Thomas Owen Care Limited

John Sturrock

Inspection report

Walter Crescent
Richmond Hill
Leeds
LS9 8NG

Tel: 01132491681

Date of inspection visit:
22 September 2021
28 September 2021
14 October 2021

Date of publication:
11 February 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
John Sturrock is a care home providing personal and nursing care to up to 40 people, some of whom were living with long term mental health conditions and some who were living with dementia. The provider was also caring for people with learning disabilities and autism, but this was not included in their registration. There were 40 people living in the home at the time of this inspection.

John Sturrock accommodates people in a purpose-build property. Each person had their own bedroom with en-suite facilities. There were indoor and outdoor communal areas.

People's experience of using this service and what we found
People and relatives shared mostly positive feedback about the care provided. However, during this inspection, we were not assured the service provided was safe and we found widespread shortfalls in the way the service was managed. We found signs of a closed culture developing at the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. The model of care was not consistent with current best practice. The management of behaviour considered challenging to others did not follow a positive behaviour support approach and there was a lack of evidence that restrictive practices were used only as a last resort. Care planning documentation was not always written from the point of view of the person.

The provider failed to implement processes to effectively monitor the quality of the service and to identify the issues found during our inspection. Records were not always complete or contemporaneous.

Several events, including safeguarding incidents, had happened at the home. Most had been appropriately reported, but in the course of this inspection, we asked the provider to report another two safeguarding incidents that had not previously been identified as such.

Known risks to people's care and the management of behaviour considered challenging was not managed well.

People's medicines were not always administered safely.

The requirements of the Mental Capacity Act were not always being followed. We found some people who lacked capacity in relation to some areas of their care, had their liberty restricted as part of their care arrangements and this was not properly assessed and documented. People were not supported to have

maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Care plans were not always individualised or reflective of the person's voice.

Management systems were not robust in ensuring consistent recording and analysis of accidents, incidents and complaints. We found gaps in staff's training, assessment of competencies and supervision.

We made a recommendation in relation to staffing levels and staff deployment practices.

The registered manager was receptive to the inspection process and told us they had taken action in relation to the issues found at this inspection.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 9 August 2019).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made, the provider was still in breach of regulations and we found new breaches.

Why we inspected
The inspection was prompted in part due to concerns about a closed culture developing at the service due to the high number of safeguarding incidents, incidents involving the police and medicines errors. 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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at 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 see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for John Sturrock 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We found breaches in relation to safe care and treatment, consent to care and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

John Sturrock

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 Care Act 2014.

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 conducted by two inspectors, a pharmacist inspector and an Expert by Experience; a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
John Sturrock is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced on both days of our inspection visits.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service including information about important events which the service is required to tell us about by law. We requested feedback from other stakeholders. These included the local authority safeguarding team, commissioning team, police and Healthwatch Leeds. Healthwatch is an independent consumer champion that gathers and represents the

views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people using the service and five relatives about their experience of the care provided. We observed care in the communal areas to help us understand the experience of people. We also gathered information from twelve members of staff including the registered manager and received feedback from four healthcare professionals who had worked with the service.

We reviewed a range of records. This included four people's care plans, risk assessments and associated information, and other records of care to follow up on specific issues. We also reviewed multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, fire safety, quality assurance records and further records of care. We contacted the Fire Safety Authority and shared the initial findings of this inspection with the local authority safeguarding manager and contracts managers from the local authority and CCG.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were not always protected from the risk of harm because there was poor management of known risks to people's care. A high number of incidents were found to have occurred, including verbal, physical and sexual incidents between people using the service. For example, there were known risks in relation to the sexual safety of one person, but their risk assessment and care plan did not indicate how this information had been used to manage the risk appropriately and prevent reoccurring incidents. Another person who was living with dementia, required full assistance with nutrition and hydration and in the last 12 months had lost weight. However, their weight was not being regularly monitored and there were widespread gaps in their food and fluid intake.
- The provider was not always managing the behaviour of people using a positive and least restrictive approach. Behaviour was seen from the point of view of staff, instead of from the person experiencing the behaviour, for example physical or verbal aggression was seen as 'assault' instead of distress by the person; this was described in people's care plans. Risk assessments and related mental health care plans did not always give specific information about the function of behaviour, triggers or de-escalation techniques needed.
- The registered manager was reviewing incidents and accidents. However, this did not include all the incidents that had actually happened because incidents recorded in people's daily notes were not always included in the registered manager's monthly analysis. We found examples where incidents were not fully investigated, and some were reoccurring.
- Fire safety was not always well managed. An external fire risk assessment noted recommendations for improvement, such as on fire doors, smoke seals and breaches to fire barriers. These should have been acted upon 3 months after assessment but evidence suggested this had started ten months after that date. Some staff did not have their fire safety training up to date and regular fire drills were not taking place. We shared concerns with the Fire Safety Authority. The registered manager told us they had taken action to address these concerns.

