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 of Scarletts residential home carried out on 19 and 21 March 2018.

Scarletts is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and we looked at both during this inspection.

Scarletts accommodates and provides personal care for up to 50 older people. At the time of this inspection, there were 18 people accommodated, who were vulnerable due to their age and frailty, and in some cases had specific and complex needs, including varying levels of dementia related needs and end of life.

The service had no registered manager in post. However, a new manager who intended to apply for registration had started work at the service on the day of our 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.

We carried out an unannounced comprehensive inspection of Scarletts in June 2017 and we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was poor leadership, management and provider oversight of the service resulting in people receiving poor care and risks to people's health and welfare not being adequately protected. We took immediate enforcement action to restrict admissions and placed conditions on the provider's registration to improve the assessment of risk, leadership, staffing and oversight.

The service was given an overall judgement rating of 'inadequate' and is therefore in special measures.

We continued to keep Scarletts under review and following information from whistle-blowers and the local authority, we carried out unannounced, focused inspections in September 2017 and December 2017 and met with the provider's representatives in January 2018. These inspections focused on the areas of 'Safe' and 'Well led'. We also checked the provider's progress in addressing the breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified at our comprehensive inspection in June 2017.

We found continued and widespread concerns with the governance, leadership and provider oversight of the service resulting in a failure to address recurring areas of risk to people and to learn lessons when things had gone wrong. There was a failure to drive and sustain improvement.

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

You can read the reports from our previous inspections, by selecting the 'all reports' link for Scarletts on our website at www.cqc.org.uk

This inspection focused on the areas of 'Safe' and 'Well-led'. We found that sufficient improvement had not been made since our last inspection 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.

Risk management processes continue to be ineffective and the provider continued to demonstrate a lack of understanding of the risks affecting people living at Scarletts. Staff were not equipped with the right information and skills so that people receive safe and appropriate care. People were not protected from the unsafe management of medicines.

Robust and sustainable auditing and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved. Failures in the service continued to be widespread and demonstrated the provider's inability to make and sustain improvements. We continue to have concerns about the provider's oversight of the service, inconsistent governance and leadership.

Some of the conditions that were placed on the provider's registration to try to encourage improvement after our inspection in June 2017 have not been met.

The Commission is currently considering its enforcement powers. This includes taking action in line with our enforcement procedures to begin the process of cancelling the provider's registration.

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.

Risks to individuals in relation to choking had not been assessed.

Staff did not support people in the least restrictive way possible.

Environmental risks were not effectively identified or managed and the cleanliness of the service needed improvement.

Staffing levels required review to ensure they met the needs of those living at the service.

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 failure to recognise and effectively act on failings which impacted on the quality of service provision.

There had been a lack of oversight of the service by the registered manager and provider to ensure the service delivered was safe and that they kept up to date with best practice.

Scarletts

Detailed findings

Background to this inspection

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

This unannounced focused inspection took place on 19 and 21 March 2018. The inspection was prompted in part by information of concern that we received in February and March 2018 from various sources including the local authority and whistle blowers. This prompted the Commission to carry out a further inspection at Scarletts. We also inspected to check the progress being made towards improving the service following our comprehensive inspection carried out in June 2017 and the subsequent focused inspections carried out in September 2017 and December 2017 and January 2018. These inspections found the provider was not meeting legal requirements.

Prior to the inspection, we reviewed information we had received about the service such as notifications. This is information about important events, which the provider is required to send us by law. We also looked at information sent to us and minutes from meetings that had been attended by the provider and professionals involved with Scarletts. We spoke with members of Essex County Council safeguarding and quality teams about their visits to the service.

We inspected the service against two of the five questions we ask about services: is the service safe? and is the service well led? This is because the service was not meeting some legal requirements and we needed to check that people were safe. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Three inspectors undertook the inspection. During the inspection, we spoke to four people who used the service. Some people could not tell us what they thought about the service as they were unable to communicate with us verbally therefore we spent time observing interactions between people and the staff who were supporting them. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the provider's representative, the manager, the supporting manager, the compliance standards officer, two external consultants, ten staff members and two kitchen staff members.

