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Korniloff

Inspection report

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Date of inspection visit:
23 April 2018
24 April 2018

Date of publication:
18 May 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The last inspection took place on 14 November 2017 and was rated "Good" in all areas.

We undertook an unannounced, focused inspection of Korniloff on 23 and 24 April 2018. The team inspected the service against two of the five questions we ask about services: Is the service Safe and Well Led? This is because we had received concerns from the local authority and safeguarding team about people's care at Korniloff.

Korniloff 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.

Korniloff is a residential care home providing accommodation and personal care for older adults. The service is set in a converted hotel on the coast, offering spacious communal areas to make the most of the wide stunning views of the sea and Burgh Island. The service does not provide nursing care. The home uses community nurses to provide this service. The home can accommodate a maximum of 17 people but as the provider does not use two rooms as doubles, the actual capacity is 15 people.

At the time of the inspection 12 people were living at Korniloff, one person was in hospital. The provider was also the registered manager who lived on site. 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.

Prior to the inspection we had received concerns from the local authority safeguarding team. These included concerns about; poor and neglectful personal care, poor care in relation to management of people's skin and risk of falls, poor medicine management, failure to recognise and respond effectively in response to changes in people's health needs, environmental concerns and concerns about the leadership at the service.

A safeguarding meeting had taken place with the local authority prior to the inspection and we were told a number of safeguarding investigations in relation to these areas of concern were on-going. We did not look at these specific investigations as part of the inspection, however, we did use this information to inform us about how we needed to conduct the inspection and areas of care we needed to consider and review.

The local authority had also informed us prior to the inspection, that due to the high number of concerns received, they had met with the provider and requested an improvement plan and assurances about people's safety. Due to the concerns, the provider and commissioners agreed to stop any admissions to the home. The provider also agreed to stop admitting any privately funded people.

We found the systems in place to keep people safe from harm were poor. There were not good medicine practices in place. Staff had not been trained to administer medicines and had little knowledge of why people were on particular medicines. There were no medicine audits in place and no individual protocols about how people should receive their medicines. We found people did not always have their medicine at the right time, some had missed their medicine and some had too much medicine given to them. These were areas of concern.

People's risks were not known, documented or well managed at the service. People at risk of falls, weight loss or skin damage were not assessed. Skin care management was poor and inconsistent. People were not repositioned frequently and did not always have the equipment they needed to help prevent skin breakdown.

Accidents were recorded but no one reviewed accidents and incidents which had occurred. This meant opportunities to analyse and prevent risk were missed.

People were at risk from staff that had not received a thorough induction, training and ongoing monitoring of their skills. Some staff had not received medicine training, fire training and moving and handling training. This affected their practice in these areas and put people at risk.

Staffing levels were not always safe. The provider did not have a dependency tool to assess what safe levels of staffing should be.

The environment was not safe and presented risks to people.

The leadership at the service was ineffective. Communication within the service was poor. People at the service did not have opportunities to suggest ideas and raise their views.

Quality assurance processes were minimal and did not drive change.

Following the inspection we took immediate action to ensure people were safe. We told the provider to give us assurances that people were safe in relation to medicines, moving and transferring, staffing levels, management of falls and skin care and the security of the property. The provider worked closely with the local authority to provide us with assurances within the timescale requested.

However, during the course of the inspection, the provider gave notice to the local authority commissioners to end their contract. The provider also submitted an application to the Commission to cancel the registration of the service. This meant they would no longer be providing care to people. Following the inspection, on 4 May 2018 the local authority confirmed to the Commission all people had been moved from Korniloff.

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.

People were at risk from inadequate staffing levels.

People were at risk from staff who had not received training to meet their needs.

People were at risk from an environment which was not secure and safe.

People were at risk from poor medicine management.

People were at risk from poor systems to identify and act on concerns, incidents and possible harm.

People were at risk as there were not systems in place to learn and improve when things went wrong.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership at the service was ineffective.

People were not given opportunities to feedback and express their views to develop the service.

People's outcomes were not monitored. People were not supported by skilled staff who were supervised and supported by management.

Systems were not in place to monitor and improve the quality and safety at the service.

Korniloff

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.

The inspection took place on 23 and 24 April 2018 and was unannounced. The inspection was carried out by two adult social care inspectors.

