Mrs Dahiya

Sailaway Residential Care Home

Inspection report

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Date of inspection visit: 23 September 2015
Date of publication: 09/11/2015

Ratings

Is the service safe?	Inadequate

Overall summary

We carried out a focused inspection on 23 September 2015 in response to concerning information about the management of risks at the home. This report only covers our findings in relation to this topic in the "Safe" domain.

The home provides accommodation and personal care for up to 18 people, including people living with dementia. There were nine people living at the home when we visited. The home is owned by the registered provider who also acts as the manager.

We found people's safety was compromised in some areas. Checks to ensure staff were suitable to work with the people they were supporting were not always conducted.

The risk of people falling was not managed effectively. For one person, only one piece of falls-prevention equipment could be used at a time, which put them at risk in some circumstances. Where people had fallen, there was no system in place to analyse them and identify any patterns across the home, in order to prevent further falls.

Window restrictors were not in place to prevent people from falling from first floor windows. Two members of staff were using equipment to support people to move that they had not been trained to use, which put people and staff at risk of injury.

Where people had been identified as at risk of developing pressure injuries, consistent action was not always taken to reduce the risk.

Suitable arrangements were in place for the obtaining, handling, safe keeping and disposal of medicines. However, staff did not always record or account for medicines accurately. One medicine was not given at the correct time, so may not have been effective.

People and their relatives told us they felt safe at the home. Risks relating to the environment were managed effectively.

We found two continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 from our previous inspection in April 2015. We are

Summary of findings

reviewing the action we will take in relation to these breaches and others identified at the April 2015 inspection. We will publish any action we take when this is completed.

Summary of findings

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.

Essential checks were not always conducted before staff started working at the home.

The risks of people falling were not always managed effectively. Medicines were not consistently managed or administered safely.

Action was not always taken when people were assessed as being at risk of developing pressure injuries.

We could not change the rating for this key question from 'Inadequate' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Sailaway Residential Care 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 was a focused inspection in response to concerns raised about the safety of the service. We checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the "Safe" domain.

This inspection took place on 23 September 2015 and was unannounced. It was conducted by one inspector. Before the inspection, we reviewed information we already held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to send us by law.

We spoke with three people living at the home and two family members. We also spoke with the registered provider, the deputy manager, the administrator and two care staff members. We looked at care plans and associated records for four people, staff duty records, staff training records, two staff recruitment files, records of accidents and incidents and the provider's policies and procedures. We observed care and support being delivered in communal areas. 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.

Inadequate

Is the service safe?

Our findings

At our last inspection on 9 and 13 April 2015 we identified that the service was not safe and was in breach of regulations. At this inspection we found people's safety continued to be compromised in some areas.

At our inspection on 9 and 13 April 2015 we found appropriate checks were not always conducted before new staff started working at the home. Since this inspection, two new members of staff had been recruited. All necessary checks had been completed for one of these members of staff, but not for the other. Where staff have previously worked in care, providers are required to obtain satisfactory evidence of their conduct in their previous employment. The staff recruitment file for this staff member showed they had worked at another care home in 2014. However, the provider had not requested a reference from this home and was unable to confirm that the staff member's conduct had been satisfactory while they had worked there.

Failure to conduct appropriate checks before staff were employed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 9 and 13 April 2015 we found the risk of people falling was not always managed safely as risk assessments were not updated or specialist advice sought when people had multiple falls. At this inspection we identified improvements had been made, but some people remained at risk.

One person had been assessed as at high risk of falling. Whilst in bed, they had access to a call button if they needed help from staff. They also had a pressure mat next to their bed that alerted staff if the person stepped out of bed and placed themselves at risk. However, both devices could not be use at the same time as the provider had not purchased the necessary electricity adapter. When the pressure mat was connected, the call bell had to be disconnected. This could have put the person at increased risk of falling as they had to get out of bed to call for assistance.

The provider did not have a system in place to review and analyse falls that occurred across the home. Whilst individual falls were reviewed, and action taken to protect the person concerned, this did not enable any patterns or trends to been identified, so broader action could be taken to make the home safer for people.

At our inspection on 9 and 13 April 2015 we found not all staff had been trained to use hoists which were used to support people who were unable to transfer independently. At this inspection staff training records showed two members of staff had not completed training to use hoists. The staff members concerned told us they used this equipment under the supervision of the provider. However, this may not have been safe as they were not suitably trained and had not been assessed as competent to operate the equipment. This put both people and staff at risk of injury.

At our inspection on 9 and 13 April 2015 we identified errors in the way some medicines were recorded. At this inspection we found suitable arrangements were in place for the obtaining, handling, safe keeping and disposal of medicines. However, medication administration records (MAR) showed that the recording of medicines was still not always accurate. The number of medicines in stock for two people did not tally with their MAR chart. The provider made enquiries and confirmed that people had received their medicines but staff had not accounted for them or recorded them correctly on the MAR charts. A medicine for another person, which should have been given 30 minutes to one hour before food, was being given with food so may have impacted on the effectiveness of this medicine.

Guidance issued by the Health and Safety Executive recommends that first floor windows are fitted with restrictors to prevent people from falling through them. We found the windows in first floor bedrooms did not have suitable restrictors fitted. Most of the first floor bedrooms were not occupied at the time of the inspection and were locked, but one bedroom was occupied, which put the person using it at risk of falling.

People were not always protected from the risk of developing pressure injuries. Assessments of the risk of people developing pressure injuries and skin damage were completed using a nationally recognised tool. However, where the assessments had identified people were at high risk, plans had not been developed to reduce this risk. Whilst some people were using pressure relieving cushions,

Inadequate

Is the service safe?

others were not. Care plans did not contain sufficient guidance about support people needed to maintain healthy skin, such as how it should be monitored, cleaned or protected using suitable products.

The failure to manage risks safely and to properly account for all medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt they received safe care and treatment at the home. A family member told us their relative had formed "good relationships" with people and staff at the home and was in "safe hands". We confirmed that some people were cared for safely. For example, one person's mobility had changed and they were having difficulty managing the stairs safely. The provider had discussed this with the person and their family and it was agreed that the person would move to a ground floor room. This had helped keep the person safe. Another person, who had experienced a number of falls, had been referred to the specialist falls service for advice. They had been assessed by an occupational therapist who had arranged for the person to receive a new walking aid. This arrived during the inspection and staff helped the person to use it safely. However it was clear that good risk management was not consistent for all people living at Sailaway.

Other risks had been assessed and were being managed safely. For example, during the inspection we saw building work was taking place at a neighbouring property, which meant the main access drive to the home could not be used. The administrator identified an alternative access route and put risk reduction measures in place for this to help make sure people's safety was not compromised.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 Care and treatment was not provided in a safe way as risks were not managed effectively and medicines were not managed safely. Regulation 12(1)(2)(a)(b)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not ensure that all persons employed were of good character and had the skills and experience necessary. Regulation 19(1) (2)(3)(a).