To help us assess how people's care and support needs were being met, we reviewed the records of 13 people who used the service including risk assessments and monitoring charts. We also looked at systems for assessing and monitoring the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

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

At this inspection, we found insufficient action had been taken to fully address concerns. Lessons were not learnt to ensure risks associated with people's health needs, support and safety were identified, planned for and monitored effectively. There was a continued lack of recognition and understanding of risk.

Despite a condition being placed on the provider's registration to ensure that each person had a risk assessment and care plan for every identified health and welfare need, we found that these were still not in place or lacked relevant information. This meant that staff did not have sufficient guidance on the level and type of care and support people required to meet their needs, recognise signs and symptoms of changing needs and to reduce risks to their health and welfare.

People were not protected against the risk of choking. Adequate control measures were not in place to ensure people with swallowing difficulties were supported appropriately with their condition in order to keep them safe. Four people who were assessed at risk of choking did not have a detailed plan in place to provide guidance to staff on how to effectively support them to reduce the risk of choking.

In February 2018, one person had choked on cornflakes. It was recorded on the incident form that the person should have porridge and a soft diet until they were assessed by the Speech and Language Therapy Team (SALT). They had not been assessed when we inspected. Food records showed that the person was given sandwiches to eat on three occasions and cornflakes on another occasion. Two other people had been referred to SALT but no arrangements were in place to guide staff on how to deliver safe and appropriate care in the interim until an assessment took place. This placed them at risk of choking on foods that were not suitable.

Staff were not equipped with the right information and skills so that people living at Scarletts received safe and appropriate care. The kitchen staff were not aware of some people's dietary needs and had not been provided with any training in this area. Nationally recognised guidance was not used across the service to ensure that people's food was produced to the right consistency to meet their needs. Where people were at risk of malnutrition, opportunities to increase calorie intake had been missed, for example, low fat yoghurt was used rather than full fat.

Staff spoken with told us that they did not read people's care plans. This meant that they may not have the information required to be able to support the person appropriately. Two staff members did not recognise symptoms of dysphagia [difficulty or discomfort in swallowing], which can be a factor of dementia, or the risk of choking such as coughing during and after a meal or drink. Thirteen staff had not received training in

relation to dementia awareness or dysphagia.

After this inspection, we wrote to the provider and requested that they took urgent action in relation to choking risks to ensure people were safe.

Gaps in the knowledge of the staff team were not identified or addressed by the management team at Scarletts. There was no specific induction to cover the responsibilities of the role of a senior. One staff member who was new in their post and had not had any previous experience as a senior said, "I didn't get enough training. I didn't feel confident and there were three or four times when I was left on my own when I felt there should have been another senior to support me. I had a person who passed away on my shift and I didn't know the procedure for what to do. I did not get enough training in medication. I was only observed administering the medication twice before I had to do it on my own."

Another staff member said, "They [Provider] keep employing people who haven't got experience and we haven't got time to train them but we are managing. Lots of new staff have started recently. I just explain as much as I can." This left people at risk of receiving poor and unsafe care.

There was no guidance for staff regarding how they should support people with their anxieties and for those living with dementia, there was very limited information regarding what this specifically meant for them and how they should be supported. Staff did not have the information needed to intervene effectively through de-escalation techniques or other agreed good practice approaches. One staff member who had been physically assaulted by a person said that they had not had training in how to support people when they became upset. When asked if there was guidance in the person's care plan they said, "I haven't read it in the care plan." Where information had been recorded regarding incidents where people had become upset, these had not been reviewed or analysed to see if there was any trigger for the incident, any improvements to practice could be made or any other strategies that could be tried.

At our previous inspections, we had concerns about the management of catheter care for people. At this inspection, we found there was a continued lack of understanding around catheter care. Fluid charts were not always completed and there was inconsistency in the totalling of fluid input and urine output. Through not monitoring fluid output effectively emerging risk relating to a potential blockage of a catheter, urinary infection or dehydration would not be identified to enable prompt action.

