SA & JO Care Limited

Crouched Friars Residential Home

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

Crouched Friars Residential Home provides accommodation and personal care for up to 56 older people. Some people also have dementia related needs. The layout of the premises is by means of three interconnected buildings; Crouched Friars [main house], Friars Wing and Colne Lodge [for people living with dementia]. There were 46 people living at the service on the day of our inspection.

The last comprehensive inspection of this service was undertaken on 12 and 13 October 2017. We identified breaches of the legal requirements and found that people were not sufficiently protected against risks and governance was not effective. After the comprehensive inspection, the registered manager told us that they were addressing the concerns.

We undertook this focussed inspection on 4 and 18 July 2018 to check that they had followed their plan and to confirm that they now met their legal requirements. The inspection was also prompted by information that we received which indicated that safety issues were not being taken seriously and risks were not being mitigated.

The service had a registered manager who had worked at the service for some years. 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.

During this inspection we found that the service did not have effective arrangements in place to identify and manage risks appropriately to support people to stay safe and protect them from harm. The fire detection systems were not working effectively and some areas of the service did not have working detection systems installed. The service was poorly maintained and hazards were created by poor housekeeping and storage. Repairs were not undertaken in a timely way; window restrictors were poorly maintained and did not provide people with adequate levels of protection. The risks of people leaving the service had not been fully risk assessed and effective measures put into place to reduce the risk of harm. Peoples safety was not being protected against the risks associated with unsecured furniture. There was a lack of oversight to identify and manage risks associated legionella, which placed people at risk of harm.

People were not protected from the risk of acquiring infections as the provider did ensure the service was consistently maintained in a clean and hygienic way. We found carpeting heavily stained, and furniture, bedding and bed bases which were not clean. Equipment was not regularly checked to make sure it was clean which placed people at risk of infection. There was an underlying odour of urine in parts of the service including the dining room where people sat to eat their meals.

Individual care plans were in place but these were not always reflective of people's current needs with steps to guide staff as to how risks should be managed.

Medicine management did not always reflect professional guidance for example there were no plans to guide staff on when they should administer medicines that had been prescribed to be administered on an as required basis. Staff did not always record carried forward medicines which meant that they were not able to effectively audit the amounts of medicines that were in stock.

Recruitment systems for new staff were not robust and did not provide adequate protection to people. There were sufficient numbers of care staff but the shortfalls in cleanliness and hygiene indicated that the housekeeping provision was inadequate.

We found significant shortfalls in the way that the service was led and management oversight and governance did not ensure delivery of quality and safe care. Audits did not identify the shortfalls that we found and so there was no improvement plan in place to evidence planning for improvement of the service.

Immediately following our inspection, we formally notified the provider of our escalating and significant concerns and our decision under Section 31 of the Health and Social Care Act 2008, to impose conditions on their registration as a service provider in respect of the regulated activity. This included placing conditions on their registration with immediate effect to restrict further admissions to the service and requiring them to take actions to mitigate the risks.

The overall rating for this service is 'Inadequate' and we are placing the service in 'special measures'.

Services in special measures will be 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. This service will continue to be kept under review and, if needed, could be escalated to 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.

This report only covers our findings in relation to Safe and Well led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Crouched Friars Residential Home on our website at www.cqc.org.uk"

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

Fire safety, Legionella and other health and safety issues were not managed effectively. The risk to people's health and welfare were not identified and mitigated.

Recruitment procedures did not protect people.

Medicine management did not follow relevant professional guidance

The environment was not well maintained and the premises were not kept clean and hygienic.

Lessons were not always learnt when things went wrong.

The systems and processes in place did not always safeguard people from abuse.

There were sufficient number of care staff to support people but shortfalls in cleanliness indicated that the levels of housekeeping were not adequate.

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 of care and safety systems were consistently assessed monitored and improved

There was a failure to recognise identify and act on significant failings relating to the safety and maintenance of the service.

Crouched Friars Residential Home

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 inspection took place on 4 July 2018 and 18 July 2018 and it was unannounced. The inspection team consisted of two inspectors. The team inspected the service against two of the five key questions we ask about services: is the service well led and is the service safe.

No risks or concerns were identified in the remaining Key Questions through our ongoing monitoring or during the inspection so we did not inspect them. The ratings from the previous comprehensive for the Key Questions were included in calculating the overall rating in this inspection.

The inspection was prompted by concerns that we received about how risk was managed at the service. Prior to the inspection we reviewed information that we held about the service and contacted the local quality monitoring team who had visited the service.

