Turner Home

Turner Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Turner Home is a residential care home providing personal care and nursing care for up to 59 people. There were 48 people living at the home at the time of this inspection.

People's experience of using this service and what we found
People were placed as significant risk of harm because there was a failure to adequately assess, monitor and manage known risks. Risk assessments lacked specific details and guidance for staff as to how risks should be safely managed. The failure to mitigate risk resulted in an incident which placed a person at significant risk of harm.

Medicines were not safely managed. A medicines trolley was left in a communal area unattended and unsecured. The trolley was accessed by a person who took an overdose and was subsequently hospitalised. People did not always receive their medicines as prescribed.

Quality assurance processes at the home remained ineffective and placed people at risk of unnecessary and avoidable harm. This was a continued breach of Regulation 17 and the fourth consecutive inspection in which we have identified a breach of this regulation. This was also the provider's fifth consecutive overall rating of requires improvement or inadequate. Clearly, this represents a sustained period of failed leadership.

People told us they felt there were enough staff at the home. Comments included, "Always seems to be enough staff" and "I like the staff, they're fabulous and there's always someone around." Staff were visible around the home throughout our inspection and people who needed assistance were promptly supported by staff.

People said they felt safe living at the home. Comments included, "Yeah I feel safe, staff are friendly, and I can trust them." Staff had received safeguarding training and safeguarding concerns were appropriately monitored and managed by staff.

We observed kind and caring interactions between staff and the people who lived at the home. The manager had a good rapport with people living at the home and staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 24 July 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. We also identified an additional breach of regulation 12 of The

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to medicines management.

The service remains rated requires improvement. This will be the fifth consecutive rating of requires improvement or inadequate for this service.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 27 June and 2 July 2019. Breaches of Regulations were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve good governance and staffing.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led. The Key Question Effective which contains the breach of Regulation 18 was not inspected at this time.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Follow up:
We will meet with the provider and local authority to discuss our findings and how the provider will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Turner Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector and a nurse specialist professional advisor (SPA).

Service and service type
Turner Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission but a manager was in post and in the process of registering. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We checked the information that we held about the service. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We also gathered feedback about the service from the local authority and used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with five people who lived at the service about their experience of the care provided. We spoke with 10 members of staff including the manager, nurse, care workers and other staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection records relating to risks associated with people's care and treatment were not updated, completed fully or accurate. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• Risks associated with people's care were not adequately assessed, monitored and managed.
• Risk assessment records noted the risks but lacked specific details and guidance for staff as to how these risks should be safely managed. For example, one person who had risks of substance misuse and self-harm accessed an unsecured medicines trolley. Following this the person took an overdose and was hospitalised.
• Another person had a history of self-harm and suicidal ideas but there was no specific risk assessment or reflection on this in their care records. A general risk screen noted the person's risk of self-harm but provided no strategies or guidance for staff as to how to manage these risks.

Risks to the health and safety of people were not robustly assessed, monitored and mitigated. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed staff had started reviewing, updating and improving people's risk assessments and care plans.

Using medicines safely
• Medicines were not safely managed. The night before our inspection a medicines trolley was left in a communal area unattended and unsecured. The trolley was accessed by a person who lives at the home who took an overdose and was subsequently hospitalised.
• People did not always receive their medicines as prescribed. Medication administration records showed people had not received essential and time critical medicines, such as medicines to treat Parkinson's disease, diabetes and blood thinners.
• Staff lacked confidence using the provider's electronic records system. The system was at times unreliable resulting in staff using paper records.

Medicines were not safely managed which placed people at risk of harm. This was a breach of regulation 12

(Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed medicines trolleys were kept secure. Competency reviews of all relevant staff were underway, and they were seeking further support and training from the local medicines management team.

