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

This was an unannounced and focused inspection carried out on 12 September 2017.

Scarletts is a care home that provides accommodation and personal care for up to 50 older people who are vulnerable due to their age and frailty, and in some cases have specific and complex needs, including varying levels of dementia related needs and end of life. There were 31 people using the service at the time of the inspection.

We carried out an unannounced comprehensive inspection of Scarletts on 6 and 8 June 2017, and we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was given an overall judgement rating of 'inadequate' and was placed into Special Measures.

Services in Special Measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this 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. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Following the inspection in June 2017, we sent an urgent action letter to the provider telling them about our findings and the seriousness of our concerns. We requested an urgent action plan from them telling us what they were going to do immediately to address them. An action plan was returned to us the following day. We took immediate enforcement action to restrict admissions, to ensure adequate staffing levels and to ensure that effective leadership and oversight was in place to mitigate the risk to people. This inspection was undertaken within the six months timescale because we received further information of concern from the local authority and whistle blowers which related to poor staffing levels and poor care. Because of this, we wanted to check that the enforcement action were had been taken was resulting in improvement.

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

The registered manager left the service after the last inspection and management support was being provided by a team from the provider's services in Leicestershire. An acting manager was in place at the time of this inspection.

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.

This inspection focused on the areas of safe and well-led. We found that sufficient improvements had not been made since our last inspection in June 2017 and the provider was continuing to fail to meet the requirements of the regulations, commonly referred to as The Fundamental Standards of Quality and Safety. These breaches had led to the continued failure to adequately care and protect people and exposed them to the risk of harm. The Commission is currently considering its enforcement powers. This service will continue to be kept under review and, if needed, could be escalated to further urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.
For adult social care services the maximum time for being in Special Measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in Special Measures.

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 and a safe and appropriate way.

People were not protected from the risk of poor moving and handling practices.

Arrangements were not sufficient for identifying and managing risk appropriately.

People's care had not been co-ordinated or managed to ensure their specific needs were being met safely.

Is the service well-led?

Inadequate

The service was not well led.

Robust audit and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved.

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 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.

We undertook this unannounced focused inspection of Scarletts on 12 September 2017. This inspection was carried out to check that improvements to meet legal requirements had been made by the provider following our comprehensive inspection on 6 and 8 June 2017. The inspection was carried out by two inspectors.

We looked at information we had received from the service, from the local authority safeguarding team and information received from whistle blowers.

During the inspection, we spoke to one person 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 spoke with the acting manager, one staff member and two agency staff members.

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, monitoring charts and quality assurance audits.

Inadequate

Is the service safe?

Our findings

At our inspection of June 2017, we found that moving and handling practices were not managed safely and people were at potential risk of harm. At this inspection, we found that this had not improved.

Many people had limited mobility and required equipment to assist them. 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. One person was being supported to stand in the lounge. When the person stood up, a staff member pushed the wheelchair closer to the person which resulted in them shouting and trying to hit out at the staff member. The staff member did not communicate with the person or tell them what they were doing. The risks of supporting the person were not documented in the moving and handling risk assessment so that staff had the information to refer to which would ensure the person was moved safely.

We saw one person supported by two agency staff to move using a hoist and sling in the lounge. The person did not look comfortable and the sling was right up under their arms. One agency staff member said that the person required a medium sling for transfers, however when they checked the sling that they had used it was a large. It was also a sling specifically designed to be used when supporting someone to use the toilet and not for transfers. They said, "I didn't notice that it didn't fit properly. I don't know what slings are [person's]. They are just hanging up. It doesn't help us as agency. I don't know which size to use. If it is in their bedroom behind their door, we use that." This put the person at risk of falling from the hoist because staff did not have the information they needed to support the person in a safe way. The failure of staff to ensure they were using the correct sling for the person exposed them to the serious risk of injury.

Moving and handling equipment was still not checked to ensure it was safe to use. The acting manager told us that equipment such as walking frames and wheelchairs were now checked, however these records could not be located on the day of inspection. We saw that weekly checks were taking place on some slings; however some slings were missing from the list and were not being checked. This put people at the potential risk of faulty equipment being used.

Risk assessments were not updated as people's needs changed. One person was at risk of falling from a wheelchair but there was no risk assessment in place to provide guidance to staff. The assessment was out of date because the person was now being cared for in bed. One person had been admitted to hospital after developing an infection in their leg. There was no care plan in place to guide staff on how to prevent the infection from re-occurring. This placed the person at risk of developing further infections and potential hospital admissions.

One person was at high risk of self-neglect and was refusing engagement with staff and personal care. There was no planning of how this was to be monitored or managed effectively by staff or guidance as to when further invention may be required from other professionals. This placed the person at further risk of harm and neglect.

The acting manager told us that there were three service user still using bed rails, since we highlighted this as a risk at our previous inspection in June 2017. At this inspection, we found that eight people had bed rails in place. Bedrails are a means of preventing the risk of a person falling from their bed. The acting manager was not aware that these were still in use. There were no bed rails risk assessments in place and the acting manager was unable to demonstrate that checks had taken place to ensure that these did not present a risk to service users. The inspectors found six did not have a protective covering in place, were loose or were not integral to the bed. This placed people at risk of entrapment and to the serious risk of injury by way of asphyxiation.

At our inspection of June 2017, we found that people's care had not been co-ordinated or managed to ensure their specific needs were being met safely. At this inspection, we found that this had not improved.

One person had a history of swallowing difficulties and there was no information in place to provide guidance to staff on how to manage or mitigate the risk of the person choking. The risk assessment for eating and drinking did not identify the risk from choking and identified that the person required monitoring and supervision from a distance. This did not occur during our observations. At lunchtime the person was given a vegetable burger to eat and left unsupervised. A letter from the SALT (Speech and Language Therapy Team) stated that the person required their food to be soft and easy to chew. Despite an information sheet providing guidance on how to prepare the fluid and diet to meet the person's needs, this was not being followed. Staff were not knowledgeable about the needs of the person. This put the person at risk of choking. The person required their fluids thickened and regularly refused these. There was no guidance provided to staff on how to ensure that the person remained hydrated.

One person's health and wellbeing had deteriorated and the acting manager thought they may be nearing the end of their life. There was no planning in place to support the person in a safe, comfortable and pain free way.

One person was unable to communicate verbally. The SALT team had recommended an approach to use to assist in communication such as using a communication book and talking mats. These approaches were not in place and staff were not aware of how to effectively communicate with the person. This placed the person at risk of neglect and isolation.

Three people had an in dwelling catheter and there was no risk assessment or care plan in place to guide staff on catheter care and management to ensure that their continence needs were supported safely. For example, the signs of possible infection or a blockage. Records of checks and monitoring of fluid input and output was inconsistent. The measuring and recording of fluid intake and output is required to identify any emerging concerns. Fluid charts were not always completed and there was an inconsistency in the totalling of records. This placed people at risk of developing infections that could require hospital admission.

Two people had a risk assessment for anxiety and agitation. These did not cover all of the risks presented or how staff were expected to deal with these, in terms of risk management and mitigation. For example, one person demonstrated behaviours of undressing in communal areas. The risk assessment did not cover the possible reasons for this or what could trigger the behaviour or how to reduce the risk of the behaviour occurring. Staff did not have the information needed to intervene effectively through de-escalation techniques or other agreed good practice approaches.

At our inspection of June 2017, we found that medicines were not managed safely. At this inspection, we found that this had improved although further improvement was still required.

There were people prescribed pain and anxiety relieving medicines 'as and when required' (PRN). This meant they were not given on a regular basis. There was no clear guidance in place to tell staff the purpose of each person's PRN medication and when it should be offered to ensure they received it appropriately and safely. There were no pain assessment tools in use to enable people to communicate the type and level of pain they had or to guide staff on how to monitor this appropriately and take action when the pain relief prescribed was not enough or too much.

