Essex County Care Limited

Scarletts

Inspection report

Recreation Road
Colchester
Essex
CO1 2HJ

Tel: 01206792429
Website: www.southendcare.com

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 6 and 8 June 2017 and was unannounced. The inspection was prompted in part following information of serious concern received from the local authority and their safeguarding team and, to check that the required improvements from our previous inspection on 20 June 2016 had been made.

We found there had been a lack of oversight of the service by the provider to ensure the service delivered was of a good quality and safe, and continued to improve. People's safety and welfare were compromised because the provider did not have in place robust and effective quality monitoring and assurance processes to identify issues that presented a potential risk to people. Thorough risk assessments had not been carried routinely to identify risks in relation to people's healthcare needs, the physical environment and equipment; necessary maintenance work and health and safety precautions had not been taken within the home to protect people from risk of harm. Cleanliness in the service had been neglected.

Scarletts is a care home that provides accommodation and personal care for up to 50 older people who are vulnerable due to their age and frailty, and in some cases have specific and complex needs, including varying levels of dementia related needs and end of life. On the day of our inspection there were 40 people using the service. This was an unannounced inspection.

Scarletts comprises of four units over two floors; Forest View and Muntjac on the ground floor and Squirrel and Badgers on the first floor.

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 culture within the home did not promote a holistic approach to people's care to ensure their physical, mental and emotional needs were being met. Robust and sustainable audit and monitoring systems were not in place to ensure that the quality of care was consistently assessed, monitored and improved. Quality assurance systems had failed to identify the issues we found during our inspection.

There was not an effective system in place to ensure there were sufficient numbers of staff on duty to support people and meet their needs, particularly at night. There were not enough staff to provide adequate supervision, nutritional support, stimulation and meaningful activity. This had a direct impact on people's safety and welfare. . There were a high incidence of falls in the service and we were concerned that this was due to a lack of staff being available to support and monitor people effectively.

People were at risk due to poor monitoring of environmental factors and essential maintenance not taking place when needed. People's care had not been co-ordinated or managed to ensure their specific needs

were being met. Risks to people injuring themselves or others were not appropriately managed. People's medicines were not being managed effectively to protect them from the associated risks of not receiving prescribed medicines.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people, we observed some interactions which were not respectful. Staff were not supporting people in a consistent and planned way. They did not always respond appropriately and in a timely manner to all of people's needs.

Care plans were task focused and not personalised or centred on individual's needs. They contained conflicting information and did not give clear guidance to staff to enable them to support people safely and effectively

Training and development was not sufficient in some areas to show that people's healthcare conditions and support needs were fully understood by staff. Staff demonstrated an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) However, this wasn't always seen in practice. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

Staff were aware of their responsibilities with regard to safeguarding people from abuse and knew how to report concerns. However, they did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

Following this inspection we sent an urgent action letter to the provider telling them about our findings and the seriousness of our concerns. We requested an urgent action plan from them telling us what they are going to do immediately to address them. An action plan was returned to us the following day. We also shared our concerns with the local authority and their safeguarding team. We took immediate enforcement action to restrict admissions and force improvement.

We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Commission is considering its enforcement powers.
The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

There were insufficient numbers of staff on duty to meet people's care and support needs.

People were not protected from the risk of poor moving and handling practices and lack of suitable equipment.

People were not protected from the risks associated with poor maintenance and ineffective cleaning systems.

People's care had not been co-ordinated or managed to ensure their specific needs were being met safely.

People were not protected from the unsafe management of medicines.

Is the service effective?

Inadequate

The service was not effective.

Training and development was not sufficient in some areas to assist staff in the delivery of safe and effective care.

People were not always supported effectively with their nutritional needs.

People were not always supported in line with the Mental Capacity Act.

Is the service caring?

Inadequate

The service was not caring.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture.

Although some staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were task focused and not personalised or centred on individual's needs, wishes choices and preferences.

There was a lack of general activity throughout the day to ensure people's whole well-being.

It was unclear how the results of people's feedback were used to drive forward improvements which were embedded and sustained.

Is the service well-led?

Inadequate

The service was not well-led.

Robust and sustainable audit and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved.

There was not a positive culture which fully reflected the best interests of the people it served.

Scarletts

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 6 and 8 June 2017. The inspection on 8 June commenced at 04.00am to give us an understanding of staffing and how people's needs were being met during the night.

The inspection team was made up of three inspectors who were accompanied on the 6 June 2017 by 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 care service.

Before the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with the registered manager and the provider's training lead for the company. We also spoke with ten care staff, housekeeping and kitchen staff.

We spoke with 11 people who used the service, five relatives and three health care professionals who visit the service. We used the Short Observational Framework for Inspections (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care and support needs were being met we reviewed 24 people's care records and other information, for example their risk assessments and medicines records.

We looked at four staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection in June 2016 we found that people were not being protected against the risk of unsafe care, particularly in relation to moving and handling practices and insufficient staffing levels. We asked the provider to inform us of the actions they would take to address our findings, protect people and raise standards. At this inspection we found improvements had not been made.

Moving and handling practices were not managed safely and people were at risk of potential harm. Many people had limited mobility and required equipment to assist them in their daily activities. Risk assessments and plans for people did not clearly specify the type of hoist and the correct type and size of sling each person required to move safely. Staff could not identify the size of slings in use or tell us which size an individual required. One member of staff said, "There are not many [slings] at the moment. Some are broken. I think there are two blue ones and a green one." Staff were seen to use the same hoist and sling for people. Selecting the wrong size sling can result in discomfort if the sling is too small, or the risk of the person slipping through the sling if it is too large.

Management and staff had limited understanding of their responsibilities in relation to checking equipment and identifying hazards that may pose a risk to people's safety. Wheelchairs and walking frames were in general use for people and had not been assessed as suitable for the person using them and they may have been using equipment that was not suitable to their needs. Staff and relatives told us that wheelchairs in the equipment cupboard were damaged and there were limited wheelchairs to transport people. One relative told us, "Sometimes it's hard to find a wheelchair. There never seems to be many around. A lot are broken." The rubber feet [ferrells] on some walking frames were worn and in one case the metal had worn through posing a risk of slipping and/or falling to the person using it. The registered manager showed us a generic assessment in relation to the risk of wheelchairs which stated that wheelchairs were to be inspected before use; footplates were to be used and only use wheelchairs assigned to the individual. This did not concur with our findings.

We received information prior to this inspection telling us that there was a high level of people falling and sustaining injuries. Whilst older frail people are more prone to falls there was a very high level of people falling at this service.

All areas of the home were accessible to people including three stair cases. On both days of the inspection we saw people, unsteady on their feet, going up and coming down stairs unsupervised. We noted that on one occasion in January 2016 an individual had attempted to come down a flight of stairs in their wheelchair and fell down some. The risk had not been reassessed following this incident and no action was taken to ensure such incidents did not reoccur. People were also at risk of scalding from an urn boiling water accessible in the open kitchenette. Urine neutralizer was accessible in the sluice room and medication creams such as anti-inflammatory gel were left unsecured in bedrooms, placing people at risk of harm if ingested.

Further risks to people's health, safety and welfare included a framed hand rail over a toilet which was very

loose and was not a solid or secure support for people. There were unidentified trip hazards from trailing electrical cables and broken wall tiles in a bathroom posed a risk of injury to people if they fell or brushed against them. Two plastic chairs in use for people to sit on whilst washing and dressing were cracked and could cause a skin injury.

Faulty equipment was identified and reported in April 2017 but had still not been addressed. The call bell system was faulty placing people at risk if they could not call for assistance. The emergency lighting was not working on one unit placing people at risk if they needed to exit the building in an event of an emergency and the fire door guards were faulty placing people at risk in the event of a fire.

Bedrails are a means of preventing the risk of a person falling from their bed. People with bedrails in place had not been assessed to consider whether bedrails or other control measures were the most appropriate means of managing that risk. The compatibility of the person, bed, mattress, bed rail and any associated equipment was also not considered. Some bed rails were not integral to beds; they were poorly fitted to old style divan beds and without padded protective covering. This meant individuals were more at risk of entrapment from between the bed rails, or between the bedrail and the bed, headboard or mattress.