There were 46 people living in the service and we spoke with four of the people living there, a relative and one visiting health professional. We spoke with seven staff, the deputy manager and registered manager. We looked at three staff records; peoples care records and records relating to how the safety and quality of the service was being monitored. We observed care practice and medication administration.

Inadequate

Is the service safe?

Our findings

During our previous inspection carried out on 12 and 13 October 2017 we found that people were not always provided with safe care and rated this area as "Requires Improvement." At this inspection we found that improvements had not been made. Risks to people had not been fully considered which put their safety, health and wellbeing at risk. This was compounded by poor maintenance and a lack of effective oversight.

The fire officer had previously visited and had found fire safety measures as inadequate, some remedial action had been taken by the provider in response to the fire officer's requirement notices but we found continued shortfalls which meant people continued not to be protected from the risk of fire. Some areas had no fire detection system installed to alert staff if a fire occurred and were being used to store highly flammable items. People's bedroom doors were fitted with automatic door closures, however we found not all doors closed shut properly. There were a number of doors which did not have fully functioning intumescent strips around the door to prevent fire or smoke escaping. This meant that the systems to prevent fire and smoke circulating around the building would not work effectively in the event of a fire. Specific information relating to people's individual needs to evacuate or reach a place of safety unaided in the event of an emergency had been completed but we noted that this was not always reflective of people's needs.

The fire risk assessment provided was out of date and had been last reviewed in December 2012. Although, the registered manager told us a recent risk assessment had been completed by an external company, this was not available when we first inspected and we spoke with the person who had completed the risk assessment. They confirmed there were gaps in the fire detection systems.

The risks of people leaving the service had not been fully risk assessed and effective measures put into place to reduce the risk of harm. We found that not all fire exits were alarmed. The fire exit with a push release bar, leading out to the garden at the rear of the building, had no alarm, which meant people could leave the building, unnoticed. Although enclosed with wall, fence and gate, the fence and gate were a wooden structure, and waist height, meant people determined to leave, would be able to exit via garden gate.

Internal fire doors that were alarmed had been turned off, on the first and second floors in Colne Lodge. Colne Lodge provides accommodation and support to people with advancing dementia who are known to walk with purpose around the building. Therefore, it was of concern that these doors opened out on to steep stairs and stairs down to the basement. A wooden gate with a single bolt had been placed at the top of the stairs to the basement stairs. The bolt was on the top of the gate, and could be opened by putting hand over the top of the gate. Additionally, the front door to the service was not locked. A chain had been fitted but was not used. The registered manager told us they could not fit an alarm to the door as the building, (and door) was listed. Whilst the registered manager advised us no incidents had occurred where people had fell down stairs, accessed the basement or left the building, no risk assessment was in place to assess the risk of harm to people, or actions considered to lessen the risk of this happening.

The lack of oversight to identify and manage risks associated with the spread and control of infection, such

as legionella, placed people at risk of harm. Legionnaires' disease is a potentially fatal type of pneumonia, contracted by inhaling airborne water droplets containing viable Legionella bacteria.

Anyone can develop Legionnaires' disease, but the elderly are one of the groups of people that are at more risk. We found taps and shower heads throughout the premises had significant build-up of lime scale, increasing the risk of harbouring harmful bacteria. There was also a number of vacant rooms where the wash basins were not in use. There were no systems in place to ensure these outlets were flushed through on a regular basis. This is contrary to the advice from the health and safety executive. Whilst it was recognised a Legionella test had been carried out by an external company in May 2018, and no signs of legionella, were detected, there was a failure to ensure adequate measures are in place to control the risks of legionella occurring.

Peoples safety was not being protected against the risks associated with window restrictors. Although window restrictors had been fitted to windows throughout the premises, we found these did not comply with the current Health Safety Executive (HSE) guidance for Falls from windows or balconies in health and social care settings. One person's room had no window restrictor in place. Although a chain had been fitted, this had broken and was hanging by the side of the window. Their room was on the second floor. The window opened out onto the roof of the first floor and was wide enough for a person to get through. The majority of other rooms had window restrictors in place but these were a mixture of purpose made restrictors, wooden blocks on sash windows and chains and were not sufficiently robust

Some rooms had patio doors on second floor which lead out onto the first-floor roof. These did not have restrictors fitted. They had a normal lock and a bolt at the top and bottom of the door. These were ill fitting and would be easy for a person to undo. When pushed both sets of doors moved, these would easily open with force. These did not meet the required standards as set out in the HSE guidance. The failure to assess the risks to the people occupying these rooms and ensure appropriate measures were taken to mitigate the risk placed people at significant risk of harm. The external wood work on windows and door frames needed repair. The wood was rooting and paint had peeled on some patio doors.

