Care UK Community Partnerships Limited

Harry Sotnick House

Inspection report

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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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced inspection of this home on 10, 11 and 17 February 2015. Repeated breaches of the legal requirements were found in relation to; the standards of care and welfare for people who used the service, lack of robust quality assurance, unsafe management of medicines and the failure to manage complaints effectively. After this comprehensive inspection we served four warning notices with respect to these breaches, on the registered provider of the service, requiring them to be compliant with the Regulations by 16 April 2015.

We undertook this unannounced focused inspection on the 5, 6 and 12 May 2015 to check they had met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Harry Sotnick House on our website at www.cqc.org.uk

The home provides accommodation and nursing care for up to 92 older people including those living with

Summary of findings

dementia. At the time of our inspection 74 people lived at the home and the provider had decided not to accept any new admissions to the home following our report of February 2015.

At the time of the focussed inspection a registered manager was not in place. An operations support manager for the provider was fulfilling the role as the manager of the home and they told us they would be applying to take up the registered manager role immediately following our inspection. 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.

At this inspection we found the registered provider and manager had not met all the requirements of the Regulations to meet the fundamental standards.

People had not received their medicines as prescribed on more than one occasion and learning from previous incidents had not been demonstrated.

Health and social care professionals were involved in the care of people and care plans reflected this. Risk assessments in place informed plans of care for people to ensure their safety and welfare, however staff did not always have clear directives on why they were monitoring people regularly.

People's nutritional needs were met in line with their preferences and needs. People who required specific dietary requirements for a health need were supported to manage these. Records of dietary and fluid intake were not always accurately recorded however this was being addressed.

Care plans in place for people reflected their identified needs and the associated risks. Further work was required to embed and sustain the practice of good care planning.

Complaints had been responded to in an effective and timely manner and this work needed to be sustained.

There had been no registered manager in post for over a year. The service required sustained and effective leadership to provide guidance and stability to the staff.

There was a lack of robust audits for medicines management although other audits were effective including those for care records and complaints.

The manager was working to establish adequate staffing levels across the home in line with the needs of people.

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 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.

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.

The provider had not fully complied with a warning notice served after the previous inspection in relation to managing medicines safely. There were instances of people not receiving their prescribed medicines.

Risk assessments informed plans of care for people however this practice needed embedding in the service. There was some confusion for staff as to why they were required to monitor people regularly. We have made a recommendation to the provider regarding the use of risk assessments.

Health and social care professionals were involved in the care and support of people to ensure the care they received was safe and in line with their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

All care records held nutritional risk assessments for people. These included information on specific diets required for health conditions and preferences.

The practice of recording nutritional and fluid intake for people required embedding in staff practice.

Is the service caring?

Requires Improvement

We could not improve the rating for this question from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst care plans reflected the identified needs of people and the risks associated with these needs, further work was required in the home to embed and sustain the practice of good care planning.

Complaints had been responded to in an effective and timely manner and this work needed to be sustained.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not fully complied with a warning notice served after the previous inspection with regard to quality assuring medicines management.

There had not been a registered manager in place for over a year and the service required sustained and effective leadership.

Summary of findings

There was a lack of robust audit for medicines management. Audits in place for the review of care records and plans were being completed.

The manager was working to establish adequate staffing levels across the home in line with the needs of people.

Harry Sotnick House

Detailed findings

Background to this inspection

We carried out this unannounced 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5, 6 and 12 May 2015 and was completed to check that improvements to meet legal requirements had been completed by the registered provider after our comprehensive inspection of the service on 10, 11 and 17 February 2015. The service was inspected against four of the five questions we ask about services: Is the service safe, is the service effective, is the service responsive, and is the service well led? This is because the service was not meeting some legal requirements.

The inspection team consisted of one inspector, a specialist advisor in the nursing care of older people and an expert by experience in the care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A pharmacist inspector also visited the service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and a service improvement plan given to us by the registered provider following our inspection in February 2015. We reviewed notifications of incidents the manager had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with eighteen people who lived at the home and eight relatives to gain their views of the home. We observed care and support being delivered by staff in all communal areas of the home. We spoke with the manager and sixteen members of staff including; two clinical lead nurses, four registered nurses, care staff and an activities coordinator. During the three days of our inspection we spoke with a number of staff from the registered provider's corporate team including; the director of quality and governance, the assistant director of quality and governance, the regional director and two clinical development managers.

We looked at the care plans and associated records for ten people and the medicines administration records (MAR) for 37 people. We looked at records relating to the management of the service including records of complaints, investigation records, quality assurance documents including medicines and care record audits.

Inadequate

Is the service safe?

Our findings

At our inspection in February 2015 we found the provider had not fully complied with a warning notice in relation to managing medicines safely. People requiring medicines for pain relief did not receive them consistently or safely. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued a warning notice to the provider requiring them to be compliant with this regulation by 16 April 2015.