We found shortfalls with equipment and practice within the service which did not protect people from the risks of poor hygiene and infection control systems. We observed eight commode pans soaking in a bath on the first day of our inspection and sluiced pans being put into the bath to soak on the second day. Premises and equipment were not sufficiently cleaned or maintained. We found numerous sinks to be dirty and carpets, armchairs and mattresses were soiled, stained and offensive smelling. A visiting healthcare professional told us, "One of my major things is that I often can't find soap and paper towels. How do people wash their hands?" There were limited toilet slings for hoists available for people and they were being shared. One person waited ten minutes to go to the toilet and we were told this was because staff were waiting for the sling to become available. Because of their purpose they should not be shared as they are a potential source for cross infection.

People's care had not been co-ordinated or managed to ensure their specific needs were being met safely. There were no individualised risk assessments and clear care planning strategies in place in relation to people's dementia related needs, moving and handling, nutritional needs, skin integrity and prevention of pressure sores and appropriate use of bed rails. Therefore staff did not have appropriate guidance on the type and level of support people required to meet their needs and keep them safe in a consistent way.

We reviewed the care of four people with indwelling catheters to maintain their continence needs. Risk assessments had not been completed and there were no care plans in place to guide staff on the signs to be aware of that could determine a blockage or infection. Urine output was not being monitored because staff were not recording the amount when catheter bags were emptied. This placed people at risk as any issues with the catheter would not be identified.

People were not protected from the unsafe management of medicines. On the first day of our inspection there was no Controlled Drug register which is legally required to record the receipt, balance checks, administration and disposal of controlled drugs. The controlled drugs in stock did not tally with the computerised medication system. It was therefore not possible to demonstrate people had received essential medication as prescribed.

People had not received all of their prescribed medication because some were out of stock. One person had not received their anxiety relieving medication for five days. During this time entries in records showed that this person's anxiety had heightened and caused distress. A daily management report produced by the

medicines system showed which items had been out of stock but there was no evidence that any action had been taken to rectify this.

There were no protocols in place for medicine prescribed to be taken 'as and when required' (PRN) to guide staff as to how and when these should be administered. This meant that staff may not be aware when a person needed medicine such as pain relief because there was no guidance to show how people communicated that they were in pain when they were unable to verbalise how they were feeling.

Fridge and room temperatures for storage of medicines were not being monitored or recorded and staff could therefore not be assured that medicines were being stored at the correct temperature. On the second day of our inspection the temperature in the stock room was higher than is recommended but this had not been recorded or any action taken. Incorrect temperatures could reduce the effectiveness of medication putting people at risk.

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

There were not enough staff to provide the right level of care and staff were not deployed in a way that ensured people's safety. A staff member said there were, "Never" enough staff. They added, "I wouldn't say they [people using the service] are uncared for its just being short staffed. If you have two helping someone and one doing medicines that leaves one. It's impossible." Two healthcare professionals told us that staff were not available to provide assistance when they visited. One commented, "I can never find a member of staff, they are supposed to come with me when I see a resident" The other told us that they had supported a person with their continence needs as no staff were available.

The systems in place for determining staffing levels and shift planning were not effective to ensure sufficient numbers of staff to meet people's needs. Staffing rotas showed some staff were working excessive hours to make up the allocated numbers. Records showed and staff told us that the numbers of staff, particularly on nights were not consistent and on some nights there were only three staff for the whole home. We were told by the registered manager that a dependency level assessment tool was used to help calculate the numbers of staff required but we found this did not accurately reflect people's dependency levels. For example, people living with complex and high level of dementia needs had been assessed as being low dependency.

Scarletts comprises of four units over two floors. The units are made up of long corridors, each with a communal area and access to stairs. The majority of people living at the service were living with varying levels of dementia and many had difficulty in communicating their needs. This meant they were dependent on care staff for their health, safety and wellbeing. We observed that people in communal areas were left unsupervised for long periods of time. There were no call bells in the communal areas for people to call for assistance which meant they were reliant on staff to be visible for support. Throughout both days of our inspection we observed people putting themselves and others at risk whilst staff were not in attendance. We observed a person move themselves to the edge of their seat. They were unable to move themselves back again and were at risk of falling from the chair. A member of staff noticed but was unable to call for further assistance to help the person as there was no call bell in the room. The member of staff had to call out for help and wait until another member of staff heard them. We saw that the call bell for another person cared for in bed was not only out of their reach but it was not plugged in which meant they were reliant on staff passing by.

