied. Given that many people using the service had dementia which meant they had some cognitive and communication difficulties there were not alternative ways of showing people what their options were for lunch. For example pictures to make a choice or showing alternative plates of food at the time of the meal.

A relative told us, “They have adjusted my relatives food to meet their needs, after they came back from hospital.” However another relative told us that their family member was not sufficiently supported to eat their meal. They were so concerned they ensured they came in to assist their relative. None of the people we observed were able to express what their favourite meal was and this had not been explored as part of their care plan with relatives or friends who might be able to help this.

We recommend that the service seek advice and guidance from a reputable source about how to support people in meeting their individual nutritional needs, especially those with specialist needs including dementia.

Inadequate

Is the service caring?

Our findings

There was inconsistencies in feedback from people and relatives about how the service demonstrated it was caring. Some people shared their experience of being treated with respect and in a kindly manner. One person said, “The staff give personal care very discreetly, I always feel my privacy and dignity are respected.” We observed some staff showing compassion in their actions, including holding people’s hands and placing an arm around people’s shoulders to provide comfort, encouragement and support. However other people did not experience this approach and were left alone or not given the support they needed which protected their dignity and privacy. For example one person called out for attention to be supported to use a toilet but staff ignored them. We intervened and staff responded. We saw that some staff spoke with people in a disrespectful manner. We observed two members of staff assisting a person to transfer from an armchair into a wheelchair and speak to them in an undignified and disrespectful way. This was reported to the manager who told us they would take action to address this.

We saw a person wandering up and down a corridor carrying a portable charged electric razor. They were unshaven and by putting the razor to their face and then giving the razor to us indicated they wanted to shave. Their care plan stated they liked to have a clean shaven face and required support and prompting to achieve this wish. This had not occurred and was causing the person visible distress. Staff kept passing them in the corridor and although they asked if they were alright, nobody stopped to give the person the assistance they required. In another incident we observed a person stand up from their wheelchair against a dining table. When we asked staff if they were safe they responded “They normally let [person] walk around after dinner and hope [person] doesn’t fall down”. This lack of care meant we had serious concerns so we reported this to the local authority safeguarding team.

No action had been taken to support a person whose first language was not English. There was no information about how they should be supported or how staff should approach their care. Staff were unable to tell us how they communicated, they did not know the language they spoke and there was no alternative communication tools. We therefore could not establish how their needs were being met

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

Inadequate

Is the service responsive?

Our findings

Improvements were needed to ensure people receive care and support specific to their needs and support to participate in activities which were important to them. Requests for assistance were not answered promptly and support was not given immediately where their identified needs showed this was important. For example a relative shared that they felt that staff had not responded to their family member's deteriorating health needs promptly. This resulted in a hospital admission they felt could have been avoided. In another case a relative said that although they had seen their family member's care records, they did not understand them and said, "It is hard to find out how they work".

One person who was epileptic did not have a care plan that reflected their needs. Their epilepsy seizure diary was blank and the care plan did not provide guidance for staff on how to support this person during and following a seizure. We were so concerned about this that we spoke with the manager who said they would take action to address this.

We also found that care plans were contradictory. For example one person's care records stated they could walk, but another section said they were 'wheelchair bound'. Additionally assessments of need were contradictory and did not provide clear, current and relevant information to guide staff on the level of this person's ability to mobilise and the type of support they required to move safely and reduce the risk of falling.

We reviewed the care plan for one person who was being nursed in bed due to limited mobility and loss of confidence. The persons care records stated that they should be repositioned regularly, however the entries made by staff at 8.00am, 10.00am, 12.00pm, and 2.00pm did not indicate what side the person was repositioned to. The entries only stated 'bed' so their position could not be tracked. Regular repositioning is required to provide relief to pressure areas and help to prevent skin breakdown. The records gave no indication of the care being delivered and the food and fluid charts did not provide an accurate account of the amount consumed. The manager was unaware that records were not being completed correctly and there were no arrangements in place to check and sign off the monitoring forms. They told us they would take action to address this.

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

Each person did not have an individual personal activities programme and there was no one-to-one activities. People we spoke to were unaware of any activities being carried out or said that there was "Not much going on". A relative told us they felt that there was not enough for people to do, and said that a carer had recently done an activity with their family member that they really enjoyed. They said this was the first and only time they had been supported to engage in an activity like that.

