Discovery Care Group

Tulipa House

Inspection report

13 Shottendane Road
Margate
Kent
CT9 4NA

Tel: 01843221600

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Tulipa House is a residential care home providing accommodation and personal to up to 31 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 28 people using the service. The service is provided in one adapted building. There is a lift to enable people to reach the upper floors.

People's experience of using this service and what we found
There were positive interactions between staff and people living at the service. People were comfortable in staff's company and with their support. Feedback from relatives/ friends was positive. One relative said, "It is clean and tidy, and the staff are sweet and caring."

However, we identified concerns at the service. Quality systems were not effective at identifying some risks and some areas where improvements were needed. The action plan put in place following the last inspection had not led to an improvement in the services quality standards. The service remained reactive to findings through inspections but were not as proactive as they needed to be. Prior to the inspection some notifications had not been submitted to CQC when they needed to be. The service worked in partnership with other services to improve care and support. However, there were times where advice from partners could have been sought quicker.

Incidents were not always well managed which increased the risks to people. When incidents occurred, there was a lack of effective trend analysis to determine if there were contributing factors such as staff deployment or environmental risks which could be mitigated. Risks to people were not always well managed. For example, medical advice was not always sought when it should have been.

Staff knew how to identify safeguarding concerns. However, concerns had not always been identified by the management where they needed to be reviewed as possible abuse. Medicines were not well managed.

There was enough staff to support people. People were kept safe from the risk of transference of infection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff offered people choices and understood where people had the right to make decisions for themselves.

Staff were happy in their role and felt supported by the registered manager. Staff treated people with kindness. The registered manager understood their responsibilities in relation to duty of candour. There were systems in place to enable people and their relatives/ friends to provide feedback about the service. Feedback had been positive.

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 30 May 2022). The service remains rated requires improvement. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part by notification of a death of a person. The circumstances of this death is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the death of a person. However, the information shared with CQC about the death indicated potential concerns about the management of risks to people's safety. This inspection examined those risks.

You can see what action we have asked the provider to take at the end of this full report.

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 not changed from 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 Tulipa House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment and good governance at this inspection.

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 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Tulipa House

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
The inspection team consisted of two inspectors

Service and service type
Tulipa House 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. Tulipa House 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with six people who used the service and two relatives/ friends or people who used the service. Some people were not able to express their views. 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. We sought feedback from the local authority and professionals who work with the service.

We spoke with ten members of staff including the nominated individual, registered manager, a manager from another of the providers services, maintenance staff. senior care staff and care staff. We reviewed a range of records. This included all or parts of five people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including audits, training records and procedures were reviewed.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. 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.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse as potential abuse was not always recognised. This meant concerns were not always reported and investigated to determine if abuse was occurring.
- One person had limited clothing and footwear and the registered manager told us the person did not have access to funds to purchase new items. During the inspection the person was wearing ordinary socks and no footwear, which increased the risk of falls. The provider also raised other concerns about the person's finances. The registered manager told us the person moved into the service in March 2022. The management of the service had not considered raising a safeguarding with the local authority to investigate if financial abuse was occurring. Following the inspection, a safeguarding was raised with the local authority.

The provider had failed to do all that was reasonably practicable to mitigate risks to people. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager knew how contact safeguarding. Staff knew how to blow the whistle if they had concerns about poor practice.

Learning lessons when things go wrong

- The management of, and response to, incidents was not robust and needed to be improved. This increased the risk of harm to people.
- There had been incidents between two people after one person had gone into another person's room. The actions taken were to put an alarm on one person's door to alert staff if the person left their room during the night. One incident occurred shortly before the inspection where the alarm was recorded as 'not on the door'. Following this incident, the person was supported to move room to reduce the risk. However, during the inspection there was no alarm on the persons door and there was a risk the person could go into another person's room unnoticed by staff. We raised this concern with the registered manager. They told us the person sometimes removed the alarm. The alarm was of a stick-on type and the management had not considered using a more robustly fixed alarm to reduce this risk.
- There was a lack of effective monitoring of trends of incidents. There had been a number of falls at the service. There had been no comprehensive overall analysis to identify if there were trends that could be mitigated to reduce further incidents of falls. Analysis considered what time of day people fell. However, other factors had not been reviewed for trends. For example, if falls occurred more often when people were wearing grippy socks or when people were in certain areas of the service.

Assessing risk, safety monitoring and management

● Risks to people were not always well managed. Medical attention was not always sought following falls or incidents where it would have been appropriate to do so. This included where people were taking blood thinning medicines. Blood thinning medicines increase the risk of excessive bleeding. There were records of incidents for two people where bruises were noted, including one person with facial bruising. Medical advice had not been sought. Whilst there was no evidence either person was injured as a result of this failure the potential risk of injury was increased as staff were not following safe processes.

The provider had failed to do all that was reasonably practicable to mitigate risks to people. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some building risks were assessed and managed. For example, there were window restrictors in place and staff undertook fire drills. However, the management team had not considered potential risks from people accessing the stairs. Some people were living with dementia. Some people walked about including at night. Some people were at risk from falls. There was no comprehensive plan of mitigations in place to reduce the risk of people accessing the stairs, where injury from a fall could be greater. We raised this with the registered manager and the provider who arranged for keypad locks to be put in place to reduce this risk.

● Some care plans lacked details about some risks to people. For example, one person was diabetic. There was a lack of detail about the person's diabetic health history and the signs that the person maybe unwell with their diabetes. However, staff knew how to support the person safely.

Using medicines safely

● We were not assured people were receiving their medicines as prescribed.

