Ultima Care Centres (No 1) Limited

Ormesby Grange Care Home

Inspection report

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09 May 2018
16 May 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8 and 9 August 2017. After that inspection we received further concerns in relation only to accidents and incidents. As a result, we undertook this unannounced focused inspection on 9 and 16 May 2018 to look into those concerns. This report only covers our findings in relation to those concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ormesby Grange Care Home on our website at www.cqc.org.uk"

Ormesby Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ormseby Grange accommodates up to 114 people across three separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia. At the time of our inspection 42 people were living at the home.

Our inspection was carried out because of concerns we had due to the notifications we received from the service. Notifications are reports of changes, events or incidents the provider is legally required to let us know about. The inspection was prompted in part by notification of an incident that involved the people who used the service. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

At our last inspection in August 2017 we found the service was not meeting all of our fundamental standards and was rated as 'requires improvement' and following this focussed inspection due to further breaches of our regulations the service was rated as inadequate overall.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.Services in special measures 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.

At the time of our inspection the service had no registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We found that people who used the service who were at risk of falls were exposed to further risk of harm from having further falls and possible injury.

Staffing levels were adequate to meet people's needs however, staff were not always deployed correctly given the large size and lay out of the building. This had an impact on staff being able to respond to people's needs quickly in emergency situations.

Staff who were designated first aiders were not highlighted to other staff on shift so they could deal with accidents and incidents. Staff were not always appropriately trained in first aid safety, falls prevention or awareness.

Accidents and incidents (falls) were not adequately, recorded, monitored or managed.

People's care and support needs were written up in care plans however, they were not updates as peoples needs changed. Management did not audit care plans appropriately to highlight any changes in people's mobility that could increase the risk of falls.

People were supported to use safety equipment such as bed sensors and chair sensors however, we found that these were not regularly checked and at times were found not to be working.

We found that the registered providers policy for reacting to emergency incidents (falls) was not reviewed, appropriately implemented with staff or adhered to consistently.

Accidents and incidents were not analysed by management to look for trends to ensure lessons were learned so that similar accidents and incidents could be avoided, or risks of a reoccurrence be reduced.

People were supported if they wished, to have DNACPR (Do not attempt cardiopulmonary resuscitation) agreements in place. This is a treatment that could be attempted when cardiac or respiratory function ceases (CPR). The home had made recent improvements in this area working with people and their relatives to respect people's dignity in emergency situations.

Staff understood safeguarding issues and procedures were in place to minimise the risk of abuse occurring. Where concerns had been raised we saw they had been referred to the relevant safeguarding department for investigation.

The deputy manager notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.
Staff felt supported by the deputy in the absence of a registered manager at the home.

You can see what action we told the provider to take at the back of the full version of the report.

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

This service was not safe.

People who were at risk of falls were exposed to further risks of harm by not having care plans and risk assessments in place that reflected their needs.

Staffing levels were adequate however staff were not deployed to meet people's needs safely across the building.

Designated first aiders were not highlighted on shift to deal with accidents and incidents (falls).

Staff were not appropriately trained in first aid safety or falls prevention or awareness.

People's safety equipment was not checked for faults.

Staff had an understanding of safeguarding issues and the action they would take to safeguard people and raise concerns.

Is the service well-led?

Inadequate

The service was not well led

Accidents and Incidents (falls) were not adequately, monitored and managed. Accident and incident records were not kept up to date.

Accidents and incidents were not analysed for trends to ensure lessons were learned. □

People's care plans were not updated or audited appropriately by management to highlight changes or risks.

The registered providers policy for reacting to emergency incidents (falls)
was not appropriately reviewed, implemented or adhered t

Ormesby Grange Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 16 May 2018 and was unannounced. This meant that the service was not expecting us. The inspection team consisted of two adult social care inspectors.

During the inspection we spoke with three people who used the service, the deputy manager, operations manager, six care staff and maintenance staff.

Before we visited the service, we checked the information we held about this location and the provider, for example we looked at the inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service; including the commissioners and social work team.

During our inspection we observed how the staff interacted with people who used the service and with each other. We spent time watching what was going on in the service to see whether people had positive experiences. We did not use our observation tool (SOFI) as people were able to communicate and express themselves to us and we felt that SOFI was not required. Our observations included looking at the support that was given by the staff, by observing activities, practices and interactions between staff and people who used the service.

We also reviewed records including; six care plans, staff training records, safeguarding referrals, incident and accident reports, risk assessments, CQC notifications, falls records, staff rotas and other records relating to the management of the service such as policies and procedures, audits, minutes of meetings and handover

records.