Systems were either not in place or robust enough to demonstrate safe care. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they would review risks to people's care and related care plans and provide additional training to staff. The provider also told us they would buy a particular piece of equipment to weigh people who could not use a weighing chair.

● 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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. During this inspection, we found there were restrictions on people's care that had not gone through this process. We found one example of a DoLS condition not being complied with.
● We saw inconsistency in how the service was ensuring people's capacity to make decisions had been assessed when needed and relevant people were involved in making best interest decisions.
● Some people's planned care interventions included restrictions, but these had not been properly assessed, documented and reviewed to ensure the least restrictive approach was being used. Staff had not been trained to restrain people in a safe way.

We found no evidence people had been harmed. However, systems were either not in place or robust enough to demonstrate safety and consent to care was effectively managed. This was a breach of regulation 11 (Need for consent)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they would improve the process and recording of decisions in relation to consent to care.

Using medicines safely
● People's medicines were not always administered safely. Systems were not in place to ensure prescriber's instructions such as to administer 'before food' were followed. Prescribed fluid thickeners were not handled safely. The required consistency was not recorded, and it was unclear if the thickener was still needed for one person. Thickeners were not always stored safely.
● Written information supporting the use of 'when required' medicines was not always wholly reflective of people's individual medicine needs. Written guidance did not describe how people were supported with anxiety and agitation, including when 'as and when required' medicines should be used. The reason for administration and the effectiveness was not always clearly recorded. We also saw one example where a medicine was being used differently from the written guidance.
● Records for the application of prescribed creams were not completed. During our checks we were satisfied these were being applied by staff and we did not find evidence of issues with people's skin integrity. The registered manager told us a new booklet had been implemented to address this following our visit.
● Medicines were administered from very early in the morning to late at night, but people's choices and preferences for this were not documented.
● Audits were taking place. However, they had not identified the issues found on inspection. The medicine errors list provided by the registered manager did not include an incident that we had been made aware of. We could not be sure medicines incidents were always recorded for investigation and learning.
● Most staff had received their training to administer medication. However, staff who had not completed an assessment of their competency were administering medication.

We found no evidence people had been harmed however, systems were either not in place or robust enough to demonstrate safety and effective management. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) and 17 (Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they would review people's medication records and make sure only staff appropriately trained and competent would administer medication.

● The home had recently changed to a different electronic medicines record.

Systems and processes to safeguard people from the risk of abuse
● There were safeguarding policies and procedures in place and we found several examples of safeguarding incidents being appropriately reported to the local authority, as required. However, during this inspection, we identified two incidents had not been reported, one in relation to an unexplained bruise and an incident of aggression between people where one had hit their head. The registered manager told us they would report them immediately.
● We found not all staff had their safeguarding training up to date. However, in our conversations with staff, they were able to describe signs of abuse and what actions to take if they had concerns about abuse or neglect.
● People told us they felt safe. One person said, "Yes, [I feel] safe. All residents are nice people."
● Relatives told us, "I think [my relative] is fairly safe [at John Sturrock]. I do have concerns about the danger if [my relative] can get access to alcohol" and "I think [my relative] is safe within the service, but I'm not sure about when they are out in the community."
● We received mixed feedback from healthcare professionals in relation to people being safe. Comments included, "I don't think my clients are always safe. Managing the risks is difficult" and "I have never had cause to think any [people] there are unsafe."

Staffing and recruitment
At our last inspection, we recommended the provider reviewed best practice guidance regarding safe recruitment of staff and incorporated this into auditing procedures. The provider had made improvements.

● Recruitment was managed safely.
● We received mixed feedback from people and staff in relation to staffing levels. People's views included, "No staff on the floor (meaning downstairs lounge) at night", "Sometimes I wait up to one hour when I buzz for things, three hours the other day, normally at night. Of late it's okay. They came straight away today", "Enough staff always, yes they come when use call bell." and "Staff always available for appointments or outings."
● The provider used a staff dependency tool and explained to us how they used it to calculate the staff required in line with people's needs.
● One person living at the home required one to one support and this was provided by an external agency. We saw examples of some of these shifts not being covered by agency staff and other staff having to be assigned to provide the care whilst no additional staff were brought in to cover. The registered manager told us the actions they were taking to address this. We also read one incident report that indicated that a behaviour incident had happened due to a planned outing having to be cancelled due to staff not being available.

We recommend the provider reviews their staffing levels and staff deployment practices and take action to update their practice accordingly.