● Medicine counts did not always match stocks of medicines. For example, a count of one person's medicines showed there were more medicines in stock that were recorded. Medicine counts are used to ensure all of the medicine recorded as administered have been administered and no medicines are missing. When there are more medicines in stock than expected there is a risk the person has not received their medicine. This put the person at increased risk of becoming unwell.

● Some medicines are subject to stricter controls. Where this was the case the records were not well managed. For example, there were gaps in the records and medicines were not recorded as soon as they were received. Some medicines were not recorded as they should have been.

● Some people were prescribed as required medicines. These medicines are to be taken only when needed and some people were taking these medicines on a daily basis. These people's medicines should have been reviewed by the GP and there was no evidence the registered manager had arranged for this to happen.

● Medicine were not always disposed of as they should have been. One person had died. Their medication for constipation was not disposed of but was put with the homely medicines. This is not best practice as medicines in care homes should only be used for the person they are prescribed for. Homely medicines were not well managed meaning there was a risk people could be given a medicine that was not suitable for them. There was no medicine policy or agreement from the GP about what homely medicines they were happy for people to have and for how long. There was no log to account for what had been in stock and what had been given.

The provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.
● Staff understood that people with capacity had the right to make choices they themselves might feel were unwise. Where there were keypad locks on doors staff ensured people with capacity knew these codes, as appropriate. Staff understood that some people needed support to make decisions and that some decisions needed to be made in people's best interests.

Staffing and recruitment
● There were enough staff to support people.
● There was a dependency tool in place which helped the registered manager to assess what staff hours were needed to provide support to people. However, incidents and accidents had not been analysed to consider if staff were deployed in the right way to reduce this risk. This was an area for improvement.
● Staff had been recruited safely. Recruitment checks continued to be carried out centrally by the provider to ensure that staff were recruited safely. For example, to make sure disclosure and Barring service (DBS) checks had been completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● 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 assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The service was facilitating visiting in line with government guidance at the time of the inspection.

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 requires improvement. The rating for this key question has remained 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; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems were in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● At the last inspection we found action was only taken to address some concerns once they were highlighted during the inspection. At this inspection we found the same concern. The provider and registered manager failed to ensure there were effective systems in place to identify some risks prior to the inspection. There was a lack of proactive risk management in some areas and this meant people were at an increased risk of harm. For example, following raising concerns about one person's lack of appropriate footwear the service reviewed other people's footwear and asked relatives to assist with making replacements. Keypads were added to stairwell doors and an alarm was fitted to one person's room.
● At the last inspection quality assurance systems were not effective and care plans were not up to date. At this inspection we identified the same concerns. Quality systems had continued to not be effective in ensuring care plans were up to date and included all of the guidance staff needed. For example, one person's care plan stated they had not fallen in the 12 months prior. However, the person had fallen in October and again in November.
● Some audits identified concerns but there was no evidence action was taken. For example, audits of medicines had identified some shortfalls such as medicine totals not matching records. However, there was no evidence this was reported and investigated to find out why this had occurred.
● Following the last inspection, we issued notices requiring the service to improve. The provider submitted an action plan. However, improvements had not always been made and we found some of the same concerns. When improvement has been made at the service it not been sustained. This is the second consecutive time the service has been rated less than good. Prior to this inspection the service has had five rated inspections, since 2017, and has been rated less than good three times. This inspection will be the fourth time.

The provider had continued to fail to ensure systems were in place or robust enough to demonstrate safety was effectively managed. This is a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notifications were not always submitted to CQC when they needed to be. Services are required to inform CQC when depravation of liberty (DoLs) applications are approved. The registered manager had not sent these notifications. Following the inspection notifications of DoLs approvals were submitted.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 registered manager spent time working alongside staff and had an open-door policy, so staff were able to speak to them when needed. However, the registered manager also told us they would benefit from more focus time where they had the opportunity to complete tasks without interruption or distraction. We raised this with the provider who told us they were planning to recruit a deputy manager to assist with this.

● Staff told us they were happy at the service and said they felt supported by the registered manager. One staff said, "We are lucky here it's a nice place to work."

● Staff treated people with kindness. People seemed relaxed in the company of staff and responded to staff when they were upset. Staff offered people regular drinks and held people's hands when they needed comfort. One relative/friend said, "In general it is very good. The staff are very supportive."

● The registered manager understood their responsibilities in relation to duty of candour. A duty of candour incident is where an unintended or unexpected incident occurs which resulted in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.

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

● There were systems in place for residents and relatives to provide feedback on the service. Feedback was positive. There had been no recorded complaints since the last inspection.

● Relatives and friends of service users were positive about communication with the service and told us they felt kept informed about important events. One relative said, "The registered manager keeps me informed if needed."

Working in partnership with others

● The service worked in partnership with health and social care professionals. However, there were times where advice could have been sought sooner. For example, during the inspection the registered manager told us one person put themselves on the floor during the night and there was a mattress in place to ensure the person was not sleeping on the floor. The person's bed had a pressure relieving mattress in place. Some people find these mattresses uncomfortable. Prior to the inspection the registered manager had not reviewed if having a pressure mattress was still appropriate for the service user with relevant health and social care professionals. After the inspection the registered manager sought this advice and was able to trial a change in mattress, with a risk assessment in place to monitor the person's skin integrity, to assess if this led to improvements for the person.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably practicable to mitigate risks to people. The provider had failed to ensure the proper and safe management of medicines.

The enforcement action we took:

We took enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had continued to fail to ensure systems were in place or robust enough to demonstrate safety was effectively managed.

The enforcement action we took:

We took enforcement action against the provider