Mr D Thomas & Ms N Gilera

Downs Cottage Care Home (with Nursing)

Inspection report

183 Great Tattenhams
Epsom Downs
Epsom
Surrey
KT18 5RA

Tel: 01737352632
Website: www.downscottage.co.uk

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

Downs Cottage Care Home provides nursing care for up to 23 older people including people who live with the experience of dementia and other mental health conditions. At the time of our inspection 13 people were living at the home. All required support with personal care and mobility.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection took place on 8 August 2016, in response to concerns we had received, and was unannounced. The inspection was planned to be a 'Comprehensive' inspection to cover all five key questions about is the service Safe, Effective, Caring, Responsive and Well Led.

At the beginning of our inspection the provider announced that the home would close in four weeks. Due to this we changed to a 'Focussed' inspection to check that people would be kept Safe during the home closure. 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 Downs Cottage Care Home on our website at www.cqc.org.uk.

People were not protected from the potential risk of harm.

People at risk of choking had been given inappropriate food that increased the likelihood of a choking incident. People who should have been on a pureed diet to aid swallowing had been given chopped up burgers, sausages, pasta back, and sandwiches. The registered manager took immediate action to ensure this did not happen again.

There were not enough staff to meet the individual needs of people. The numbers of staff deployed left people at risk of falls unsupported. Arrangements for staff to call on other staff for help in an emergency, such as if someone fell, were inadequate. Staff made reference to sounding the alarm bell to call for aid, but this could not be found on the day of our inspection.

The home had not been maintained to assure peoples safety. The landlords gas safety certificate expired in April 2016, so they could not be certain the gas appliances were safe at the home. Risks to people from the spread of infection had also not been managed in a timely way. A risk identified during a night shift was not dealt with by staff the next day, until we brought it to the provider's attention. This increased the chance that the infection would spread around the home. The provider took action to alert the appropriate authorities, and have the situation dealt with the day after our inspection.

We identified one breach in the regulations. We met with the provider, and wrote them a formal letter to

outline the actions we required them to take to ensure people where kept safe during the closure of the home.

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.

Identified hazards to people's health and safety had not been managed in a safe way, for example the management of choking risk.

There were not enough staff deployed to meet the individual needs of people.

The environment was not suitably maintained. People were at risk of infection because infection control was not managed well.

People were at risk because accidents and incidents were not always reviewed, or reported to the appropriate authorities.

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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 focussed inspection took place on 08 August 2016 and was unannounced. We had planned to carry out a comprehensive inspection, however shortly after the inspection began the provider announced the home would be closing in four weeks. We decided to focus on the Safe domain, to ensure people would be safe during the closure process.

The inspection team consisted of three inspectors.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion, as we were responding to concerns that had been raised about the home. The PIR 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.

We spoke with two people who lived at the home, one relative and four staff which included the registered manager. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how staff cared for people, and worked together. We also reviewed care and other records within the home. These included six care plans and associated records, and three medicine administration records.

At our previous inspection in April 2016 we had identified the home had made improvements to meet the regulations, however our findings on this inspection showed these had not been maintained.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at Downs Cottage. A relative said, "I definitely feel it is safe here for my family member." However we identified a number of concerns during our inspection.

People were not safe from identified hazards. Although the risk of harm to their health and support needs had been assessed, these guidelines had not been followed by staff. Assessments had been carried out in areas such as choking, mobility, and behaviour management. Guidelines for reducing the risk of choking had been given by a Speech and Language Therapist for people. Records of food given to people were not in line with the recommendations made by the SaLT. People on pureed diets had been given food that was not the right consistency which increased the risk of choking. Staff also described how they gave one person sandwiches, due to behaviour that may challenge, even though they knew the person was at risk of choking and should only be given pureed food. The registered manager immediately reviewed people's needs with staff to ensure people received appropriate food and drink.

There were not enough staff deployed to keep people safe and support the individual health and welfare needs of people living at the home. The registered manager had completed an assessment of people's needs which identified all 13 people needed two staff to support them with personal care and when mobilising, such as moving from their bed, or chair. A relative said, "I never grumble about the care staff because they are so good, but there is a lack of staff. If two staff support someone to the toilet, there is no staff left in the lounge to care for the others."

During our inspection there were a number of times during the day when people at risk of falling were left unattended, or not monitored by staff as per their assessed need. One person was independently mobile but had a falls risk assessment in place. This detailed that staff must observe when they get up from their chair to ensure they use their walking frame. They were also to guide them when walking through the house. This did not happen. A staff member was in the room when the person got out of their chair; however they were at the other end of the room, with their back to the person as they were supporting someone else. Other staff had left to support someone in their bedroom. The registered manager said they would immediately review staff deployment to ensure people's needs were met.

People's care and support could be compromised in the event of an emergency. When only one staff was supporting people in the lounge, we asked them how they would call for help if someone fell, or there was an emergency. Both staff said they would ring the alarm bell to call staff who may be in other areas of the building. When asked to show us the call bell, neither were able to locate it in the lounge area. They then said they would shout for help. This would not be effective at summoning other staff. Due to the layout of the building, staff may be some way from the lounge, and behind closed doors, so may not hear a shout.

People were not cared for in a safe environment. We identified concerns with regards to the safety of the premises and the control of infection risks. The provider had failed to keep people safe by not having the gas installation within the home regularly maintained. The provider did not have a current landlord gas safety certificate. The previous one had expired in April 2016 and the provider had failed to get a safety check

completed. As a result the safety of the gas systems in the home was unknown. The risk to people from this had not been addressed by the provider. A significant infection risk had been identified by staff during the night prior to our inspection. Neither the provider nor the registered manager had responded appropriately to address the issue and reduce the risk of it spreading through the home.

People were not safe because accidents and incidents were not reviewed to minimise the risk of them happening again. They had also not been reported to all the relevant agencies. For example one person had fallen, which had resulted in a dislocated elbow. Due to the nature of the injury this should have been reported to CQC, who are the lead agency with regards to investigating possible avoidable accidents, but the registered manager had only notified the local authority. By the provider not reporting in line with regulation, people were at risk of accidents not being investigated and managed to ensure the risk of them happening again was minimised.

Due to the number of concerns listed above that could affect people's health and safety, there was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were given safely, however some improvements were required. A nurse was available on each shift to ensure that people received their medicines at the times they required them and the right dose. One person who experience Parkinson's disease was on a daily patch to relieve some of the symptoms associated with their condition. There was no log maintained of where the patch had been place on the skin. This is important as the guidance for this medicine states 'Do not use the same skin area twice within 14 days.' Staff were unable to demonstrate that these guidelines had been followed. For 'as required' medicine, such as pain killers or medicines to relieve anxiety, there were no guidelines in place which would tell staff when and how to administer the medicines in a safe way.

Staff that gave medicines to people had not kept up to date with current information. One lead nurse was unaware which medicines would now be classed as 'controlled'. This was important to ensure they are stored and managed safely, and not misused. A non-controlled medicine was treated as if it should be, so the risk to people was low.

The ordering, storage, and disposal of medicines were safe, although some minor improvements had been identified with regards to how medicines were stored. Medicines were stored in locked cabinets; however the room was recorded at being 32C which was not within the recommended temperature to keep them safe when not in use. Medicines that required storage in the refrigerator had the temperature checked daily and monitored. Temperature records showed that the refrigerator temperature had been maintained within safe limits, so risk to people was low.

People were protected from the risk of abuse. People knew who they could speak to if they had any concerns, and believed their concerns would be addressed promptly. Staff had a clear understanding of their responsibilities in relation to safeguarding people. Staff were able to describe the signs that abuse may be taking place, such as bruising or a change in a person's behaviour. Staff understood that a referral to an agency, such as the local Adult Services Safeguarding Board or police should be made, however they expressed a lack of confidence in doing this, saying they would prefer to report it to the manager.

Information on what to do in an emergency, such as fire, were clearly displayed around the home. Fire safety equipment and alarms were regularly checked to ensure they would activate and be effective in the event of a fire. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely. There was also a continuity plan in place to ensure people would be cared for if the home could not be used after an emergency. A recent fire safety inspection,

completed in August 2016, had given a positive report about how fire risk was managed at the home.

No new staff had been employed since our last inspection, so we did not look at the recruitment of staff during this inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was provided in a safe way.