A care plan for one person with diabetes did not detail if the person needed to have their blood glucose levels monitored. It did not provide guidance for staff on the signs to look for to indicate if a person's blood glucose levels were too high or too low, or what action to take if this was the case.

Where people were nearing the end of their life, there was no care planning documents in place to provide guidance to staff on how to keep the person comfortable. Where people should be receiving oral care twice a day, records did not demonstrate that this was being provided.

Although some staff had received end of life training, one staff member said that this had not been effective in providing the information they required to safely support the person and told us, "It didn't seem like much of a refresher. Most of it was about signs that someone was at the end of life but not how to manage that. It didn't cover anything like mouth care."

At our previous inspections, we found that moving and handling practices were not managed safely and people were at risk of potential harm. At this inspection, we found this had not improved and people continued to be at risk.

There was no system in place to ensure staff knew and understood the individual moving and handling needs of people or the correct equipment and aids to use. Moving and handling assessments for people requiring the use of the hoist did not state details of the type of sling to be used according to their support needs, size and weight, how to use the sling or the best way to support the person when using the hoist. Information within care records was conflicting, for example, one person's risk assessment stated that they needed a medium sling and their care plan stated they needed a large sling. Selecting the wrong size sling can result in discomfort if the sling is too small, or the risk of the person slipping through the sling if it is too large. This put people at serious risk of personal injury and falls.

We received information from a whistle blower in January 2018 telling us that it was difficult to find the correct equipment at the home, such as hoist slings. They told us, "You don't know what belongs to whom and who can use it. There's nobody to consult with, the management disappear at 3pm, with very little involvement in care."

The provider had given us numerous assurances that they had put systems in place to ensure staff moved people safely. They told us that people requiring lifting equipment to assist them to move had their own individually sized moving and toilet sling, stored in their bedrooms. At this inspection, we found this was not the case.

In the equipment room, we found toilet slings hanging from wall hooks labelled with different people's names. This posed a potential risk to people if staff did not check the names and used the wrong sling to move them. We also noted one of the toilet slings had two different name labels and was potentially shared placing people at risk from cross infection.

Safety checks on hoist slings had not been completed since October 2017. A new checklist, implemented in January 2018, included a prompt to check the correct person was using each sling; however, no checks were completed and therefore the risks that we found were not identified and addressed. This placed people at risk of using the incorrect slings or slings that could be faulty.

Fire safety arrangements placed people at potential risk. The fire risk assessment was due for review in Feb 2018. This had not been reviewed and there was no prompt on the health and safety audit to check the fire risk assessment to see if any changes were required or any action needed. This had not been effectively monitored. The assessment had a list of people and the rooms they were in but this was not up to date which could impact on a timely evacuation in the event of a fire.

Personal emergency evacuation plans (PEEPS), identifying the level and type of assistance each person needed in the event of an emergency evacuation were kept in individuals care plan folders and were not easily accessible in an emergency. An emergency plan was secured to the wall in a vertical position and was difficult to read. This meant that staff may not have the information they needed to support people to evacuate safely in the event of a fire.

A health and safety audit completed in November 2017, identified that fire extinguishers and fire safety equipment were due a service in January 2018. At our inspection, we found the service was overdue for the fire extinguishers and equipment and had not been completed because the account was 'on hold'. The lack of effective governance and oversight failed to ensure fire safety equipment was consistently fit for purpose placing people at risk of harm in the event of fire.

Fire safety checks of escape routes, emergency lighting, alarm, door closers and the emergency call bell system had not been completed since February 2018 due to the maintenance employee who carried out the

checks, leaving the service. The provider's representative confirmed this. The lack of effective governance and oversight failed to ensure interim arrangements and responsibility for safety checks were in place.

In February 2018, we received information from three people via the 'Share Your Experience' web form that there had been occasions when there was no hot water. On 6 and 7 February 2018, there was no hot water to wash people and people were being washed with cold or luke warm water. On 7 March 2018, the provider assured us that water temperatures would be checked and pumps replaced where required ensuring that there was access to hot water.