At this inspection we found that, whilst systems to audit and monitor the management of medicines and incidents associated with the administration of medicines had been put in place, the provider had not fully complied with the warning notice. This corresponded with a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Systems were in place to check people received their medicines as prescribed by their doctor. The service monitored and audited the use of medicine for governance purposes. A GP visited once a week and people's treatment was reviewed and changed according to their medical condition. However, during our inspection of February 2015 we identified pain management medicine prescribed in the form of a transdermal (skin) patch which was missed on three separate occasions. This was detailed in the warning notice to the provider. On this visit we found a similar incident where a patch due for a change was not administered and was picked up by an audit and administered the next morning. Two further incidents of missed medicines were reported to the Commission prior to our inspection which the service had identified. A week following our visit to this service we received a notification from the provider of another such missed dose of a pain medicine patch. This medicine had been omitted for three days. People were at risk of experiencing avoidable pain as a result of not receiving their prescribed medicines with a potential significant impact on their health and wellbeing. The service did not show evidence of learning from incidents to ensure safe management of medicine.

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

At our inspection in February 2015 we found people were not protected against the risks of receiving care or treatment that was inappropriate or unsafe because arrangements for care, as advised by healthcare professionals, were not followed. Risk assessments had not always been completed to ensure the safety of people and care plans did not always reflect these risks. This was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued a warning notice to the provider requiring them to be compliant with this regulation by 16 April 2015. At this inspection we found they had met the requirements of this notice.

Care records showed health care professionals were involved in the care and support of people and any information or instructions provided were clearly identified. Care plans had been updated to reflect these needs and daily records showed staff followed these instructions. For one person who had significant mental health needs, records showed they had been supported by the mental health team and planned changes to their treatment were clearly documented and included in their care plan. For another person who had required a specialist piece of equipment to ensure their comfort and safety, we saw this was in place and clear instructions were available for staff on the use of this equipment. One person who was receiving end of life care was supported by visiting healthcare professionals who worked closely with staff to ensure the person's safety and dignity. This was reflected in their care records.

The provider used a computerised system for care records. Risk assessments available on this system were completed but did not always provide clear information on the identified risk or how it could be minimised. For example, for one person who had a recorded risk of 'Medium' for falls, there was no supporting information as to how this risk presented for this person on the assessment. Care plans recorded the medium risk, but not what this meant, the impact this had on the person or how staff could reduce this risk. However, for other people care plans provided clear information on the risks associated with their care and the actions to be taken. For one person who was at risk of choking, they had been seen by a speech and language therapist and an agreed plan of management was documented. For another person who was at risk of a break down in their skin integrity due to poor mobility, risk assessments and care plans in place reflected the need for them to be supported to change their position regularly and ensure their hygiene needs were met. Care records

Inadequate

Is the service safe?

reflected this was completed. For three other people who required the use of a pressure relieving mattress to reduce the risk of a breakdown in their skin integrity, we saw risk assessments and care plans reflected this need.

For people who were at risk of isolation or being unable to summon help with the use of the service' call bell system, risk assessments were in place to ensure they were monitored and supported to maintain their own safety on an hourly basis. There was some confusion with staff as to the reason for this monitoring, four members of staff told us people were on behaviour management charts and these were completed hourly to ensure they observed the person and documented they had been seen and were safe. Care records showed many people were observed hourly and people had been; asleep, awake, sitting in lounge, watching television or some other activity. This showed staff had observed the person but lacked detail in the efforts made to ensure their safety and any interaction they had with the person, particularly if they were isolated.

At the inspection in February 2015 people who displayed behaviours that challenged the service were not always supported in a way which ensured their safety and that of others. At this inspection we found the provider had taken steps to improve the monitoring of people to ensure their safety and that of others. Care plans reflected behaviours people may present with and how they could be supported to ensure their safety and that of others. For one person, who often would lie on the floor of the home during the day, staff were aware of this activity and monitored the person's whereabouts at 15 minute intervals. Staff were seen to be kind, compassionate and supportive of the person whilst ensuring their safety and that of others. Another person became frustrated at times throughout the day. One to one time with staff was available for this person for periods of time noted to be particularly difficult for them. Staff were able to demonstrate the actions they needed to take to ensure the safety of the person if they did not have their one to one carer. They interacted with this person to reassure them and assist them to maintain their own safety and that of others.

Whilst we saw improvements had been made to the management of risks for people, further work was needed to embed this work and ensure all staff were aware of their responsibilities in relation to the management of risks. We spoke with the manager about the lack of consistency with risk assessments on the computer system and staff understanding of behaviour management monitoring. They agreed these were areas which required further development to embed the practice in the service.

Requires Improvement

Is the service effective?

