Essex County Care Limited

Scarletts

Inspection report

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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 undertook an unannounced focused inspection of Scarletts residential home on 18 December 2017 and met with the manager, the area manager and the provider's external consultants on 23 January 2018. As part of our monitoring, we inspected to check the managerial and staffing arrangements for the service at the time and for the forthcoming seasonal holiday period. We also reviewed the progress of the provider's planned improvements following our comprehensive inspection carried out in June 2017 and focused inspection carried out on 12 September 2017, which found the provider was not meeting legal requirements.

Scarletts 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 we looked at both during this inspection.

Scarletts accommodates and provides personal care for up to 50 older people. At the time of this inspection, there were 23 people accommodated, who were vulnerable due to their age and frailty, and in some cases had specific and complex needs, including varying levels of dementia related needs and end of life.

Scarletts is in Special Measures, which resulted from an Inadequate rating following a comprehensive inspection undertaken in June 2017. The purpose of Special Measures is to ensure providers found to be providing inadequate care significantly improve. We keep services placed into Special Measures under review and, if we have not taken immediate action to propose to cancel the providers' registration of the service, will be inspected again within six months. The expectation is that providers found to be providing inadequate care should have made significant improvements within this timeframe.

At the inspection in June 2017, we identified a number of breaches of legal requirements. There was poor leadership, management and provider oversight of the service, which led to people receiving poor care and risks to their health and welfare not adequately protected. We took immediate enforcement action to restrict further admissions and to improve leadership, staffing and oversight. We shared our concerns with the local authority. In response, the local authority monitored the care people received and held regular meetings involving healthcare professionals to support the provider through the improvement process.

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

We continued to keep Scarletts under review. The reports the provider submitted regularly to us did not provide the information we needed to demonstrate the progress they were making in improving the service for people. It was therefore necessary and within the six month timescale to re-inspect again on 12 September 2017. The inspection focused on the areas of 'Safe' and 'Well led'. The provider had not made sufficient improvement and the service remained Inadequate in these areas. Despite support provided by a team of senior managers, managers and care staff brought in from the provider's services in Leicestershire,

there continued to be a lack of provider and managerial oversight and a failure to recognise, identify and act on significant concerns affecting the quality and safety of care for people. We took further enforcement action, with the agreement of the provider revised the existing conditions, and imposed further conditions on the service registration in an effort to force improvement.

You can read the report from our last focused inspection, by selecting the 'all reports' link for Scarletts on our website at www.cqc.org.uk

After the inspection on 12 September 2017, we received concerns in relation to staffing, management and provider oversight. As a result, we undertook this focused inspection to look at those concerns and this report only covers our findings in relation to those. This inspection did not assess performance against all five key areas and focused only on the areas 'Safe' and 'Well Led'. The ratings from the previous comprehensive inspection for the other three key questions were included in calculating the overall rating in this inspection. We will be returning to the service to provide a comprehensive overview of each key question.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had replaced the management team they had previously brought in with a new manager and the Commission was processing their application for registration.

We continue to have concerns about the provider's oversight of the service, inconsistent governance and leadership. A reliance on multiple and various managers to act on issues of concern continued without giving any effective direction or support. This in turn led to a failure to address recurring areas of risk to people's health, safety and welfare, and to drive and sustain improvement.

A high staff turnover and failure to support and retain staff impacted on staffing numbers, deployment of staff and skill mix which meant people's needs were not always met safely, effectively or consistently, or in a way that reflected their preferences and choice. People's experiences of care varied considerably depending on which staff were providing it and how well they knew them.

The local authority safeguarding and quality monitoring teams continued to monitor the service through regular visits and support, mitigating the risk to people using the service.

In the latter part of December 2017 the provider engaged further external consultancy support. At a meeting on 23 January 2018, the external consultants shared with us an extensive action plan they had drawn up to address and drive improvement and meet fundamental standards of care and safety. They confirmed the beginning of March 2018 was the expected target date for completion.

The Commission is continuing to monitor this service and will be returning to carry out a full and unannounced comprehensive inspection. If not enough improvement is made within the 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.

For adult social care services, the maximum time or being in Special Measures will usually be no more than 12 months. If the service has demonstrated improvements when we next inspect it and it is not rated as inadequate for any of the key questions it will no longer be in Special Measures.

Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work there.

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.

Staff did not have the skills, competence or knowledge to meet people's specific needs in a safe and appropriate way.

Arrangements were not sufficient for identifying and managing risk appropriately.

People's care was not co-ordinated or managed in a way that ensured their specific needs were met safely.

People were not protected from the unsafe management of medicines.

People were not protected from the risks of unsafe management of equipment.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of managerial oversight at all levels. There was a failure to recognise, identify and act on significant failings impacting on the quality and safety of service provision.

Scarletts

Detailed findings

Background to this inspection

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

This unannounced focused inspection took place on 18 December 2017 and was followed up on 28 January 2018.The inspection was prompted in part by information received since we inspected in September 2017 from whistle blowers, the local authority quality improvement and safeguarding teams. We also checked the provider's progress in addressing the breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified at our comprehensive inspection on 6 and 8 June 2017.

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

We also used the information the provider had sent us in their action plans and reports sent to us following our last comprehensive inspection. This included what action they had taken to address shortfalls, and how improvements were being implemented, monitored and maintained.

We inspected the service against two of the five key questions we ask about services: is the service safe? and is the service well led? This is because the service was not meeting some legal requirements. We did not inspect the service against the other three key questions and the ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection.

Three inspectors undertook the inspection. We spoke with members of Essex County Council safeguarding and quality teams about their visits to the service.

During the inspection, we spoke to four people who used the service. Some people could not tell us what they thought about the service as they were unable to communicate with us verbally therefore we spent

time observing interactions between people and the staff who were supporting them. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We also spoke with the manager, the supporting manager, three permanent staff member, one agency staff member, and the cook.

To help us assess how people's care and support needs were being met we reviewed the care records of 11 people who used the service including risk assessments and monitoring charts. We also looked at systems for assessing and monitoring the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

Our inspection of June 2017 found widespread and significant shortfalls in the safety of the service provided and people were at risk of receiving unsafe care. We saw limited improvement in this key area at our focused inspection in September 2017 with a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action following each of these inspections to force improvement.

At this inspection, we found insufficient action taken to fully address concerns and further improvement was needed. Lessons were not learnt to ensure risks associated with individuals health needs, support and safety were identified, planned for and monitored effectively.

The manager had revised and updated care plans. We found they were either incorrect and/or lacked relevant information and effective care planning strategies in relation to various health needs and dementia related needs. Staff therefore did not have sufficient guidance on the level and type of care and support people required to meet their needs, recognise signs and symptoms of changing needs and reduce risks to their health and welfare.

A care plan for a person with diabetes incorrectly stated to choose low carbohydrate options, the manager confirmed that this should read low sugar options. The care plan also stated the person checked his or her own blood sugar levels daily and self managed their health condition. The manager confirmed that this was not the case. The care plan referred to the action to take if the blood sugar level was too high or too low but omitted relevant detail of the signs and symptoms of the levels for staff to recognise them. Information about diabetes in the back of the individuals care records was not linked to their care plan. There were no records to show staff checked the person's blood sugar level; the manager confirmed they were not checking this because they were waiting on instruction from a healthcare professional on the frequency for checking. They had been waiting for this instruction for over six weeks and had not chased this up. This placed the person at risk to their health and welfare of having a blood sugar that may be too low or too high.

There was a lack of recognition and understanding of risk particularly in relation to supporting people with dementia related needs. A basket of snacks and fruit were available and accessible to people in the communal areas. Some snacks wrapped in cling film posed a potential choking hazard from ingestion. We saw a staff member give a snack covered in cling film to a person living with dementia, they did not remove the cling film for them and the person took a bite from the snack, fortunately, the person removed the cling film from their mouth. We brought this incident to the attention of the manager.

At our inspection in June 2017, we found risk assessments were not completed for people with long term indwelling catheters and there were no care plans in place to guide staff on the signs to be aware of to determine risk of blockage or infection. At this inspection, we found that care plans for people with indwelling catheters included the control measures for staff to help prevent infection, which included monitoring urine output levels. However, staff demonstrated a lack of understanding around the purpose

for monitoring fluid output and the output was either not recorded, recorded incorrectly or recorded in the wrong place. Incorrect monitoring of urine output meant that people with indwelling catheters were at risk of undetected blockage or possible urinary tract infection (UTI).

Our inspections in June and September 2017 found that there were not enough staff to provide the right level of care and staff were not deployed in a way that ensured people's safety. This inspection found the service continued to have a high turnover of permanent staff and reliance on temporary agency staff with basic training. Managers and permanent staff told us that they were too busy to orientate and support temporary and new staff. Managers had not assessed the competency of new and temporary staff to ensure they had the correct skills to meet people's needs, and inform workforce planning. A staff member told us that they had taught themselves how to carry out risk assessments using recognised risk assessment tools by researching on the internet.

Our inspection in June 2017 found care was not co-ordinated or managed to ensure people's specific needs were met safely. This inspection found people continued to receive inconsistent support due to a lack of organisation and co-ordination of staff. Management and senior staff were not leading and organising each shift and staff felt there continued to be a lack of organisation and delegation on shifts.

At lunchtime, people requiring assistance to eat did not receive personalised and one to one support. For example, Staff A gave a person milk to drink; Staff B was unaware they had milk and offered them a drink. Staff A came back and fed the person Weetabix, Staff B returned unaware the person had eaten Weetabix, offered the person a meal to which they declined and they fed the person yoghurt. Shortly after, Staff C went to the person to offer them a drink but by this time, the person had become agitated telling Staff C to go away. This disorganised approach did little to encourage and promote eating in a way that maintained people's dignity, health and wellbeing.

Staff did not support or monitor people effectively to protect them from the risk of dehydration or malnutrition. We observed a person sleeping in a chair in a lounge all day. Staff did not attempt to wake them and encourage them to have hot drinks and biscuits. At lunchtime, this person remained very drowsy and staff did not attempt to stimulate their senses and encourage them to eat. At 16.00pm, we informed the manager they had not eaten or drunk all day. In response, they woke the person, sat with them and encouraged them to eat a banana, which they enjoyed. Staff did not record in their daily records that the person had not had sufficient food and fluids.

The manager had introduced shift allocation sheets to identify staff responsible for specific care and support activities such as answering call bells, repositioning people, supervising communal areas and administering topical cream. This system was ineffective because they were not always completed. Staff, therefore were not always clear of their responsibilities and people were at risk of not receiving the care and support they needed. Topical cream administration records were not consistently completed and the allocation records for the same days were also blank. It was unclear whether individuals received their prescribed topical creams, and when. There was no record to show if there was a staff member allocated responsibility for checking people's creams were administered and the administration records completed.

In June 2017 we found there were no protocols in place for people prescribed medicines to be taken 'as and when required' (PRN) to guide staff as to how and when these should be administered. At this inspection, we found that protocols put in place lacked sufficient and relevant information to protect people from the risk of incorrect administration of medicines. One person had two different PRN medicines prescribed, each from the same group of medicines (Benzodiazepines). The protocols did not specify what they were for, include a strategy to guide staff on when to administer each medicine and there was no guidance as to

whether it was safe to administer at the same time.

There were no medication care plans in place for people to identify their prescribed medicines and to guide staff on their purpose and any signs to be aware of in relation to side effects.

Some topical creams and lotions have a limited efficacy once opened. Not all creams in use had a date of opening recorded.

Many people had limited mobility and required equipment to assist them. At our inspection in June 2017 we identified that management and staff had limited understanding of their responsibilities in relation to checking equipment and identifying hazards that may pose a risk to people's safety. Worn rubber feet [Ferrule's] on some walking frames posed a risk of slipping and/or falling to the person using it. At this inspection, we found worn ferrule's on the walking frames for two people. The manager confirmed that a system to check the safety of this type of equipment was still not in place. They believed the maintenance person, employed since November 2017 had a stock of new ferrule's and would address the walking frames. The lack of checks meant that the wear and tear of equipment went undetected and placed people at risk of harm from using equipment that may be damaged and/or unsafe.

In June 2017, we identified that some people did not have a moving and handling risk assessment, and where they did, the risk assessment and plan did not clearly specify the type of hoist and the type and size of sling each person required to move safely. Following the inspection, the provider purchased new hoist slings and they informed us they had assessed individuals for their own moving and toileting slings. Moving and handling risk assessments identified the size of sling a person required for their safety but the slings were not stored in the room of the individual and they did not have an identity label. This posed a risk of infection to people from sharing toileting slings.