Despite these assurances being given, we found checks of hot water outlets to ensure the temperature of water was within a safe range had not been completed since 5 February 2018. Only two checks of water temperatures had taken place previously. The temperature of the hot water in two bedrooms in November 2017 were low and recorded at 22 and 16.4 degrees and considerably lower on 5 February 2018 at 10.6 and 12.2 degrees. No action was recorded as being taken to address the low temperatures identified at that time to prevent reoccurrence.

At our inspection in December 2017 and January 2018, there were no medication care plans in place for people to identify their prescribed medicines and to guide staff on their purpose and any signs to be aware of in relation to side effects, despite this being a condition placed on the registration. At this inspection, we found this had still not been actioned.

We looked at medication administration records (MAR) for ten service users. Two people received their medicines covertly [in a disguised format, for example in food or drink without the consent of the person receiving them]. Records showed that the GP had agreed that covert administration was in the person's best interest. Despite recommendations made by Boots pharmacy in February and March 2018, care records did not include a plan on exactly how to administer the medicines covertly, with recorded pharmacist input to demonstrate the suitability of chosen methods. This placed people at risk of receiving medicines inappropriately.

We found there were no systems in place to ensure that people receive their prescribed medicines as intended. One person did not receive their Citalopram, Mirtazapine and Quetiapine medicines on 12 occasions between 12 February 2018 and 9 March 2018. The reasons recorded on the MAR were 'spat them out' on seven occasions and 'asleep' on five occasions. Comments also recorded on the MAR included 'agitated' and 'in a foul mood'. These medicines are used to stabilise the person's mental health and depressive illness and sudden withdrawal could affect deterioration. The senior carer confirmed that no other strategies were in place to guide staff on how to support this person to take their medicines and no further support had been sourced from other professionals.

One person was prescribed Alendronic acid to be administered weekly. However, staff had not been made aware of the specific protocol that needs to be observed when administering this medicine to ensure its safety and effectiveness. There was no guidance or protocol attached to the medicine administration records or information in the care plan regarding potential side effects. There was also no consideration of how this information would be communicated to the person or their ability to retain and act on this information. This put these people at a higher risk of complications associated with this medicine such as irritation of the oesophagus or dyspepsia, causing them unnecessary pain and discomfort.

Informative and person centred plans were not in place to support staff to administer 'as and when required' [PRN] pain relieving medicines to people 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.

The arrangements for the administration of PRN medication at night was not satisfactory. One staff member told us that there were times when a senior was not available at night, which meant that there was no one trained to administer this medication. This meant that people would not have access to pain relieving medication if this was required.

Many people had limited mobility and required equipment to assist them. At our previous inspections, we identified that systems were not in place to check that moving and handling equipment was fit for purpose and safe to use. At this inspection, we found that improvements had not been made and checks were still not completed.

There was a pool of eight wheelchairs used for transporting people. A safety check carried out in January 2018 for seven of the wheelchairs found that one wheelchair did not have a safety belt and the right arm pad was not secure. On a second wheelchair, a right side brake was not working. We found the wheelchairs were still broken and accessible to staff, and others, placing people at risk of harm from faulty equipment. Contrary to the checklist stating that wheelchair safety checks should be carried out at least monthly, no further checks were carried out which may have identified sooner that no action was taken to remove or repair the faulty wheelchairs. We brought this to the attention of the new manager, who took action to dispose of the faulty wheelchairs immediately.

The supporting manager informed us that individual wheelchair checks were completed; however these could not be located on the day.

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

Although there was positive feedback regarding the number of staff on duty, we observed that staff lacked understanding in how to meet people's needs. For example, one person spent a large proportion of the day walking around the service and was becoming distressed at times. We did not observe staff interacting with this person in a positive and meaningful way in order to alleviate their distress and improve their well-being.

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

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

Inadequate

Is the service well-led?

