Care Quality Commission

Nellsar Limited

# Silverpoint Court Residential Care Home

## Inspection report

Silverpoint Marine
Canvey Island
Essex
SS8 7TN

Tel: 01268515564
Website: www.nellsar.com

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## Ratings

| Overall rating for this service | Requires Improvement |
| --- | --- |

| Is the service safe? | **Inadequate** |
| --- | --- |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Silverpoint Court is a residential care home providing personal care to up to 36 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 28 people using the service.

People's experience of using this service and what we found
People were not protected from the risk of harm. People's care plans and risk assessments were not accurate and daily care records did not evidence people received appropriate support with their healthcare needs.

People's medicines were not always safely managed, and guidance was not always in place to ensure staff knew how to support people with their medicines. The provider's fire safety documentation was not up to date and did not provide staff with clear guidance about how to support people safely.

The provider did not have robust processes in place to ensure accidents and incidents were documented appropriately and safeguarding notifications had not always been raised when necessary. Incidents had not been analysed to ensure lessons were learnt and improvements made.

The provider had not ensured staffing levels, or the deployment of staff across the service, adequately met people's needs. We observed people waiting for prolonged periods for staff to support them.

The provider did not have oversight of the service and the systems in place to monitor the safety and quality of the care provided were not effective. Staff did not always feel listened to and people's relatives did not always feel involved in the service or kept up to date about people's care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 02 May 2019).

Why we inspected
We received information of concern in relation to the management of risks to people's health and safety and the provider's processes for reporting safeguarding concerns. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question.  We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Silverpoint Court residential care home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety, staffing and the oversight of the service at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** |
| **Is the service well-led?**<br>The service was not always well-led.<br>Details are in our well-Led findings below. | **Requires Improvement** |

CareQuality Commission

# Silverpoint Court Residential Care Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three inspectors.

Service and service type
Silverpoint Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Silverpoint Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection and sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the operations manager, registered manager, deputy manager, care staff and kitchen staff. We 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found on inspection and reviewed quality assurance documentation.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people's health and safety were not managed appropriately. People's care plans and risk assessments were not up to date or accurate and did not include all relevant information needed for staff to support people safely. For example, information about how often people required support to weigh was not always correct and there was a lack of guidance for staff about how to identify and manage risks related to people's diabetes care.
● People's daily care records were not completed accurately. People's food and fluid records were not always up to date and did not evidence when they had been supported to take daily supplements recommended to aid pressure wound healing. Where people had sustained an injury, this had not always been recorded on an accident or incident form and the provider had not reviewed people's risk assessments to understand what had happened and minimise the risk of a reoccurrence.
● The provider had not effectively monitored accidents and incidents or analysed information to see where improvements could be made and lessons learnt.
● Information in people's care plans did not link to their daily charts, or incident reports and this meant we could not be assured the provider was able to monitor any trends effectively. Where reports had been completed or concerns raised, it was not always clear what action had been taken as a result or how this had been shared with staff.
● The provider had not ensured effective fire safety processes were in place. People's personal evacuation plans, which provided guidance for staff about how to support people safely in the event of a fire, had not been updated since 2019.

We found no evidence people had been harmed. However, the provider had not effectively assessed and managed risks to people's safety. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback, the provider sent us an action plan which included an immediate review of people's risk assessments and their fire safety documentation.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Using medicines safely
● People's medicines were not safely managed. During our inspection, we observed a medicines trolley left unattended with boxed medicines left on top of the trolley, accessible to anybody walking past.
● People did not always have protocols in place for medicines they may need to take when feeling distressed or upset. This meant staff did not have appropriate guidance in place to follow to assess when these medicines may need to be administered. People's liquid medicines had not always been labelled when opened to ensure staff knew when they needed to be used by.

We found no evidence people had been harmed. However, the provider had not ensured effective systems were in place to manage medicines safely. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider did not have a robust system in place to calculate staffing levels in the service. The tool used by the provider to determine how many staff were needed on shift did not consider the length of time taken to administer medicines across the service and this meant there were less staff available to provide direct care to people.
● During our inspection, we saw people waiting for support with their care. For example, we observed people waiting for prolonged periods for support to go downstairs to the dining room for lunch and to return upstairs afterwards. One person told us, "I've been waiting for a while. I just want to go to down but there's no one here to take me downstairs for lunch. I sometimes have to wait a while."
● Staff had raised concerns with the provider about not having enough time to complete people's daily care records at the point when care was being given. During our inspection, we saw some monitoring charts which were still blank for the day and witnessed staff completing people's morning care records late in the afternoon. This meant records were not always up to date and there was a risk information may be inaccurate or forgotten.

We found no evidence people had been harmed. However, we could not be assured there were enough suitably qualified, competent and experienced staff to support people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Following our feedback, the provider told us they were reviewing staffing levels in the service and had increased the staff on duty during the day by one member of staff.

Systems and processes to safeguard people from the risk of abuse
● The provider did not have effective processes in place to ensure people were protected from the risk of abuse. Incident reports had not always been completed appropriately and the provider had not always submitted safeguarding notifications to the local authority or CQC in a timely manner.
● The provider responded to concerns raised during the inspection and by the local authority, reviewing incident reports and submitting notifications retrospectively. The provider told us they had been given support from the local authority to better understand when a safeguarding notification needed to be raised.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning schedules were in place; however, communal bathrooms contained equipment which was stained and in need of more thorough cleaning.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes

- The provider had supported visits to the service in line with government guidance. People received regular visits from friends and relatives.

Requires Improvement

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider did not have effective systems in place to monitor the quality and safety of the service. The provider's audits had not identified all concerns found on inspection and there was a lack of information about what actions had been taken when audits had identified areas for improvement.
●The provider was not able to demonstrate how they had oversight of risk or how they ensured people's care documentation was reviewed and updated to ensure it remained reflective of their needs.
● The provider had not always documented incidents appropriately or submitted the relevant notifications to the local authority and CQC, in line with their regulatory responsibilities. The provider was not able to evidence how they had been open and honest with people when things went wrong.

We found no evidence people had been harmed. However, the provider did not have robust processes in place to monitor the safety and quality of the service. This demonstrated a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider responded promptly to the concerns we found and implemented a service improvement plan, detailing what actions they planned to take to drive improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We received mixed feedback from staff about how valued they felt and their support from the management team. One member of staff said, "I feel we could be listened to a bit more about things because we know the residents we care for." Another member of staff told us, "I feel supported by the staff team and manager and I like working here."
● Relatives spoke positively about the way staff supported people; however, they did not always feel they were involved in the service. One relative told us, "I don't really get told anything specific about [person], there's a circular sent out and they let us know about new government updates but there's nothing more personal." Another relative said, "We don't really get any contact or calls, so we only know how [person] is if we call and ask them."
● The provider completed annual feedback surveys with people, staff and relatives and told us they were currently in the process of completing a new survey which would enable them to focus on the areas of

improvement which were important to people.

Continuous learning and improving care; Working in partnership with others

● The provider worked in partnership with other healthcare professionals to meet people's needs. People's care plans evidenced input from the GP, district nurses and speech and language therapists. People's health visits had generally been recorded; however, some records lacked detail and it was not always clear how information had been shared.

● The provider had engaged with the local authority to start implementing a plan of improvements for the service. Following the inspection, the provider promptly sent additional information to CQC and identified the immediate actions they planned to take to address the improvements needed.

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 | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not effectively assessed and managed risks to people's safety or ensured effective systems were in place to manage medicines safely. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have robust processes in place to monitor the safety and quality of the service. This demonstrated a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had not ensured there were enough suitably qualified, competent and experienced staff to support people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |