Essex County Care Limited

Trippier

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.

Trippier is a care home that provides accommodation and personal care for up to 36 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. On the day of our inspection there were 21 people using the service.

We carried out an unannounced comprehensive inspection of Trippier on 19 and 21 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 is therefore in Special Measures.

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

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.

The service had a registered manager in post but they were not present during this inspection. An acting manager was in position whilst the registered manager was on leave. 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.

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.

This inspection focused on the areas of safe and well-led. At this inspection, we found that sufficient improvements had not been made since our last inspection on 19 and 21 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. 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 were not effectively deployed and were unclear on their role and responsibilities.

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

People were not protected from the risks associated with equipment which was out of order.

People were not protected from the unsafe management of medicines.

Is the service well-led?

Inadequate

The service was not well-led.

Robust and sustainable 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.

Trippier

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 Trippier 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 19 and 21 June 2017. The inspection was carried out by two inspectors.

During this inspection we spoke with three people using the service, a relative and another visitor. We spoke with the acting manager, deputy manager, and four other members of staff. We also observed the interactions between staff and people.

To help us assess how people's care and support needs were being met we reviewed eight people's care records and other information, for example their risk assessments and medicines records.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that people's care had not been co-ordinated or managed to ensure their specific needs were being met. Risks to people injuring themselves or others had not been appropriately managed. At this inspection we found this continued to be the case.

Despite the concerns we raised at our inspection in June 2017 relating to lack of care planning and risk assessment for a person diagnosed with epilepsy we found at this inspection that this was a continued concern. Where another person had epilepsy there was no specific care plan in place. There was no mention of their diagnosis of epilepsy on the 'At a glance profile' which was provided to staff and agency workers. Care records did not include history of any past seizures, risk assessments or guidance for staff. Staff were unclear whether the person was still at risk of seizures and did not know the person's potential triggers for seizure or signs to indicate a seizure may be about to occur. This meant it was not clear whether staff would recognise the signs or be aware of what action to take. Without this knowledge there was a potential serious risk that the person's needs would not be met and they could come to harm.

One person was in hospital at the time of our inspection due to a chest infection, urinary tract infection and de-hydration. A senior member of staff had failed to escalate concerns raised by the person's relative meaning a delay in calling the emergency services occurred. The member of staff had attributed the person's symptoms to medicines they had been administered but had failed to recognise the risks associated with the person's health conditions or taken action to ensure they received appropriate medical intervention in a timely manner.

Risk assessments for people with indwelling catheters continued to be ineffective. The care plan of a person with an indwelling catheter stated that this should be checked hourly. However, records of checks and monitoring of fluid input and output was inconsistent. There were no target fluid inputs, no totals of fluid input/output and staff were unable to demonstrate if or when these records were monitored. This put the person at risk of catheter blockage which could cause pain and discomfort and at risk of infection.

People were not protected against the risks associated with moving and handling. The moving and handling assessments for two people requiring the use of the hoist to assist them with repositioning did not give adequate details as to how the hoists and slings should be used in line with their assessed care needs. The lack of information meant there was a risk staff would not understand how moving and handling equipment should be used safely and in accordance with up to date and relevant individual risk assessments. This exposed people and staff to the potential risk of harm or injury as a result of unsafe moving and handling.

People whose behaviour may challenge were not effectively supported. Positive actions were not put into practice when staff were faced with difficult situations that could potentially cause harm or compromise people's safety. The care plan of one person who had recently hit out at another person and at a member of staff did not mention the risk of physical aggression. This person was
taken to hospital for an MRI scan on the morning of inspection which the acting manager told us was in relation to their dementia. However, they were unable to have the scan as the member of staff

accompanying them had failed to take relevant paperwork. This person was observed to be very unsettled throughout the day of inspection and the un-coordinated approach to their care meant they were not receiving the support they needed. Staff were not provided with the information they needed to analyse and recognise particular triggers and strategies which may help to de-escalate situations and alleviate the person's anxiety.

People remained at risk due to the unsafe management of medicines. Staff had a lack of understanding about controlled drugs and the importance of following specific requirements in recording their administration. The training matrix showed that three staff responsible for administration of medicines had not received appropriate training to enable them to carry out this task safely and effectively.

We checked the management of morphine for one person and found that the stock recorded in the controlled drug register did not tally with the medication system used by the service. We found missing signatures for witness of administration of morphine in the medicines records for the administration of controlled drugs. It was not clear if this was a failure to record two signatures or a failure to administer prescribed medication. One person had not been administered morphine since February 2017 but their pain levels had recently increased and morphine had begun to be administered again. We noted that the same bottle which had been opened in February 2017 had been used and administered in September 2017. This is against the manufacturer's guidance which states that Morphine Oral Solution should be discarded 90 days after first opening. Medicines that are used after the date for disposal are at risk of becoming contaminated or losing their effectiveness.

Medicines audits had not identified any of the concerns we found during our inspection. We discussed our concerns relating to the management of controlled drugs with the acting manager who advised us that no-one apart from them would administer controlled drugs until competency of staff could be demonstrated. We had serious concerns about this proposed arrangement, as this relies on one person to administer these essential drugs and it was therefore unclear how they would be managed safely in their absence.

The provider had not ensured that all aspects of the premises and equipment used to support people were effectively monitored to check they were in working order and safe to use. One person told us, "Yesterday I went [to the toilet] on my own but I like to make sure there is a buzzer on the wall that works. One day I sat there and shouted for half an hour." We asked them what they meant by this and they explained that they didn't think the call bells in the ground floor toilets were working. On investigation we found all four call bells in this area to be out of order. On further investigation by the acting manager and a member of staff it was discovered that batteries had been removed from the unit which sounded the call bell when the button was pressed. It was thought by the person we spoke with and by staff that this unit had been out of operation for some time. However, audits carried out in relation to the maintenance of the premises showed that all call bells had been checked and were working. The maintenance person for the service was on leave and the maintenance checks had been crossed through to indicate that they were on leave but no one had been delegated to cover these checks. The acting manager arranged for the call bell unit to be made operational again so that it was in working order before the end of the day of our inspection. However we were concerned that the lack of appropriate monitoring of premises and equipment meant that other defaults or items needing repair may be missed, placing people at risk of harm.

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

At our last inspection in June 2017 we found there were not enough staff to provide adequate supervision, nutritional support, stimulation and meaningful activity. This had a direct impact on people's safety and

welfare.

At this inspection we found that whilst numbers of staff had increased they were still not effectively deployed and were unclear on their role and responsibilities. Senior members of staff had not been provided with training or guidance to enable them to effectively run a shift or supervise other staff. One staff member told us there was an expectation that they should lead a shift and train others but they themselves had not been provided with the knowledge and training they needed to be able to do this safely and effectively. This inexperience and lack of competency along with ineffective oversight meant that that staff were not recognising or managing risks accordingly. This meant that people continued to be at risk of harm.

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

Despite assurances and responses to conditions placed on the providers registration stating that improvements would be made following our inspection in June 2017, 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.

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

Audits had failed to identify concerns we found on 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 a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

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 sustainable 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