Inadequate

Is the service safe?

Our findings

During our inspection we identified many concerns around the management accidents and incidents relating to falls. We found current practices placed people who used the service at a high risk of harm.

People who used the service were experiencing a high number of falls, both witnessed and unwitnessed. Many people who had limited mobility were falling from their bed, in some cases repeatedly. When we looked at the accident and incident records in people's care files we found that in the six months from December 2017 to 16 May 2018, 85 recorded falls took place at the service.

People were at times referred to the falls team who offer support and guidance on falls. However, we found that not everyone was referred or only referred after they had fallen three times or more and advice from the falls team wasn't always recorded or implemented.

When we looked in people's care records we saw correspondence from the falls team following assessments carried out over the telephone. One stated 'interventions will now be put into place to minimise risk of further falls including; general falls prevention advice and education of staff'. We were unable to find any evidence of this advice being put into practice or relayed to the staff team through training or messages within handover records. The person's care plan was not updated to reflect the advice given by the falls team. Another person's care records we looked at showed us they had become immobile within two months. The only action recorded to respond to this was to refer the person to the falls team and we found no evidence within their care records to show staff had contacted the falls team or that advice from the falls team was followed up by staff.

People had care plans in place however, they were not updated appropriately to highlight risks or note changes to people's care and support needs. We saw in people's care files that their needs had changed when their dependency was assessed, or in some cases from the accident and incident records we viewed. One person's care plan for their mobility stated that they were 'independently mobile (walking frame)' however records stated their dependency had been reviewed on four occasions and each time they were assessed as being less mobile and their care plan wasn't updated to reflect these changes, nor were appropriate risk assessments in place to reduce known risks. Another person's mobility care plan wasn't updated but we could see from the introduction of positional charts (to reduce pressure from being in bed) that they had become immobile and required hoisting equipment at all times.

People were supported to use safety equipment including call bells, bed sensors, and chair sensors that go off to alert staff if people who were at risk of falls were, for example, out of bed. Where people were using this equipment, we found there were no records in care plans to reflect this or describe how it was to be used. When we looked at incident reports we saw that there were incidents where people had fallen and their sensor mat had not worked to alert staff. We looked at maintenance records of health and safety checks carried out in the home and in people's bedrooms and found that falls prevention equipment, including bed and chair sensors, were not checked. When we spoke with the deputy manager and maintenance staff they confirmed that this equipment was not checked to see if it worked correctly.

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

People were supported by an adequate number of staff to meet their needs. However, we found staff were not deployed to ensure people's needs were met safely across all areas of the building and this had an impact on dealing with accidents and incidents.

The home was registered for up to 114 people. At the time of our inspection only 42 people were living at the home and they were spread out over three floors and in separate areas. People's bedrooms were spaced out along the corridors with empty bedrooms in between them. There were sections of corridors closed off completely. Staff were allocated to each floor and a further 'floating' member of staff worked between the three floors as and when needed. The floating staff member was to be called on via an intercom that rang to an office on each floor. Once the intercom was answered by a staff member they then had to go and find the floating member of staff and let them know where they were needed. The staff didn't have a mobile phone or other means of contact. We tested this and it took 10 minutes for the floating member of staff to arrive where we wanted them to be. This meant it was difficult to quickly respond to requests for support to deal with falls or accidents or emergencies.

We saw that staff had not always received suitable training to meet people's need for example a number of people who used the service were identified as at high risk of falls and people sustained falls and staff had not received any training in falls prevention, management or awareness. Staff training records showed us that not all staff were trained in first aid at work. One staff member identified as the first aid champion for the home had not received first aid at work training and had only received online first aid awareness training. Some senior staff were first aid trained by St Johns Ambulance.

We found from looking at accident records and discussion with staff during our inspection that senior carers, were not all first aid trained to check people over following a fall. Senior care staff checking people did not describe recognised or consistent practices for dealing with falls. For example, staff got people to roll on their back and raise their legs following a fall. Another example recorded was visually checking people and then using hoist equipment to support them back into bed. A further described was to lift the person's limbs to check that they were not injured. None of the practices would be recommended as a means for assessing if a person was injured following a fall. When we spoke with the deputy manager and the operations manager we were unable to establish the content of the current first aid training.

This meant we could not find any evidence to demonstrate that the registered provider complies with the Health and Safety at Work Act in relation to having sufficient qualified first aiders on duty. First aiders were not identifiable on the rota and it was not it clear how staff could utilise these staff as first aiders when someone had fallen.

