Symphony Care Limited

Symphony House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Symphony House is a residential care home that can provide personal and nursing care for older people. The service is registered care to a maximum of 25 people. At the time of inspection 24 people were living at the home.

People's experience of using this service and what we found
The registered manager had failed to notify the commission when people using the service had died. The registered person is required to notify the commission when people die without delay. 21 deaths had not been reported to the commission since October 2018.

There were systems in place to assess the quality and safety of the service. However, the provider lacked oversight by failing to ensure that notifications were sent to the commission.

People using the service were safe. Staff were trained to safeguard people and knew how to keep them safe from risks to their safety and well-being. The registered manager had arrangements in place to maintain and service the premises and equipment to make sure they were safe. The premises were clean and tidy. Staff followed good practice when providing care and when preparing and handling food which reduced infection risks.

There were enough trained and competent staff to support people. The registered manager carried out safe recruitment checks on staff before they started work to make sure they were suitable for the role. They met with staff regularly to keep them up to date with any changes at the service.

Medicines were safely managed. Systems were in place to regularly check staff competency when administering medications.

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

Rating at last inspection
The last rating for this service was good (published 24 September 2019)

Why we inspected
The inspection was prompted in part due to concerns about the lack of statutory notifications received. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed following this focused inspection from good to requires

improvement. This is because there was a breach of regulations. A breach of any regulation is a ratings limiter. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the well-led section of this report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach of regulation in relation to notifications of death of a service user at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we 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?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Symphony House Nursing 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Symphony House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced 15 minutes in advance.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included the lack

of statutory notifications received by the commission. A statutory notification is information about important events which the provider is required to send us by law.

We contacted health and social care commissioners who have a responsibility to monitor the care of people at Symphony House Nursing Home. We used all of this information to plan our inspection.

We 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.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with seven members of staff including care staff, a nurse, administrative staff and the registered manager. We reviewed a range of records. This included four people's care records and multiple medication records. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, training, two recruitment files and information relating to statutory notifications.

Good

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 good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

The purpose of this inspection was to check a specific concern we had about identifying, recording and reporting concerns about people's safety.

Systems and processes to safeguard people from the risk of abuse

- People continued to be cared for safely and were protected from the risk of harm. Staff knew what signs to look for to keep people safe from harm or abuse. There was up to date procedures and information available to support them.
- People told us they were safe, and we saw people looked relaxed and happy around staff. One person said, "I am happy and safe, I get everything I need and more."
- The registered manager understood their responsibilities to keep people safe and we saw that they had raised concerns appropriately with the local authority.

Assessing risk, safety monitoring and management

- People's care needs were risk assessed and care plans provided staff with the information they needed to manage the identified risk. For example, people at risk of falls had plans in place to mitigate the risk, and equipment such as crash mats were in place.
- People had personal emergency evacuation plans in place which meant staff and emergency services knew what support people needed in the event of an emergency.
- Fire and health and safety checks were in place which ensured that people and staff were safe in the environment they lived or worked in and equipment to support people was regularly maintained.

Staffing and recruitment

- Staff recruitment processes protected people from being cared for by unsuitable staff. There were enough staff to provide consistent safe care and support to meet people's needs.
- Staff had been checked for any criminal convictions and references had been obtained before they started to work at Symphony House.

Using medicines safely

- Medicines systems were well organised, and people were receiving their medicines when they should. Safe protocols for the receipt, storage, administration and disposal of medicines were followed.
- Staff confirmed they had received training to administer medicines and their competencies were tested regularly.
- Audits of medicine administration were undertaken which ensured any shortfalls were addressed quickly.

Preventing and controlling infection

● People were protected by the prevention and control of infection. Staff were trained in infection control and were provided with personal protective equipment to prevent the spread of infection. There were up to date policies and procedures in place for staff to follow.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● Systems and processes had been reviewed to identify ways to continuously improve the service. For example, a recording tool had been developed to record all contact made with professionals and relatives following a hospital admission or if someone's health had declined. The registered manager told us this had proved to be useful in identifying at a glance a timeline of who had been involved or informed of developments.

Requires Improvement

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 good. At this inspection this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

The purpose of this inspection was to check a specific concern we had about identifying, recording and reporting concerns about people's safety.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager and provider had failed to notify the commission about 21 deaths of people living at the home since October 2018. The registered manager was clear about their roles and responsibilities and knew this was a legal requirement. The registered manager had not been transparent with the provider about the failure to submit notifications and had offered assurances this had been completed. This is the second time this offence has been committed.

This was a breach of regulation 16 (Notification of death of service user) of the Care Quality Commission (Registration) Regulations 2009 (Part 4)

- The provider visited the service at least twice a week. They completed quality checks of their own which were then shared with the registered manager to action any necessary improvements. We saw these always involved talking with people, visitors and staff.
- Staff were clear about their roles and responsibilities towards the people they supported and felt listened to and well supported. They had regular supervisions and comprehensive training which ensured they provided the care and support at the standards required.
- Staff felt valued and listened to. The registered manager continued to run an annual awards ceremony where staff members were chosen by people, relatives and other staff because of their individual qualities and contribution to the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager demonstrated values such as kindness, empathy and dedication. They were motivated to provide a person-centred service which helped people achieve goals. This was supported by the provider.
- Staff had a good understanding of how delivering high-quality care helped people to experience positive outcomes.
- Feedback from relatives in a recent survey was positive. They praised the registered manager and staff for how their relatives were cared for.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager ensured there were systems in place to ensure compliance with duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; continuous learning and improving care; working in partnership with others

● The registered manager and senior team had engaged with people, relatives and care staff throughout the coronavirus pandemic. They felt assured the service was safe and people were being well cared for.

● Staff were kept well informed of changes and best practice guidance in relation to the pandemic. Staff had plenty of opportunities to share their concerns and make suggestions. Clear audit trails were in place to evidence how practice had changed when new guidance had been issued.

● Staff felt valued in their role and said the management were approachable. One care worker said, "Management have been really supportive."

● Staff worked in partnership with external professionals and engaged well with them to provide a better service. They referred people directly to other services and worked in collaboration with external professionals to improve people's health, safety and well-being.