The inspection was prompted in part by safeguarding concerns we had received via the local authority safeguarding team. These included concerns about people receiving poor care, staff not recognising when people were unwell, concerns about staffing levels and concerns about medicine management and the leadership at the service. We did not look at these specific investigations as part of the inspection; however, we did use this information to inform us about how we needed to conduct this inspection and areas of care we needed to review as part of the inspection process.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tell us about by law.

During the inspection we spoke and / or met with the 11 people living at the service. We spoke with the provider who was also the registered manager and six staff. We spoke with visiting professionals from the local authority and one visiting district nurse.

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 to us. We undertook this observation in the communal lounge. We observed how people spent their day and the interactions they had.

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After our inspection, because of identified concerns, we told the provider to send us an action plan and assurances about people's safety. We also informed the commissioners and local authority safeguarding

team about our immediate concerns.

Inadequate

Is the service safe?

Our findings

At the previous inspection in November 2017 we found the service was safe.

Prior to this inspection we had received concerns from professionals, the local authority and the public. These included concerns about people's care, staffing levels, staff not recognising when people were unwell, medicines management and staffing levels. At this inspection we looked at these concerns and found these concerns were valid.

People were at risk from staff who did not know their care needs. There was no regular handover system in place and staff had not read people's care records. Staff told us handovers sometimes occurred in the car park as the shift changed. We saw that instructions from the district nurse to staff, for example, to elevate people's legs, were not carried out consistently. We asked staff to do this for one person.

People at risk of skin damage, falls and weight loss did not have risk assessments in place to assess and mitigate the risk to them. Staff had not received training in these areas to identify when people were at risk. People with diabetes were at risk because staff did not have the skills and knowledge to identify changes in their health which might indicate they were hypoglycaemic or hyperglycaemic. Care plans and risk assessments for one person did not clearly guide staff on the action they should take to ensure the safe management of this person's diabetes. One person we reviewed was very sleepy during the inspection. We asked external professionals to review their care as this had not been done by the staff or registered manager.

People did not have skin care management plans in place even when they were identified as at risk of skin breakdown. They were not regularly repositioned and some people's skin had broken down due to poor, inconsistent care and delays requesting district nurse advice. We asked external professionals to review two people's skin.

People were at risk of skin breakdown due to poor continence management. We reviewed one person's continence care. Their skin was sore and they were never offered to go to the toilet. Notes consistently referred to "pad" changes and not a regular toileting regime to support their continence needs. We asked the district nurses to review their skin.

People's falls and injuries were recorded in the accident book. However, these had not been reviewed or analysed to see whether they could be prevented in the future, if people needed any equipment to reduce the likelihood of further falls or if a notification to the Commission was required.

Some staff had received moving and handling theory training but they had not had practical manual handling training. Their lack of practical training placed people at risk. We saw staff carrying out poor manual handling techniques for one person using two staff and a manual handling belt unsuccessfully. Eventually, staff tried a hoist which they did not know how to use. The person's room was upstairs so they could not be supported back to their room. Staff made them comfortable and they remained in a low

recliner in the lounge.

Staffing levels were inadequate at the service. There was no dependency tool at the service to assess staff numbers according to people's needs. The provider and staff view differed on people's dependency. We asked this to be reviewed urgently after the first day of the inspection. Prior to the inspection the local authority had asked the provider to ensure two staff were on duty at night. The first day of the inspection was the first night that two staff were on duty. Prior to that, one care staff had been on duty and the provider could be woken at night. Staffing numbers were better in the day however; staff had not been trained in essential areas to be able to provide safe care, for example moving and handling, fire safety and medicine management. This placed people at risk.

Staff we spoke with told us they kept people safe and understood how to protect people from harm but not all staff had undertaken training in this area or were able to tell us what they would do if they had concerns people were being were being harmed. We noted in the accident book there had been an incident which should have been reported to the local authority safeguarding team and the Commission. We read in one person's care notes staff had described the person as aggressive and they had "difficult moods". There were no further plans or explanations to guide staff how to support this person's behaviour or protect other people.

Medicines management was not safe at the service. Not all staff administering medicines had been trained to do so and checked as competent. Medicines were not kept securely at the time of the inspection. We found the medicine trolley open on the first day of the inspection with one person's medicines easily accessible. The medicines trolley was in a room which was not locked and was accessible to people in the home and the general public; and the external door was also open.