Our findings

At our inspection in February 2015 we found the registered person had not protected people from the risk of malnutrition and inadequate fluid intake due to lack of consistency in assessing people's needs and in planning and monitoring the delivery of their care. This was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued a warning notice to the provider requiring them to be compliant with this regulation by 16 April 2015. At this inspection we found they had met the requirements of this notice.

Care records held nutritional risk assessments for people. These included information on specific diets required for health conditions such as diabetes and any allergies. All care records held detailed eating and drinking care plans which identified to staff how they should support people with their nutritional and fluid intake. Specific risks such as choking or the need for a special diet to be provided were clearly documented. For five people we saw a speech and language therapist had reviewed their needs in relation to their swallowing and care plans reflected the need to ensure their diet was appropriately adapted. Staff demonstrated a good understanding of people's needs in relation to their nutritional and fluid intake and records reflected this care was given.

If people's nutritional and fluid intake required monitoring, this was recorded in their care plan and regular recording charts were in place in their rooms to ensure this need was met. This information was reviewed daily by registered nurses and audited for any shortfall in their needs or in the recording by staff. Whilst these records were in place they were not always maintained accurately. For one person who was at risk of reduce fluid intake we saw their daily fluid chart had not been reviewed and totalled for the two days prior to our visit. We asked staff why this had not been completed and they told us this should have been done but had been missed. This was completed by the registered nurse when we returned to review the record later the same day. This work needed to be embedded in the daily practice of staff.

Requires Improvement

Is the service caring?

Our findings

We could not improve the rating for this question from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in February 2015 we found the provider had failed to ensure care plans were responsive to people's needs. The care plan system in place had not been utilised to ensure people's needs were identified, assessed and addressed. This was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued a warning notice to the provider requiring them to be compliant with this regulation by 16 April 2015. At this inspection we found they had met the requirements of this notice.

At this inspection care plans reflected the identified needs of people. Preadmission assessments and information from families and friends were available on file and had fully informed people's care plans. People had discussed their care with staff and agreed with this, where they were able. A system called, 'Resident of the day' had been introduced to ensure people and their families and representatives had the opportunity to discuss and agree their care. During a designated day every month, one person would have a full review of their care needs and the care plans in place to ensure these needs were met. A review of their room was completed by maintenance staff and their catering needs were reviewed by kitchen staff. We saw that this was in the early stages of development but had been very effective for people as a full review of their care had been completed. Two family members had fed back to the manager how helpful this had been for both themselves and their loved ones to understand their needs and how these were being met.

A computerised system of care records held clear care plans for people which met most of their needs. Care records held information regarding specific health conditions such as diabetes, epilepsy and Parkinson's disease and the impact these had on the person. However, the manager acknowledged there were some areas which required further development such as improved recording of risk assessments and ensuring consistent and effective recording in care records. For one person we noted they had a urinary catheter in place following discharge from hospital which had not been addressed as a need in their care records. This had been omitted from the hospital discharge note and hence not updated on the care record, and staff had failed to document this need in care records. For another person their falls assessment document had not been updated following a fall in March 2015 which meant we could not be sure the service had reviewed and planned appropriate care to ensure the safety and wellbeing of this person. These areas of development were being addressed by the manager.

Care records and plans held clear information and preferences on the activities and pastimes people enjoyed. However this was not always reflected in the activities and opportunities people were offered at the home. Staff often appeared to lack confidence or initiative to approach people and offer them an activity. Activities which were coordinated on the day of our visit lacked direction for many people and were focused on very small numbers of people. Equipment and activity items were available for use at the home but staff required further direction to ensure these were offered to meet this need for people. This was a matter of concern which the manager had identified and was taking action to address.

Staff handover sheets were up to date and contained information for registered nurses to allocate appropriate staffing to areas to ensure people's needs were met. A 'Care Needs Summary' was available for each person who lived at the home. This gave staff an at a glance overview of the care people required including; activities, wound and skin management, medicines management needs, communication and nutritional needs. This ensured staff who came to the service to work on an occasional basis were provided with information on each person. These records were informed from care plans on the computerised system and as such were reliant on all entries to the system being accurate and up to date at the time of printing them off.

At our inspection of February 2015 we found the provider had failed to assess or reduce the impact of unsafe or inappropriate care or treatment as the system in place for identifying, receiving, handling and responding to complaints was inadequate. This was a breach in Regulation 19 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued a warning notice to the provider requiring them to be compliant with this regulation by 16 April 2015. At this inspection we found they had met the requirements of this notice.

The provider had a, 'Comments, compliments, concerns and complaints policy', dated September 2014 in place. A copy of the complaints policy was available for view in the

Requires Improvement

Is the service responsive?

home. We saw five formal complaints had been forwarded to the provider in the period since our inspection in February 2015. All of these had been actioned and reviewed in line with this policy by a senior manager with responses having been forwarded to four complainants. The fifth complaint was awaiting further information from an investigation in order to be resolved. Each complaint had been investigated and responded to in a timely manner.