There were five people living with dementia who were unoccupied and observed to wander unsupervised around the home throughout the day and night. This meant their safety and welfare was not safeguarded

and they were at risk of harm or falling. We observed a person about to sit on a small coffee table and lose their balance before we intervened. Staff were not aware of this persons location until they were told by us. We also intervened in the main entrance hall where a person was pulling on a curtain and could have brought the curtain pole down and, in the dining room where another person was pulling on an electrical cable attached to a mains socket and a third person was pulling out a roll of plastic aprons, causing a trip hazard.

We received concerns from relatives about the lack of bathing and hair washing. One relative said their relative had not had a hair wash for over four weeks. Another relative told us, "Don't know how often they are bathed or hair washed, sometimes [person's] clothes are dirty, rarely in [person's] own clothes, today [person] is not in [their] own clothing." Staff told us that they did not have enough staff to provide full personal care. A member of staff commented, "There is not enough time or not enough staff." We observed that some people had unwashed and uncombed hair and had not received a shave.

There were insufficient staffing levels to promote people's wellbeing and meet their social needs. A relative told us that there was not enough for people to do and they seldom saw activities taking place and, "Staff never seem to talk". Relatives told us that although staff were very kind and caring only basic personal care needs were being met and staff did not have time to engage properly with people to promote their wellbeing. One relative said, "Staff are very good generally. I think they are just very stretched." We did not observe staff interacting in a meaningful way with people other than when they were delivering personal care.

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

People whose behaviour challenges were not effectively supported. Positive actions were not put into practice when staff were faced with difficult situations that could potentially cause harm or compromise people's safety. We observed a person with a high level of anxiety and agitation loudly shouting abuse at, and provoking others, in the lounge; placing their self and others at risk. This person was threatened by another person waving a walking stick at them. A staff member as they were passing stepped into the lounge, asked if everybody was ok, and then left. We noted that entries recorded in the staff communication book indicated that altercations between individuals often occurred.

Staff were aware of their responsibilities with regard to safeguarding people from abuse and knew how to report concerns. However, they did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The provider could not demonstrate people were receiving effective care and support from staff who had the knowledge, skills and competency to carry out their roles and responsibilities.

The providers' website states, 'Scarletts staff are all highly trained with exceptional teamwork with their primary focus being the wellbeing and comfort of the elderly'. We found that this was not the case.

Following our last inspection staff had received further training in moving and handling however practice continued to be poor. On two occasions we observed staff assisting people to move with a hoist and on each occasion another person's foot was caught by the hoist because staff had not ensured there was sufficient room to manoeuvre the hoist. Staff did not recognise poor practice or understand the impact this had for individuals they cared for. For example inadequate moving and handling equipment and injuries due to poor moving and handling techniques.

Training for staff was not managed effectively. There were shortfalls in mandatory training and not all staff had received training and/or update training in subject areas relevant to their role.

People were at different stages of their dementia ranging from early onset to advanced stages; there was no plan about how the service kept up to date with developments in this area to ensure the care provided was appropriate and reflected best practice. Staff had a limited understanding of how dementia affected people in their day to day living. Appropriate strategies were not in place and staff did not know how to respond effectively to people's heightened anxiety which resulted in unsettled or aggressive behaviours.

This is a breach of Regulation 19 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014

There was poor monitoring and management of people's eating and drinking which put people at risk of dehydration and malnutrition. Support provided to people with complex and dementia related needs was not sufficient to ensure they ate and drank enough.

Following recent safeguarding concerns people who had lost weight had received support from a dietitian. People's nutritional needs had been re-assessed but monitoring was still ineffective. Records for one person showed a continued and steady loss of weight which meant their risk of malnutrition was increasing. Although their assessment had been reviewed the weight loss had not been considered and the assessment was recorded as 'remains the same', a referral to the dietician had not been made.

Where people were assessed at risk of dehydration or poor skin integrity their fluid intake was not monitored effectively. Fluid intake was being recorded by care staff but there was no oversight to ensure people were having sufficient to drink to meet their needs or take necessary action when they were not. In some cases staff encouraged individuals to drink but in others drinks were placed out of peoples reach or people were not provided with their fluids in a way in which they could easily drink them. A visitor told us that their

relative preferred a straw to drink because their drink was thickened but staff didn't always think to give them one.