Our findings

At our last inspection in December 2017 and January 2018, we found that despite continued assurances that improvements would be made following our inspection in June 2017 and September 2017, the provider had failed to establish effective systems and processes to assess, monitor and improve the quality and safety of the service, to ensure people received safe and effective care.

Following our previous inspections, we informed the provider in writing and in meetings of the seriousness of our concerns. We placed additional conditions on their registration requiring them to take urgent action to address the concerns and restricted further admissions to the service to give them the opportunity to focus on and address areas for immediate improvement. The provider has not challenged any of the CQC's previous inspection findings or appealed against any enforcement decisions. We continued to monitor the service closely in conjunction with commissioning bodies and the local authority quality improvement and safeguarding teams.

Despite numerous discussions between the Care Quality Commission (CQC) and the provider about overall responsibility, expectation and required improvements and continued extensive support from local authority safeguarding and quality improvement teams, improvements have not been made as required. This has resulted in a lack of confidence that the improvements promised will be actioned, embedded and sustained.

Responses from the provider to the Commission's requests for information have demonstrated a continued lack of understanding and have not identified the root cause of failings within the service or how to make improvements. This inspection found the provider was still unable to demonstrate that they had effective oversight and governance and improvements required from previous inspections were still not addressed.

Since our comprehensive inspection in June 2017, the provider's failure to retain a registered manager had led to inconsistent governance and leadership of the service. The provider had failed to develop the infrastructure needed to effect and drive improvement. The provider had replaced the management team that they had previously brought in with a new manager who had since left and a new manager had started at the service on the day of inspection. The provider's failure to oversee and monitor any new infrastructure and processes put in place by various management teams has not ensured that the improvements have been actioned, or are effective, embedded and sustained.

Over the past nine months, managerial arrangements at Scarletts have been extremely unstable and this has had an impact on the quality and safety of care provided and on the morale of the staff team. One staff member said, "The stability needs to improve and they need to maintain the staff they have. There is never any reward and they need to make the work more appealing. We had no Christmas card or any extra money over Christmas and there are no incentives. Staff need to feel more valued." Another staff member said, "I think things are improving but there is a long way to go. There could be more support and understanding from the management."

Quality assurance systems have failed to identify the issues we found during our inspection, including shortfalls relating to risk assessment, auditing, medication, training and development needs, inconsistencies in care records and the absence of information to be able to support people with all of their physical and psychological needs. Audits did not always detail who was responsible for completing actions with clear timeframes or identify the action that was being taken. The auditing of care plans and risk assessments was not effective in identifying inconsistencies and the provider failed to identify that they are not meeting the conditions placed on their registration or taken action to rectify this.

There was a failure to recognise and identify significant failings affecting the quality of service provision. The provider has continued to miss opportunities to protect people from the risk of receiving inconsistent, inappropriate or unsafe care. There has been a continual failure to recognise and take action on the serious shortfalls we have found during our previous inspections of the service. This has resulted in continued poor outcomes for people.

The provider has failed to initiate and sustain the improvements required to provide a safe service despite similar concerns being found by the local authority and external consultants as those that have been found by CQC. The local authority and external consultants have provided extensive support, however this has not resulted in the required improvements being made.

Our enforcement processes have not prompted the provider to comply with regulations and meet the fundamental standards in safety and quality.

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

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 Risk management processes continue to be ineffective and the provider continued to demonstrate a lack of understanding of the risks affecting people living at Scarletts. Staff were not equipped with the right information and skills so that people receive safe and appropriate care.

The enforcement action we took:

The Commission took action in line with its enforcement powers and removed this location from the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Robust and sustainable auditing and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved. Failures in the service continued to be widespread and demonstrated the provider's inability to make and sustain improvements. We continue to have concerns about the provider's oversight of the service, inconsistent governance and leadership. Some of the conditions that were placed on the provider's registration to try to encourage improvement after our inspection in June 2017 have not been met.

The enforcement action we took:

The Commission took action in line with its enforcement powers and removed this location from the providers registration.