Staff spoken with confirmed they had recently received moving and handling training delivered by the provider's in-house trainer. A staff member told us, "It was very practical, we practised by hoisting the trainer and the trainer talked through slings with us." Moving and handling practices observed using a hoist were safe and staff supported people with patience, providing reassurance and encouragement. Staff were not aware of moving and handling techniques consistent with best practice when assisting people requiring walking frames to sit or stand. While being assisted by staff to sit one person fell backwards into their chair still holding their walking frame up in the air. Another was pulled by staff from under their armpits while assisting them to stand from their chair. Both manoeuvres posed a risk of injury to the individuals being assisted.

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

There was no log of safeguarding concerns raised or actions taken to address them and the manager was unable to tell us of lessons learned taken forward from recent safeguarding investigations. The provider did not have a continuous improvement plan to keep track of progress and ensure incidents did not reoccur.

Following recent safeguarding concerns and following our last inspection, there had been a significant amount of support provided to the service from the local authority with the aim of improving outcomes for people, particularly in identifying and addressing their health needs. Where there were changes in people's wellbeing action was taken to seek guidance and treatment from health professionals. A nurse practitioner visited the service twice a week.

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

Inadequate

Is the service well-led?

Our findings

Following our previous inspections, we informed the provider in writing and in meetings of the seriousness of our concerns. We placed additional conditions on their registration requiring them to take urgent action to address the concerns and restricted further admissions to the service to give them the opportunity to focus on and address areas for immediate improvement. We continued to monitor the service closely in conjunction with commissioning bodies and local authority quality improvement and safeguarding teams.

The provider had submitted regular progress reports in response to the conditions placed on their registration but these demonstrated a lack of understanding and did not identify and address root cause for the failings of the service. This inspection found the provider was still unable to demonstrate that they had effective oversight and governance. Improvements required from previous inspections were still not fully addressed.

Since our inspection in June, the provider's failure to retain a registered manager had led to inconsistent governance and leadership of the service. The range of managerial input at all levels had failed to develop the infrastructure needed to effect and drive improvement. The new manager had been in post for a relatively short period and this was their first managerial position. The CQC and the local authority were concerned about inconsistent and unstructured support from the provider to the manager particularly as they were new to the role. The provider was not giving the support needed to run the service and effectively implement and sustain improvement. Staff turnover was high, which in turn posed a significant challenge to develop a skilled staff team. Due to insufficient support from the provider particularly with staff recruitment and retention, the manager had neither time nor resources required to develop a positive culture within the service, and to make and embed improvements to raise standards of care.

In a meeting with the local authority and CQC the manager described a feeling of being "swamped". They had worked 55 consecutive days before having a weekend off. In response, the provider brought in another manager to provide support in the day-to-day management of the service. The supporting manager told us on the day of our inspection that it was their first day; the provider told them that they would receive an action plan but they had not received it. They said they did not have a job description but believed their role was to support the new manager with the introduction of new paperwork and supporting staff in understanding it.

Staff employed, who were responsible for the care and welfare of people, did not access the information they required to ensure the care they provided was appropriate and consistent. Staff did not participate in the planning of care and did not read or follow care plans. There were no systems or processes for induction, support and oversight of agency staff. The competencies of agency staff were not assessed to ensure they had the right knowledge and skills required to meet the individual and specific needs of people using the service.

The supervision process was not fully embedded to ensure all staff received regular, planned and structured supervision to support them and reflect on their day-to day- practice, and professional development.

Observation and discussion with staff showed that they had not had the training and support they needed to give them the skills to support people living in the service. One staff member told us they had an app on their phone and 15 units of e learning to complete in their own time. Systems were not in place to check the learning staff had undertaken was effective and to ensure the competency of staff.

There was no plan about how the service kept up to date with developments in dementia care to ensure the care provided was appropriate and in accordance with best practice.

Governance systems continued to be ineffective and did not ensure the safety and quality of the service. Audits carried out for health, safety, and infection control identified areas for improvement but fell short of actions taken to address them, by who and when.

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

Since our inspection the provider had engaged further external consultancy support. The consultants have carried out a full assessment of the service and drawn up an extensive action plan to address and drive improvement and meet fundamental standards of care and safety. The expected target date for completion is the beginning of March 2018.