The manager told us they actively encouraged people and their families to approach them with any concerns they may have so that these could be reviewed and addressed appropriately. People told us they would talk to staff if they needed to complain, although many relied on their families to do this for them. Relatives told us they would be happy to approach the new manager to raise any concerns they may have. One told us, "…things are getting better since [manager] has been here…. things are gradually improving." Feedback held in the compliments file for the home since our inspection in February 2015 identified two families who were very happy with the care their loved one received and that any concerns they raised had been dealt with promptly.

Inadequate

Is the service well-led?

Our findings

At our inspection in February 2015 we found the registered provider had not assessed and monitored the quality of the services provided for people. This included a lack of robust audits to identify concerns with care plans and records, staffing levels and deployment and medicines management. This was a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued a warning notice to the provider requiring them to be compliant with this regulation by 16 April 2015. At this inspection we found they had not met all of the requirements of this notice. This corresponded with a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection in February 2015 the manager told us medicine audits had been completed daily at the home and a review of medicines administration records and controlled drug stocks had been completed at each handover of staff. Some audits of medicines had been completed and identified omitted medicines in a timely way. For example, one medicine patch had been omitted for a person during the evening medicines round but this had been identified the following morning and the issue addressed to ensure the person received their medicine. However, following the days of our visit an incident occurred where one person did not receive their controlled medicine for three days. This omission was not identified through the audit of medicines in place and was a recurrence of an incident which had informed the warning notice served on the provider. This showed the lack of robust audit in place to ensure the safety and welfare of people in the administration of medicines. We requested a copy of the investigation completed following this incident. There was no formal investigation report completed to identify how this omission had occurred or had been missed by four different members of staff in the following periods of medicines administration. The provider could not identify or demonstrate how learning from a previous incident had informed the practice of staff in the safe administration of medicines which meant the risk of this type of avoidable incident happening again was still present.

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

The service had not had a registered manager in post for over 15 months since June 2014. The provider had employed several people to support the management of the service, however no registered person had been appointed for the service. It is a requirement of the provider's registration that a person manages the service and the regulated activities associated with this. A senior manager for the provider was managing the home at the time of our inspection. They told us they were applying for the role of registered manager in the home to provide stability in the management of the service. They recognised the service had not been safe and had required significant input and management from the provider. They told us another registered manager would be recruited when they were assured the service was stable and at a point of sustainability to ensure people received a safe service. At the time of inspection CQC had not received any application for a registered manager for this service. Following our visit to the home we were advised a new applicant was being interviewed for this post. We were not assured of the provider's commitment to ensuring stability and direction in management for this service.

Audits were in place to review and monitor the effectiveness of care plans and records. The computerised system of records supported a programme of monitoring reviews of care and identifying the need for records to be reviewed in a timely way. This work needed to be further embedded in the service. Registered nurses were aware of the need to update and review care plans and records to ensure care staff had up to date information to meet the needs of people. The clinical lead nurses told us how they planned to ensure they monitored staff use of the system to ensure effective care plans were in place. The manager and clinical lead nurses told us this system of monitoring and review of care plans needed time to be fully embedded in practice. Staff spoke highly of the new care plans and records available to them. They were aware of people's needs and how to have these amended on the system if they identified a new or changed need.

The manager had implemented a system to deploy staff across the home in line with the care needs of people. This change had been newly implemented and with the homes recruitment needs, required some time to establish permanent staff in each area of the home. There was still a high use of agency registered nurses due to a lack of permanent staff but through recruitment processes this was being addressed. Staff reported they continued to have

Inadequate

Is the service well-led?

to move to different areas of the home although this was less often than previously. Staffing levels were addressed every morning by the clinical lead whose responsibility it was to ensure adequate staffing was available across the different areas of the home and continuity of care for people as far as possible. This work was in progress; however the manager told us they were confident they could recruit additional staff to continue to build a stable workforce as the home admitted more people.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA2008 (Regulated Activities) Regulations 2014 The registered provider had not ensured the proper and safe management of medicines. Regulation 12 (1)(2)(g)

The enforcement action we took:
A condition was placed on the provider's registration for this location preventing admissions to the service.

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 Regulation 17 HSCA2008 (Regulated Activities) Regulations 2014 The registered provider had failed to established systems processes to effectively ensure compliance with the safe administration of medicines. They had failed to learn from and improve the poor practice of medicines administration following incidents at the home over a sustained period of time. Regulation 17 (1)(2)(a)(b)

The enforcement action we took:
A condition was placed on the provider's registration for this location preventing admissions to the service.