People had little interaction with staff which did not encourage or promote practical help to eat more either independently or with support.

On the first day of our inspection there was only one staff member in the upstairs dining room; they were supporting one person to eat. Other people were distracted from their meals by some people getting up and down from the tables; many meals were left partially uneaten. There was no effective support and prompting to encourage individuals to eat more. There was no system in place to ensure that staff knew the whereabouts of people during mealtimes or whether people had received sufficient to eat and drink. We observed different staff members entering and leaving the dining rooms throughout the mealtime. One staff member was heard to ask another if a person had eaten their lunch. The staff member replied that they didn't know because they had been working in the dining room alone.

On the second day of our inspection there was only one staff member in the downstairs dining room serving meals. On this occasion a plate smashed and the member of staff stopped serving the meals to clear up the broken plate. One person was becoming very agitated, shouting out and another was walking into the area where the plate had smashed. There was no available staff in the area to respond and support people or continue to serve the plated food to others. When the staff member in the dining room eventually served the food to others it was no longer hot and appetising.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decision for living in residential care.

Mental capacity assessments had been completed, however the exact decision to be made was not specified and the action to be taken was not specific to the individual's needs. There was no evidence of any involvement of relatives or relevant healthcare professionals to demonstrate why the decision was in the person's best interests. Staff had some understanding of mental capacity and spoke about people being given choice. However this wasn't always seen in practice and people were not given the opportunity or support to make choices and decisions throughout the day. For example, people were taken from one dining area to the lounge without being asked where they would like to go. A member of staff turned on the TV in this area without asking if anyone would like it on.

Following our last inspection there had been a significant amount of support provided to the service from

Commissioners and health care professionals, with the aim of improving outcomes for people, particularly in identifying and addressing any change in their health needs. One healthcare professional told us that communication with health professionals had improved.

Inadequate

Is the service caring?

Our findings

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. Whilst some staff showed real interest and consideration in meeting people's needs, this was not consistent across the whole service. One person told us, "One [staff] helps me, [They are] pleasant" A relative said, "[Staff] are so nice, they make [person] smile." The provider had not encouraged a culture to support these efforts alongside appropriate knowledge and resources, to help staff to understand the needs of people and how they should be cared for.

We observed kindness and consideration shown by some staff. For example, a member of staff knelt down beside people to check how they were feeling and said to one person, "Tell me [person] what is wrong, and tell me that you are okay, do you want to rest in your room?" However we also observed care that was task and routine based, rather than led by the needs of the individual. One person asked for assistance to go to the toilet but was told by a member of staff that they had to wait until they had received their medicines. The person said, "I want the toilet. I'm not messing about." However, they still had to wait until their medicines were dispensed and administered.

Staff did not understand the reasons people became anxious or upset. There were no details in peoples care plans to tell staff why people may become agitated or anxious, triggers that might make this worse, or ideas about how to distract or engage positively with them. Without this understanding staff were unable to provide person centred care with a holistic approach to ensure people's well-being.

We saw examples where staff had a general lack of respect for people and this led to a poor culture within the service. For example we heard a conversation between two members of staff take place in front of the person they were discussing. One of them said, "Don't ever go to cut [person's] nails. [Person] clawed me." This showed a lack of compassion and respect. Relatives told us that people were often wearing other people's clothes. One relative said, "Sometimes you come in and [relative] has all of someone else's clothes on. [Relative] doesn't like wearing someone else's clothes."

Information about people's care and support needs was not kept confidential. We observed that care notes were left unattended throughout the day in lounges and corridor areas.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People did not receive care that was personalised and responsive to their needs and there was no consistent and planned approach to support people.

The providers' website stated, 'We believe in providing a level of personal care and support that meets the needs of each individual and aim to promote and maintain freedom of choice and independence. Together with our residents, their families and friends, we create a personalised Care Plan which we review and update regularly to reflect changing needs to ensure the utmost care and support at all times'. This did not concur with our findings.