We spoke with six staff about medicines. There was not a policy in place at the service which reflected current and relevant medicines guidance. Three of these staff had received training to administer medicines safely. When we checked the medicine administration records (MARS) we could see all of these staff had administered medicines in April 2018. Staff administering medicines did not know what people's medicines were for. We asked why one person was taking pain relief, staff told us they did not know, "maybe tooth ache?" They told us they had not read this person's care records and they did not know their health needs. This person had been recently admitted following a fall and broken arm. They also suffered pain from an arthritic knee. This meant staff were not monitoring whether the pain relief was effective or whether the person needed further medical attention.

Staff did not know why people were taking antibiotics to be able to monitor improvement and check these were effective. We asked staff why one person was taking antibiotics. We noted they were wheezy and the staff diary also noted this person chest "was not good". However, staff administering this person's medicine told us they did not know what the antibiotics were for, "I don't know, I have been on holiday." We asked this staff member whether this person's health needs had been discussed in handover. They had not been informed about the person's chest infection.

There were no PRN (as required) protocols in place to guide staff how to assess people's individual pain levels. We observed one staff member take out one tablet of co-codamol (a pain relief medicine). The person was prescribed 1-2 tablets up to 4 times a day. We asked why the person was on this medicine. Staff did not know. We asked how staff decided whether they required 1 or 2 tablets for pain and how this had been assessed Even though the person had the ability to make this decision and tell staff about their pain levels. Staff told us, "I give [x] as he's been refusing." There was no care plan or PRN protocol in place regarding

their medicine or any other people's medicines.

Where medicines were required to be given at specific times or before food or other medicines, there was no evidence this was done. One person was on a medicine which was meant to be given 30 minutes before other medicines. They told us they had all their tablets in the morning at the same time. This can affect the effectiveness of medicines but staff were not aware of this.

We found staff were administering medicines without a prescription from a doctor. For example one person had a handwritten entry on their medicine administration record (MAR) with no staff signatures, adding a cranberry tablet to be taken once daily. Staff were unable to confirm who had prescribed this or if the person's Gp was aware they were taking this medicine. Cranberry tablets were not on the person's homely remedy list of medicines. Staff told us this had been started after another staff had been told by someone they had consulted in America that this tablet was helpful for people who have urinary infections.

We also found there were no systems in place to monitor people who were frequently using a homely remedy. For example between the 15 April and 24 April one person had been given one or two grams of paracetamol a day for shoulder pain. Staff had not considered seeking advice from the person's doctor about their shoulder pain.

People were at risk of being overdosed due to poor medicine procedures. One person was prescribed a sleeping tablet. This had been printed twice on his MAR. Between the 9 April and 17 April this person, according to the medicine record had received twice the prescribed amount.

The systems of communication and sharing information about people was poor, did not keep people safe and placed them at risk. We noted one person had not been well during April 2018 and was feeling unwell on 24 April. Inspectors had reviewed the diary where staff had noted the person was confused. After reviewing the person's care records we saw they were at risk of recurrent urine infections. Staff did not know this and told us they had not read people's care records. We asked the provider and visiting district nurse to review this person's care. The district nurse was unable to as the service had no urine pots to test the person's urine and check for an infection.

We found Korniloff was not a safe environment for people. We checked the first floor fire door by Room 1. This would not easily open. There was a bolt on the door which was stiff and prevented the door release working. We asked a staff member to open the door. They were unable to and told us they had not had fire training and, "didn't know it was here." Another staff member was also unable to open the fire door. People would not have been able to leave safely from this door. The provider told us people and firemen could access their roofs from their room in the event of a fire. Some people had significant mobility issues and dementia and would not have been able to leave safely this way. New staff told us that they had not received fire training and they were not sure of the evacuation procedures. We also found personal evacuation plans (PEEPS) which detail how people should be supported by staff or the fire service to leave the building safely, were out of date. We requested the fire and rescue service visit and following the inspection the provider was issued with a fire order.

On the first day of the inspection we found an airing cupboard next to the first floor toilet. There was a sign saying the door should be locked at all times. We found the door open and inside was the boiler and hot pipes which had the potential to burn people. We fed this back to the provider and on the second day of the inspection the door was locked.

During both inspection days we found the front door was open. This meant people; visitors and members of

the public could enter Korniloff without staff knowledge. It also meant people could leave the building without staff knowledge. Some people at the service were living with dementia and could be at risk from traffic outside of the home.