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

At our inspection of June 2017, we found that there was not an effective system in place to ensure that staffing levels were sufficient to meet people's needs. This had a direct impact on people's safety and welfare. At this inspection, we found that while staffing levels had improved, robust systems were not in place to ensure that staff had the right information and skills so that people received safe care.

The majority of shifts were being covered by agency staff. Two agency staff said that they had not read the care plans for those they were supporting. One agency staff member said, "We don't look at the care plans, I have never looked at them. I don't get a minute. We are muddling through." Another said, "I get told at handover if people need a stand aid or full hoist. I don't get a chance to read the care plans." This put people at risk as staff would not have the consistent and appropriate information they needed to be able to provide safe care and treatment.

There was no system in place to demonstrate that agency staff competence in moving and handling had been assessed and that they had the knowledge and skills that they needed to be able to support people. This exposed people to the risk of unsafe moving and handling.

At lunchtime, there was no guidance provided to staff to ensure they were effectively deployed, organised and able to meet people's needs. One staff member was seated at a table with three people; prompting them to eat and initiating conversation. This provided a positive experience for those people but this was not demonstrated by staff elsewhere in the dining room. People were wandering around and not being supported to eat. It was noted by three different staff members that one person was not eating. None of the staff were aware of this person's communication methods or dietary preferences. They did not have the knowledge or the skills to ensure that they provided support to meet this person's needs. At tea time, the deputy manager was trying to manage a similar situation and did not appear to know where the staff were or which staff should be in the dining room providing supervision and support for people.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our inspection of June 2017, we found widespread and significant shortfalls in the way the service was managed. At this inspection, we found that improvements had not been made.

Despite assurances and responses to conditions placed on the providers registration stating that improvements would be made following our inspection, there continued to be widespread and significant shortfalls in the way the service was led. There was a lack of managerial oversight at all levels and leadership was not pro-active. There was a failure to recognise and identify significant failings impacting on the quality of service provision.

The oversight and governance systems in place to ensure that risks are minimised and actions taken to mitigate risks as far as practicable were ineffective. Not all risks to service users were being identified and where they had been, there was a lack of subsequent evaluation which meant missed opportunities to put systems in place to protect service users from the risk of receiving inconsistent, inappropriate or unsafe care that did not meet their needs.

At our inspection of 7 June 2017, we were concerned that a root cause analysis had not been undertaken for individuals who had a high number of falls. At this inspection, the falls analysis was not available because fall information was still being collated. Because of the delay in recording and analysing this information, the provider did not have effective oversight and could not identify if people required additional control measures to be put in place to reduce the risk of them falling.

The provider was failing to demonstrate that the staff employed, who were responsible for the care and welfare of people had access to the information they required, were competent in terms of their skills, or that they fully understood their roles and responsibilities.

Audits had failed to identify concerns we found at this inspection and the multiple non-compliance with the Fundamental Standards of Quality and Safety. Audits did not give clear information to show who was responsible for actions, what timeframe they should be completed in or how outcomes should be monitored and maintained. There had been insufficient input from the provider to ensure a suitable and effective monitoring system was now in place to assess, monitor and identify risk and improve quality. Without this oversight the provider had failed to ensure that improvements were being embedded, capable of being sustained and that future shortfalls would be identified, appropriate action taken and lessons learnt.

This was resulting in service users receiving inconsistent and inadequate care which did not meet their needs because it put them at the potential risk of harm or actual harm. The provider was failing to do everything that was reasonably practicable to mitigate health and safety risks to people. This resulted in continued non-compliance with regulations and poor outcomes for people.

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

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 Care and treatment was not provided in a safe way to prevent the risk of harm.

The enforcement action we took:

Urgent Notice of Decision to impose Positive Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Robust and effective audit and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved. There was a lack of managerial oversight at all levels and leadership was not pro-active. There was a failure to recognise and identify significant failings impacting on the quality of service provision.

The enforcement action we took:

Urgent Notice of Decision to impose Positive Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed and were unclear on their role and responsibilities.

The enforcement action we took:

Urgent Notice of Decision to impose Positive Conditions.