There was a lack of understanding from management and staff of the purpose for person centred planned, recorded and delivery of care. Care plans were prepared and written by senior staff; care staff were not involved in the planning and review process of care plans. One staff member said, "I was told I wasn't allowed to look at care plans, only the seniors and managers. I've not looked at them." Other staff also confirmed they did not look at them and that they relied on information given to them during shift handover. They had a limited overview of people's immediate needs provided within a booklet that contained charts for recording food, fluid and repositioning and daily report records. The booklets did not include individual's choices and preferences about how they wished their care to be delivered and how they chose to live their daily lives. This meant care delivered was not personalised or consistent, and may not be appropriate or safe.

Senior staff reviewed the care plans they had written but this process did not include a re-assessment of people's needs or risk and revision of a care plan where required. The majority of reviews read as 'remains the same' or 'no change'. We found where a person who was immobile and unable to bear their own weight had fallen out of their wheelchair, the fall had not been taken into consideration when their care plan was reviewed, the risk had not been re-assessed and their care plan had not been revised to include any further actions by staff that could help to prevent any reoccurrence of the event.

The care records for another person had not been revised to reflect a change in their mobility needs from walking with the aid of a frame to now requiring the assistance of two carers and a hoist. Without up to date information people were at risk of not receiving the right level of assistance.

There was a lack of clear guidance and key information for staff to enable them to support people with their specific health conditions such as diabetes or catheter care and maintenance. Therefore staff did not know the signs and symptoms to be aware of, or their relevance to indicate a risk to the persons health, safety and wellbeing and may not recognise the need to take action in order to prevent them from becoming seriously unwell.

Records were disorganised and not easily available. Where people had a Do Not Attempt Cardiopulmonary Resuscitation (DNA-CPR) document in place these were filed amongst other paperwork and were not easily accessible in the event of a cardiac emergency. In one person's care records it stated that no DNA-CPR was

in place, however we found a completed form in their file. This meant there was a risk that people may not receive the appropriate interventions or their wishes may not be followed through.

The provider states on their website, 'We provide a comfortable and secure environment that is stimulating and preserves and enhances residents' life skills. We do this through reminiscence. By triggering and exploring memories of the past we build self-confidence and most importantly we aim to keep residents engaged and communicating. We found this was not an accurate reflection of the service.

None of the care records looked at contained a care plan that adequately demonstrated how staff responded to individuals differing needs in terms of interests, social activities and meaningful interventions, types of dementia and the varying stage of dementia they were at. We observed people being left largely to their own devices on the days of our inspection which resulted in anxiety levels, distress and social isolation escalating.

Throughout our inspection we observed two people walking continually around the service. There was no management strategy in place for staff to provide consistent and effective support and their experience of day to day living at the service was very poor. We saw that by late afternoon they became very distressed and no action was taken to try and address this through exploring different approaches and routines. Management and staff told us that this was the way people were and they "walked with a purpose". They had little understanding about how they could improve this experience for people. They lacked relevant information and knowledge about people's backgrounds and past lives which would have enabled them to explore different ways of communicating and understand more about the person they were supporting.

People who spent their time in their bedrooms had little or no stimulation, only that from staff performing a care task. We observed that people were either very restless or withdrawn as they had little to occupy their time throughout the day. There was an expectation that care staff would engage in activities with people as there was not a member of staff employed specifically for this role. However, staff did not have the time to promote people's wellbeing and meet their social needs. A relative told us, "There is not enough to do, seldom see any activities, they [staff] never seem to talk to them one to one, one carer does their nails, I've seen a puzzle once, there are no outings."

There were limited resources available to assist in the delivery of meaningful activities throughout the day for people who were living with dementia. For example, reminiscence activities or the use of familiar daily tasks to encourage physical and mental stimulation.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy and procedure in place. The registered manager told us that there had been no complaints or concerns raised for the year 2017. We were aware that serious concerns had been raised by a family in March 2017. There was no information to demonstrate that the provider or manager had followed their complaints policy by acknowledging the complaint, investigating it or responding with an outcome.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We found widespread and significant shortfalls in the way the service was managed with regulations not being met.

There were limited processes in place to effectively monitor the quality of the service and if it was operating safely. Systems in place to help identify risks were not robust. The provider was failing to continually assess the quality and safety of the service to drive improvement or identify where lapses had occurred. This had led to a lack of effective oversight and governance, to ensure people were living in a safe environment, protected from risk to their health, safety and welfare and supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs in a safe way.