During the inspection the kitchen door, which was off the dining area, was open and accessible to people. On both days of the inspection we saw one person who was living with dementia trying to access the kitchen. No staff were in the kitchen. The kitchen oven was still hot from lunch. Throughout the course of the inspection other service users, some who were living with dementia, were unaccompanied in the dining area with access to the unstaffed kitchen. There were no individual risk assessments in place to assess if people could safely use this area.

We also checked some of the windows within the home. None of the dining room windows had restrictors and there was a significant drop from the window to the garden. We also found the first floor toilet window opened fully. This posed a potential risk to people who were living with dementia. One person lived in a room where the bedroom door opened fully onto a large, high veranda. The door was left unlocked and there was no risk assessment in place to assess whether this person was safe to access the veranda.

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

Inadequate

Is the service well-led?

Our findings

Prior to the inspection we had received concerns from the local authority about the provider's ability to formulate and address an action plan following safeguarding issues which had been raised. Since the previous inspection in November 2017, the manager and deputy manager who supported the provider and provided leadership to staff, had both left.

We found widespread and significant shortfalls in the service at all levels. The values of the service were not clear. We observed some staff who were very caring and kind, and other staff who did not treat people in a dignified way, for example trying to give them their medicine whilst they were talking to family on the telephone.

There were no systems in place to induct new staff and explain the culture, procedures, policies and working ways of the service. Communication systems were inadequate, for example formal handovers between shifts about people's care needs did not take place. The provider did not have a system in place to ensure staff were trained in essential subjects such as moving and transferring, safeguarding and fire safety. This meant staff new to care were shadowing other staff who had not been trained and were not aware of best practice or relevant legislation in these areas.

Leadership at the service was ineffective. The provider lacked an understanding of how to run the service and had relied upon the manager and deputy manager. . The provider was not up to date with current practice or regulation. There were no quality assurance processes in place to identify or drive areas for improvement. The provider did not guide or lead staff. Staff did not know who was in charge and the provider's knowledge of care was poor when staff sought guidance. Care was intuitive, not guided by best practice Systems to support, supervise and appraise staff were not in place. We observed poor practice at the inspection which the provider had not identified themselves or taken action to address.

People's outcomes were poor at the service and they were at risk. Staff were not trained to identify changes in need so people's health had deteriorated in some cases. There were no systems in place to review people's care, record changes in their care needs or seek support promptly.

Checks were not in place to ensure people were not at risk within the service. Doors were left open, windows not secure and medicines accessible to people.

The service was registered to care for people with dementia but there was limited understanding of the mental capacity act to ensure people had their human rights respected and ensure people were not deprived of their liberty unlawfully.

Systems were not in place to ensure people's confidentiality was respected. Staff discussed people's care in communal areas and people's care records, for example bowel charts, were left in public areas.

Not all staff we spoke with were happy at Korniloff. They cared about people but lacked leadership and

guidance to offer high quality care. They shared their concerns with us about people's care and the lack of training, support and supervision they received.

Quality assurance processes were not in place to obtain regular feedback from people, family and professionals who knew the service. This meant opportunities to improve and listen to people's views were missed.

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

We spoke with the provider during the course of the inspection. They were working with the local authority to try and put things right but told us they found the task overwhelming in the time given to do this without management support. The local authorities were working closely with the service, reviewing people's needs during the inspection. On the second day of the inspection, the provider gave notice to the local authority commissioners. This meant people who were funded by the local authority would need to find new homes and the provider would no longer admit local authority funded residents. They had also agreed they would no longer provide care to privately funded people?

Due to our concerns, on the 25 April we asked the provider to urgently tell us what they would do to make people safe until people were moved from the service. This included requesting a plan to address staffing levels, the risk of falls, medicine management, people's skin care, fire safety, the security at the service and how people would be safely moved. We collected this plan on 26 April from the provider. On the whole this gave us assurances people would be safe until they were moved from the service. Most of the assurance were because people from the commissioning team, district nursing teams and overnight nursing services were visiting each day and every night and staff were committed to staying until the home closed. However we remained concerned about the management of medicine. The provider agreed to employ an agency nurse to administer medicines.

The provider also sent an application to CQC to cancel their registration.

Following the inspection, we liaised closely with the local authority regarding the closure of the service. All people had been successfully moved to their new homes by 4 May 2018.