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 somewhat 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 assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were somewhat assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Inadequate

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 the last inspection this key question was rated as requires improvement. At this inspection this key question had now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. At our last inspection, we found the provider was in breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and at this inspection we found a lack of improvement and further deterioration with another two breaches of regulation identified.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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

- During this inspection, we found widespread failings in the management and oversight of the service, which meant people did not always receive safe care.
- Systems in place to record and investigate accidents and incidents were not robust. This lack of oversight did not allow for an adequate analysis of incidents to ensure effective measures were put in place to prevent reoccurrence and lessons learnt.
- The provider's statement of purpose was not up to date. The home was caring for people with learning disabilities and autism traits and this was not indicated in the provider's statement or registration.
- Quality assurance processes were not effective in identifying issues found at this inspection and in driving improvements in areas such as medication and care planning. This issue had already been identified at the last inspection where the provider had been found to be in breach of regulation. The provider had a service development plan, but the issues found at this inspection had not been previously identified for action.
- We found supervision was not always completed regularly, including for nurses, for example, eleven out of forty three staff had not received a recent supervision also noted gaps in training, for example in fifteen staff members did not have up to date fire safety training and eleven lacked up to date safeguarding training.
- The provider was not always using relevant guidance and good practice to support people with their specific needs. During this inspection, we discussed and shared with the registered manager relevant guidance in relation to promoting safe sexual wellbeing and managing the behaviour of people using positive approaches.
- Care plans and records of care were not always complete, accurate and contemporaneous.
- At the last inspection we found some issues in relation to safety of external windows. At this inspection, we found one window did not have a restrictor; we shared this with the registered manager and they took immediate action.
- We could not be sure complaints were managed well and lessons learned to make improvements. There was not a systematic record of complaints and there was lack of evidence these were all acted upon and responded to in line with the provider's own complaints policy. The registered manager told us he was aware this was an area needing improvement.

● Governance systems in place had either not identified or addressed these shortfalls.

Systems were either not in place or robust enough to demonstrate effective oversight and management of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager was receptive to the inspection process and responsive in acting on the issues found at this inspection. People, relatives and staff shared positive about the registered manager and the senior management team. Comments included: "He has been extremely supportive to us as a family.", "Staff very good. Very well managed." and "I feel supported, [registered manager] comes in and askes about staff, [registered manager] is an easy person to speak with."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We found signs of a closed culture developing. CQC defines a closed culture as being as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm. Some examples of signs found during this inspection and reported on in the safe domain, include: restrictive practices used at the service which were not properly assessed or documented, care plans did not always reflect the person's voice, there was an inconsistent application or understanding of the Mental Capacity Act (MCA), there were concerns around medicines management in particular in relation to medicine to manage behaviour.

● We found inconsistent provision of activities. We saw evidence of activities taking place during our inspection visits and the registered manager told us their plans to improve this area. However, we also observed people sat in the communal areas not being engaged or offered activities. Good practice guidance on managing violence and aggression in care settings includes the regular provision of meaningful activities.

● Relatives told us, "[Person] is more independent and is able to do a lot more. [Person] likes to go shopping and [they were] going out quite a lot before lockdown" and "I don't think they push [person] enough [to be active.]"

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Communication care plans were not always person centred. Although the provider had a policy focused on accessible communication, and the registered manager told us about plans to have pictorial menus, at this inspection we did not find evidence of communication being presented in an accessible way for people who required it, for example for people living with dementia or learning disabilities.

● There were mixed views about the culture of the home and the impact it had on people. Comments from people included "It's a very good place. Food is excellent. Can't fault chef. If need medical attention they get it, everything is on tap." Relatives told us: "My impression is that [person] has really good relationships with the staff" and "I think sometimes it suits [the staff] just to leave [people] in their bedroom rather than getting them to join in." Healthcare professionals said, "Staff do appear to take on board my observations and will often seek medical or Adult Social Care advice. However, at times, things don't get done" and "The staff are always receptive, professional and helpful. They do follow my advice."

Working in partnership with others

● The home maintained good working relationships with partner agencies. This included working with commissioners and health and social care professionals such as social workers and GPs. We also saw examples of partnership work with universities.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	We found inconsistency in the application of the principles of the MCA, mental capacity assessments and best interest decisions. We found some people had their liberty restricted as part of their care arrangements and this had not been properly assessed, documented or reviewed.

The enforcement action we took:

We served a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Known risks to people's care were not managed safely. People's medication was not administered safely.

The enforcement action we took:

We served a Warning Notice.

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	We found failing in the management and oversight of the service. There was continued lack of effective quality assurance process in place to identify the issues found during our inspection and to drive the necessary improvements. Records were not always accurate, complete or contemporaneous.

The enforcement action we took:

We served a Warning Notice.