Peoples safety was not being protected against the risks associated with unsecured furniture. We found free standing wardrobes in people's rooms which were not fixed to the wall and were being used to store heavy items and we expressed concerns that people could inadvertently pull the wardrobes over. The risks relating to this had not been identified or addressed. There was a lift for people to use to move between different floors but on one floor we observed that the lift stopped some way below the floor level creating a lip and potential trip hazard which we could not see had been assessed.

A number of people in the service required the use of a hoist to mobilise, we observed staff assisting an individual to mobilise but they did not follow the guidance in the care plan which had been given by the physiotherapy service. People did not have individual slings for which they were assessed and care plans did not always document the size of sling for them to use. Staff spoken with were not able to tell us clearly what sling that they would use to assist people. This meant that people were at risk of falling from a sling which was not suitable for their needs.

Individual risks to people, such as from malnourishment, choking or developing pressure wounds had been assessed and management plans were put in place to minimise the risk of harm. These provided guidance to staff to help people stay safe, including regular monitoring, provision of equipment and the competing of food and fluid charts. However, the assessment tools were not always completed and systems not always consistently implemented. For example, we observed one person who had been identified as being at risk, had not eaten at lunchtime however staff had subsequently written, "Eaten and drank well." This meant that

the records were not reliable and did not inform how a person was cared for.

The shortfalls we found in safety demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Infection prevention and control systems did not protect people. Policies were in place and the service had copies of the expected best practice guidance. However, these policies were not always implemented and essential elements of general cleaning were not carried out. For example, we found, some people's en-suite bathrooms, were not clean. Toilet basins were heavily stained, due to build-up of limescale. These were unsightly and had the potential for harmful bacteria to grow. Bathroom cabinets were not always clean and we found staining and damage to the surfaces. We also found heavily stained bedding, mattresses and bed bases.
Communal areas and several bedrooms had strong or underlying odours of urine. We saw that floors were stained and bed bases and mattresses were not consistently clean. Other areas of the service were dusty and some furniture stained. We found cupboards and some wardrobes were used as general dumping grounds and we found areas filled with discarded electrical items, parts of wheelchairs and broken furniture.

Equipment such as moving and handling aids and bath hoists were not clean. For example, the back of the bath chair was stained and the floor of the hoists dirty. Other items such as food trolleys were rusty which meant that they could not be cleaned effectively.

Areas of the environment had not been maintained to a high standard which meant that they were difficult to keep clean for example we saw a number of cracked windows and torn wallpaper. Some walls had signs of damage and in one ensuite toilet the call bell was hanging off the wall.

We looked at the cleaning schedules. These listed all bedrooms and the areas to be completed such as bedframes, toilet seats and sinks. These were all ticked as completed throughout June 2018, however we found some areas were unclean and had been routinely missed. We spoke with domestic staff about their role and how work was allocated and they told us that they were expected to clean between 20 and 24 rooms a day but that sometimes areas were missed.

We saw that infection control audits had not been carried out and therefore issues of poor cleanliness, in people's rooms and communal areas had not been identified.

This demonstrated a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified shortfalls in staff recruitment. New staff had not been appointed in line with the providers own policy and procedure. At this inspection we found that the systems in place were not sufficiently robust. There were application forms in place and some references and checks on staff's identity had been completed. Disclosure and Barring checks had been requested but there was no record of an outcome having been received and an assessment of staff's suitability for the role before they commenced employment.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received updated safeguarding training and were aware of different forms of abuse. We saw that a serious incident had recently taken place which had been reported to the local safeguarding

team and an investigation had been undertaken. However, the risk assessment that was in place to guide staff on how to keep people safe was not current, had not been reviewed and did not reflect the current position or risks. We saw that night staff were regularly checking the safety of these individuals at night but there was not no clear monitoring system in place for during the day. This meant we were not assured that adequate measures were in place to mitigate the risk of any repeated incident.

This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke highly of the care staff and told that staff were available when they needed them. Staff told us that there were sufficient numbers of staff to meet people's needs. One member of staff told us, we would always welcome more staff but thought that there was enough. They said that "They never ever remember a shift where we were short staffed." Staff told us a number of staff were long serving with some staff having 20 years of service. Staff sickness was covered from within the existing staff team so that it did not impact on people using the service.

The service did not always follow relevant national guidance with regard to medicines which meant that people were a risk of not receiving their medicines as prescribed. Medication administration charts were in place and reflected what people were prescribed and what medicines were administered. However, we saw that handwritten entries on the chart where not checked by a second member of staff to ensure that they were correct. Staff were not consistently recording carried forward medicine which meant that it was difficult to effectively audit the stock of medicines and we found some overstocking. Some medicines were in a monitored dosage system and the amounts of these and the antibiotics that we checked tallied

There were no clear arrangements in place for the use of, as and when required medicines (PRN). We spoke to the deputy manager about this and they told us that they were aware that they needed to develop PRN protocols which set out how the individual may show signs of, for example pain or distress and the circumstances that medicines should be administered.

Safety concerns were not consistently identified or addressed. There were limited use of systems to record and report safety concerns and near misses. For example, we looked at the oversight systems that were in place to review falls. The registered manager had recently introduced a document in which they recorded the date that people fell, the timing and location. However, they had not started to analyse the information to identify trends and patterns which would initiate further risk assessment to guide staff with preventative measures and only one month's data was available. We noted from our analysis that in the previous month the majority of falls had taken place at night or in the early morning. People had been referred to medical professionals such as their GP and occupational health service but there had been no analysis or action taken to look at other contributory factors such as noise level at night and staffing levels.

Inadequate

Is the service well-led?

Our findings

During our previous inspection undertaken on 12 and 13 October 2017 we found the provider was not meeting the requirements of the law in that there was a lack of appropriate systems in place to monitor the quality of the service and to identify where improvements were needed. This lack of oversight had led to shortfalls in the way the service was being managed and a failure to identify potential risks to people living there. We found shortfalls in the monitoring of areas such as care plans, the management of risks accidents and recruitment of staff.

At this inspection we found that sufficient progress had not been made and people remained at risk of harm. Risks to people and the provider's understanding of action they should take to ensure compliance with regulatory requirements were not fully understood or acted on.

These issues are outlined in the SAFE section of this report but in summary we found that the building was not well maintained and repairs were not undertaken promptly. The service was not sufficiently clean to protect people from acquiring infections and there was an odour of urine in parts of the service. Infection control systems did not work effectively and the management of legionella did not provide people with protection. We also identified a number of environmental risks which had not been identified by the provider such as the risk of harm from free-standing wardrobes in people's rooms which had not been secured to the wall and radiator covers which did not reach to the ground, which meant that the pipework feeding the radiator remained exposed posing a risk of scalding.

Where risks had been identified they were not consistently acted on and there was a lack of a robust risk assessment framework. For example, we saw that the risks identified by the fire officer had not been responded to and addressed in a timely way.

Processes to assess and monitor the quality and safety of the service had not consistently been carried out by the registered manager or the provider. For example, audits with action take to address potentially risky areas such as fire safety, safe staff recruitment and the management of people's medicines. The audits that were in place were not well developed or effective as they had not identified or resolved the issues that we found at the inspection.

The provider completed regular visits to the service and following the inspection sent us copies of reports which were completed following their visits. These reports were brief. They did evidence that the views of people using the service and staff were gained as part of the quality assurance process and referred to an inspection of the premises, however the provider did not identify the shortfalls that we found including the works required to ensure people lived in a safe, well maintained environment. A recent provider's report referred to the service as being in "good order" which was contrary to our findings.

The shortfalls in governance and oversight are a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager's response to some of the issues we found was to blame a range of others including professionals for perceived shortcomings and their focus on documentation. They did not always recognise the importance or significance of some of the environmental issues. There was no ongoing action plan or improvement plan in place to prioritize the areas needed.

Despite the shortfalls, residents staff and relatives spoke highly of the registered manager and other senior staff. They told us that they were approachable and supportive. They told us that communication was good and the manager worked hard to create a "team ethos" and ensure that people received a good service. Newly appointed staff told us that they shadowed other more experienced staff before working independently.

Arrangements were in place for seeking the views of people using the service, their families and health care professionals and we saw that surveys were sent out for people to have a say in how the service was being provided. We looked that this information as part of our inspection and saw that the feedback on the care provided was positive.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person was not taking adequate steps to protect people from abuse and improper treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service and the equipment in place was not consistently clean or properly maintained

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure that the recruitment procedures in place provided people with protection and fulfilled the requirements of Schedule 3.

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 registered person was not taking adequate steps to protect people from harm and mitigate risks

The enforcement action we took:

We issued a notice of decision requiring the registered provider take urgent action to address the shortfalls we found and restricting admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess monitor and improve the quality and safety of the service did not work effectively.

The enforcement action we took:

We issued a notice of decision requiring the registered provider take urgent action to address the shortfalls we found and restricting admissions to the service.