There was some information about people's preferences or personal history in their care records. However this was inconsistent or the information had not been explored to support staff to understand people's needs or help develop ways to engage with them in a meaningful way. It was not clear how people spent their time other than sitting, eating meals or in their own bedrooms There was no consideration about how to address social isolation of people who were unable to move independently or leave their rooms due to ill health. One person said they would like to go out for "A breath of fresh air" but they hadn't been out "For years". There was no reason provided other than there was no one to support them. The day of the inspection was warm and sunny but none of the people using the service were encouraged to access the extensive gardens.

There was a system in place to respond to complaints received. Complaints had been received and there was evidence that these had been investigated and responded to in line with the providers complaints policy. However there was no evidence that any learning had taken place from these complaints and outcomes shared with people, staff or relatives. The opportunity to use these complaints to improve the service for everyone had not been taken forward. In one case a relative told us they felt they were not listened to and their concerns were not being addressed effectively. In another case a relative had raised concerns about medical equipment that was needed for their family member, which had not been provided. The management team had not explained what was happening with their request.

Inadequate

Is the service well-led?

Our findings

Systems in place for assuring the quality of the service were not robust. The provider's quality team carried out monthly visits to the service. The team completed audits of the systems and practice to assess the quality of the service, which the registered manager said were then used to make improvements. We saw that staff undertook internal audits on infection control, medicines and care plans. These internal audits were not effective because they had not picked up the issues and causes for concern that we had identified in many areas including gaps in training, poor practice and maintaining an ensuring a safe environment.

There was a lack of managerial oversight of the service as a whole. The registered manager was unable to demonstrate how they identified where improvements to the quality and safety of the service was needed on a daily basis. However staff told us that the manager was very supportive and encouraged them to contribute to the running of the service during the bi-monthly team meetings. One staff member said, "The manager walks around the service every day they are here and talks to people, they encourage us to sit and talk with people and do activities with them".

We asked the registered manager to show us what arrangements and systems they had in place to drive improvement. They said that the provider's Care Quality Manager checked the audits that had been carried out. These were not linked to actions taken to make improved changes for people as a result of assessing and monitoring the quality of service provision.

We were also shown a 'Hotel type standard' audit. This was carried out each month by the registered manager and care quality manager to ensure the overall cleanliness and tidiness of the service and the visitor's first impression.

We also found that the service was not following some of its own policies and procedures including checks on equipment being serviced and regular safety checks.

The provider, management and staff did not have a clear vision or focus on the service they were providing. The service did not consistently enable and encourage open communication with people who use the service or their representatives. The registered manager told us that resident and relative's meetings were not held. We asked how the experiences of people using the service were sought and we were shown a 'listening form'. This had broad questions about the service which in most cases staff completed on people's behalf. There was no information provided to show how these were used to improve the quality of the service or show how comments from people were considered. The provider did not have an effective quality assessment which enabled them to evaluate the impact on people with dementia using the service.

Incidents and accidents were not analysed to identify any trends or themes across the service that could be addressed and improved. Learning had not been taken forward with the care team from these events to ensure they were not repeated and future incidents less likely to occur. For example Moving and Handling issues, and incidence of falls across the service.

Because of our concerns about the suitability of the call bell system we asked how it was monitored to ensure it worked effectively. The care quality manager told us that the call alarm system could not be monitored to ensure they were answered promptly and appropriately. They also confirmed there was no other system in place for checking that the system for responding to people who needed help or support was in place.

Whilst we found that staff were trying to meet the needs of people, the way in which they were managed and how the service was being run overall did not ensure that there was a consistent positive culture, ethos and vision being promoted. Staff did not recognise poor practice because they had not received the training and support they needed. The service had not identified that this was an issue because the audits and oversight from the provider was not robust enough. Care records showed that information was out of date or contradictory. This resulted in a serious shortfall in the quality of the service being provided.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2)(a)(b)(c)(d)(e)(h) How the regulation was not being met: The registered person had not taken all reasonable steps to ensure the health and safety of people, by doing all that is reasonably practical to mitigate any risks to the individual and within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (a)(b)(c), (3)(b) How the regulation was not being met: We found that people did not receive care and support that was personalised specifically for them. People's needs were not properly assessed and care and support was not designed and delivered in a way that ensured it was appropriate for each individual to meet their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person did not have an effective operation of systems or processes designed to enable them to regularly assess and monitor the quality of service provided and to identify, assess and manage risks relating to the health, welfare and safety of people using the service.

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 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: We found that the registered person had not taken people's needs into account and ensured that premises and equipment were suitable for the purpose for which they were being used.