The home had a first aid champion whose role was to keep other staff informed of first aid awareness and we found this person only had received online first aid training and had not received any practical training. When we spoke with staff during the inspection they were unable to identify who they would use as a first aider that day apart from the deputy manager or nursing staff from the nursing area. When we raised this, we were informed this would be addressed and that first aid training would be reviewed and first aiders would be identified to everyone.

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

People were supported if they wished, to have DNACPR (Do not attempt cardiopulmonary resuscitation) agreements in place. This is a treatment that could be attempted when cardiac or respiratory function ceases (CPR) in an emergency. The home had made some recent improvements in this area working with people and their relatives. People who had chosen to have one in place were given a red heart sticker that was placed on their bedroom door discretely. They were also made identifiable in red on a white board in the nurses station and senior staff office. This enabled staff to identify people who needed CPR or not to paramedics or to staff in an emergency. Staff we spoke with told us; "This is working well, we have it on the handover sheets too so it's easy to know who has one in place and who doesn't."

Staff had received training in respect of abuse and safeguarding. They could describe the different types of abuse and the actions they would take if they had any concerns that someone may be at risk of abuse. We saw records that demonstrated the service notified the appropriate authorities of any safeguarding. One member of staff told us, "I would look out for changes in mood as well as physical signs and report it straight away."

We looked around the home and found that all areas were exceptionally clean and well presented. We observed staff wearing protective clothing such as aprons and gloves. Personal protective equipment (PPE), paper towels and liquid hand sanitizer were available throughout the home. We also witnessed care staff using PPE appropriately, for example when serving food.

Inadequate

Is the service well-led?

Our findings

The home did not have a registered manager in post. A registered manager is a person who has registered with CQC to manage the service. We saw that the service had a management team in place that consisted of a manager and an assistant manager. However, a new manager had been recruited and was beginning their induction during the second day of our inspection. The operations manager assured us that the new manager would commence the registration process once they had completed their induction.

During our inspection we looked at falls records in the accidents/incidents monitoring file and in people's care plans. We found some falls records were in people's care files but were not reflected in the main folder that was used by the deputy manager for falls monitoring. At the time of our inspection there were no action plans in place to reduce the rate of falls occurring across the service. When we spoke with the deputy manager and operations manager they told us there was no over sight or analysis of falls that occurred across the service.

One person's accident and incident records showed that over a three month period they had 13 unwitnessed falls. These had all occurred in their bedroom when going the bathroom or from falling out of bed. They also had two falls from bed on the same day and both incidents involved them injuring their head on bedroom furniture. These falls records were not analysed by the management to establish possible causes or to record actions taken to reduce repeat incidents as the person continued to have these similar unwitnessed falls.

Care plans regarding people's mobility and falls risks were not up to date. People's care plans stated they were mobile and independent however further entries stated this wasn't the case and they required more support and were not mobile. These care plans were not updated by management to reflect significant changes. Care plan audits carried out by management had not picked up these changes. This meant care plan audits carried out by management were not effective and information in care plans were not updated as a result.

People's care plans were unclear and did not state if they were using assistive technology such as bed sensors or chair sensors to help with falls management. Some care plans stated that people used walking frames to mobilise and were independent when they weren't or failed to state that people were not mobile. Care plan audits carried out by management did not highlight this missing information.

During our inspection we looked at the registered provider's Accident and Incident policy and found that although there was a policy in place it was not implemented by management or followed correctly or consistently by staff. From viewing the policy and speaking with the deputy manager and staff it was found that different actions were being taken when falls occurred at the service. There were no management plans in place to ensure that the falls policy was implemented and no arrangements in place from management to review this policy or to ensure staff were aware of the policy and how to respond to falls appropriately.

Policies, procedures and practice were not always regularly reviewed in light of changing legislation to

inform good practice and provide advice. The accident and incident policy didn't include what actions staff should take when checking people over following a fall.

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

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The deputy manager always informed the CQC of significant events in a timely way by submitting the required notifications. We found that safeguarding referrals had been made appropriately to the local authority and also police incidents were recorded within the incidents log and the CQC were notified of these events.

All records we observed were kept secure and were maintained and used in accordance with the Data Protection Act.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not deployed across the building adequately to meet peoples needs and respond to emergency situations.

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 12 HSCA RA Regulations 2014 Safe care and treatment The management of falls and current practices placed people who use the service at a high level of the risk of harm.

The enforcement action we took:

We issued urgent conditions on the registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Accidents and incidents were not managed or analysed to reduce risks appropriately.

The enforcement action we took:

We issued a Warning Notice to the provider to make improvements to the service.