Systems and processes to safeguard people from the risk of abuse
• People were not always safeguarded from the risk of harm from abuse because risks associated with their care were not effectively managed.
• People said they felt safe living at the home. Comments included, "Yeah I feel safe, staff are friendly, and I can trust them" and "I feel safe, the staff take care of me."
• Staff had received safeguarding training and understood their role in recognising and reporting safeguarding concerns.
• Information and guidance about how to raise safeguarding concerns was accessible throughout the home and the provider had appropriate systems in place to manage concerns of a safeguarding nature.

Staffing and recruitment
• There were enough staff available to meet people's needs. People told us they felt there were enough staff at the home. Comments included, "Always seems to be enough staff" and "I like the staff, they're fabulous and there's always someone around."
• Staff were visible around the home throughout our inspection and people who needed assistance were promptly supported by staff.
• Staff were safely recruited. Appropriate checks were carried out to ensure new staff were suitable to work with vulnerable adults.

Preventing and controlling infection
• The home was clean and staff maintained good standards of hygiene.
• Staff received training on infection prevention and control and followed the correct IPC practices including the use of personal protective equipment (PPE).
• Additional measures had been put in place in line with national guidance in response to COVID-19, such as regular testing of staff and residents, enhanced cleaning schedules and supporting residents and staff to isolate when required.

Learning lessons when things go wrong
• Accidents and incidents were effectively monitored and managed by staff.
• The provider had systems in place to ensure appropriate action was taken in response to any accidents and incidents. This information was regularly reviewed by the registered manager to ensure lessons were learned and steps taken to prevent recurrence, when necessary.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider did not have robust or effective systems in place to assess, monitor and improve the safety and quality of care being provided. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• Quality assurance processes at the home remained ineffective and placed people at risk of unnecessary and avoidable harm.
• People were placed at significant risk of harm because the provider failed to assess, monitor and mitigate risks to people. For example, a failure to mitigate risk had placed a person at significant risk of harm.
• Risks associated with people's care had not been adequately documented in their care records and there was a lack of robust guidance for staff to follow on how to manage known risks.
• Audits had failed to identify and bring about improvements in relation to poor risk management and risks associated with the poor management of medicines.
• This was a continued breach of Regulation 17 and the fourth consecutive inspection in which we have identified a breach of this regulation.
• This was the provider's fifth consecutive overall rating of requires improvement or inadequate. Clearly, this represents a sustained period of failed leadership.

The provider had failed to implement robust and effective systems in place to assess, monitor and improve the safety and quality of care being provided. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Ratings from the last CQC inspection were not being displayed within the home at the start of our inspection but this was rectified by the end of the inspection. Ratings from the last inspection were being displayed on the provider's website, as required.
• The service did not have a manager registered with the Care Quality Commission but a manager was in post and in the process of registering.

• CQC had been notified of all significant events which had occurred, in line with the registered provider's legal obligations.
• There was a range of policies and procedures in place to help guide staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and their relatives were able to give their feedback about their care and experience at the home. Examples of this included an annual survey and regular residents' meetings.
• Relatives' involvement had been limited due to COVID-19 visiting restrictions but staff had supported them to keep in touch with their loved ones via telephone and video calls.
• Staff told us they felt well-supported and valued in their roles. Comments included, "[Manager] is very approachable with any issues. [Manager] is always thinking of how to keep us safe."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; and how the provider understands and acts on their duty of candour responsibility; Working in partnership with others
• We observed kind and caring interactions between staff and the people who lived at the home.
• The manager had a good rapport with people living at the home and staff. One member of staff commented, "There have been very positive changes made by [manager], staff morale is good."
• The manager understood their responsibilities regarding the duty of candour and promoted openness and transparency within the service.
• The manager and staff worked in partnership with other agencies when required. This included working with commissioners, safeguarding teams and other health and social care professionals.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not safely managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Care records did not robustly identify risks or demonstrate how risks associated with people's care were effectively managed. The provider had failed to implement robust and effective systems to assess, monitor and improve the safety and quality of care being provided.