There were limited processes in place to assess and monitor the quality of the service and if it was operating safely and effectively. For example the provider and manager were unable to demonstrate how they identified any trends and themes in incidents and accidents across the service. Without this they could not see where improvements were needed in order to minimise risks of similar incidents happening again.

There was not an effective system in place with regards to ensuring suitability and safety of equipment in use for people including hoists, slings, wheelchairs, walking frames and commode/shower chairs. The registered manager was unable to identify individual ownership, provide a current inventory of equipment or identify equipment that was damaged or decommissioned. Safety checks were not carried out.

We were told that a wheelchair loan and maintenance service had ceased and that the home was now responsible for the maintenance of wheelchairs. On the second day of our inspection the maintenance person told us that they had managed to 'salvage' six of the ten wheelchairs to go back into circulation by making minor repairs and swapping parts. We were concerned that the repaired wheelchairs were going back into general use and may be unsuitable to meet peoples assessed needs.

The system in place to determine sufficient numbers of staff, and their deployment was ineffective. Our findings demonstrated that there were insufficient numbers of staff deployed across the service to meet people's needs. The registered manager was unable to tell us how the system worked and how staffing levels were calculated because staffing levels were determined by the provider's head office. We were told that the service was continuing to recruit new staff but they were being recruited to fill the gaps in the rotas otherwise filled by agency staff and staff working additional hours and not for the purpose of increasing staffing levels overall.

Whilst the provider was aware of the very high number of falls in the service from monthly reports no action had been taken by the provider to investigate and identify any underlying cause. The registered manager told us that they had recently started their own process to analyse falls. The process identified the number of falls each month that had occurred for each individual which prompted a referral to the falls prevention team. However a root cause analysis was not undertaken which may help to identify other issues, for example demonstrate when and where staffing levels were insufficient or if there were any safety issues

within the environment.

The provider had failed to provide effective oversight of the service which had led to a failure to address recurring areas of risk to people's health, safety and welfare. Support and resources needed to run the service were not available and the provider was not operating the service in line with their own philosophy of care which stated that, 'Our belief in caring for the elderly is to maintain the highest standards of quality care. Our abiding personal and professional concern is safeguarding the interest and well-being of all residents as well as offering person-centred care'.

Roles and responsibilities were unclear and staff were unsure what they were accountable for. The culture of the service was not a positive one and staff lacked time, knowledge and understanding. Observation showed there was no effective leadership to oversee and direct staff on each shift and staff did not have the skills and support they needed to support people living in the service.

We immediately informed the provider of the seriousness of our concerns and requested an urgent action plan from them to tell us what they were going to do to make improvements. This was followed up with a meeting with them. We were told that the provider had deployed a response team of management and staff selected from some of their other services to provide support to the manager, assist in the day to day running of the service as well reviewing

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

Following our inspection we asked the provider to submit an action plan detailing how they proposed to address the shortfalls we had identified. We were informed that an additional response team were to be immediately deployed by the provider to address the concerns raised. We have since had a meeting with the provider and we will continue to monitor the service and the provider's action plan.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People using the service were not receiving care and support that was personalised and specific to meet their assessed needs and reduce risk to their health safety and welfare.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect and people's independence and involvement was not respected or upheld.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always sought from people using the service.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users to prevent them from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from improper care and support.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of people were not being met.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints received were not investigated and necessary and proportionate action was not taken in response to any failure identified to improve outcomes for people.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Robust systems or processes were not established and operated effectively to ensure compliance, including assurance and auditing systems and processes to assess, monitor and drive improvement in the quality and safety of the service provided, including the quality of the experience for people using the service.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff employed by the provider were unable to provide care and support appropriate to their role and did not have the training, competence and skills to enable them to provide safe and appropriate care to meet the specific needs of people using the service.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet all the assessed needs of people using the service.

The enforcement action we took:

We have imposed conditions on the providers registration that require them to take further action where we consider that some specific improvement is necessary to manage risk and protect people using the service from the risk of harm or from exposure to risk of harm. We have also prevented further admissions to the service.