Care Quality Commission

Subhir Sen Lochun

High Dene

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out unannounced comprehensive inspections of this service on 26 January 2015 and 2 June 2015. Both found the service to have serious shortfalls and ongoing breaches of legal requirements including Regulation 12 (care and welfare), Regulation 17 (good governance), Regulation 18 (staffing), Regulation 19 (fit and proper persons employed), Regulation 14 (meeting nutritional and hydration needs) and Regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We carried out an unannounced comprehensive inspection of this service on 26 January 2015 and 2 June 2015. After that inspection we continued to receive further information of concern relating to staffing, people's safety and how the service was being managed. We requested information from the provider to assure us of what action was being taken to safeguard people from harm. The provider was unable to provide us with all of the information requested within the timeframe we set, and this meant we needed to undertake an inspection of the service to look into the concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

The service is registered to provide care for up to 15 people. On the day of our inspection there were 9 people living in the service, some of whom were vulnerable because of their circumstances.

On the day of our inspection the service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

There were insufficient staff on duty to meet people's needs effectively. This meant people had to wait extended periods of time for support from staff, and did not have their social and emotional needs met by staff. Staff did not have the time to complete care records and documentation appropriately.

New members of care staff had started work without having completed the appropriate training. The staff on shift during our inspection did not have the appropriate knowledge, skills and experience to deliver safe care that met people's needs.

Risks to people were not being appropriately managed. Where risks had been identified by the service, there was no clear guidance for staff on how to minimise the risks and keep people safe.

Care planning for people remained ineffective and did not accurately reflect people's current needs in sufficient detail.

People were not supported to eat and drink sufficient amounts. Care plans did not set out people's specific needs in relation to eating and drinking, and records of what people ate and drank were not being completed properly.

People's health, safety and welfare were compromised because the provider did not have in place a robust quality assurance process to identify issues that presented a potential risk to people. The provider did not have a system in place to ensure that improvements were made in area's that had been previously highlighted to them.

During this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

There was not sufficient staff to provide the care people needed.

Risks were not managed effectively.

The service remained dirty in some areas.

Is the service responsive?

Inadequate 

The service was not responsive.

Care plans were not up to date and did not reflect people's current needs

Is the service well-led?

Inadequate 

The service was not well-led.

Quality assurance processes in place were not robust enough to identify shortfalls in the care people received.

There were no robust plans in place to ensure that improvements are made to meet the regulations under the Health and Social Care Act 2008 (Regulated Activities) 2014.

High Dene

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.

We undertook an unannounced focused inspection of High Dene on 23 July 2015. This inspection was carried out in response to concerns about staffing and people's safety and welfare. The team inspected the service against three of the five questions we ask about services: is the service safe, responsive and well-led?

The inspection was undertaken two inspectors. During our inspection we spoke with two people who were able to express their views verbally, the relatives of one person and a visiting health professional. 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 looked at the care records for seven people. We spoke with three members of care staff and the manager. We looked at records relating to the management of the service, staff personnel and training records, and the systems in place for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Our previous inspection of 2 June 2015 identified a breach of the regulation due to concerns that there was not enough staff to keep people safe and meet their needs.

During this inspection we identified there was a continuing breach of this Regulation as there were still not enough staff on duty to keep people safe and meet their needs.

For example, one person using the service told us, “Well if you need help and they’re helping someone else, you just have to wait. Who knows how long, but you’ll wait regardless.” Another person told us, “The staff try but they struggle. It’s not their fault, I’m lucky I can do most things for myself. We just sit here all day, it’s no life. They don’t have time for a chat. They never have time to sort anything out and because I’ve not lost my marbles yet I end up looking after other people, getting them a drink, some food. The poor people who can’t say anything don’t get help, full stop.”

There were three members of care staff on shift at the time of visit. Staff told us that seven of the nine people using the service required two staff to support them with mobilising, and that many of the people using the service had other complex care needs that meant they required more support. Staff found it difficult to support everyone, commenting, “It’s impossible. One person needs to go to the toilet and then you end up with eight people being looked after by one member of staff. Then if someone else needs the toilet they just have to wait or go in their pad.” Another member of staff said, “We barely have time to get people up and dressed in the morning. People go without washes because there aren’t enough of us to stretch. I never have time to chat with people and I feel awful for it, but we don’t have time even to take people to the loo, let alone time to sit and chat. I’ve never looked at anyone’s care plans because I just haven’t had time.”

We observed that people who required support to visit the toilet regularly were not helped to do so. In one person’s care plan it stated they needed supporting to the toilet once every two hours, but the person was not helped to the toilet during our seven hour inspection. We saw that people were left for extended periods of time without interaction from staff and some of these people had no way of calling for staff if needed. One person who was at risk of falling got out of their chair and attempted to leave the room without their walking frame, before struggling and being brought their walking frame by another person using the service. Another person was crying out and was anxious about their surroundings. No staff were available to support the person so we sat with the person and tried to comfort them. When a staff member did enter the room some time later, the person grabbed the staff members hand and said, “You’re not going anywhere are you? You aren’t leaving?” The staff member assured the person they wouldn’t be leaving until later that day but then proceeded to exit the room, leaving the person in a distressed state.

We spoke with a visiting health professional about the staffing levels, they told us, “There is not enough staff available whenever I visit. You see people just sitting alone, no staff anywhere. The staff turnover is too high in my opinion. Staff don’t seem to have a caring rapport with people, they’re not very responsive to their needs and feelings."

We looked at the skill mix, competencies and qualifications of staff on duty during our inspection and found that one senior member of care staff present during our inspection was supplied by an external agency, and said it was their first shift at the service. Another member of staff told us it was their first shift, and the other member of care staff said it was their second. Both said they did not feel confident in their role and had only received moving and handling training from the provider before starting work. One of the staff members also said they had no previous experience in care. As a result of our serious concerns we made a safeguard referral to the local authority. In addition we asked the provider what action they would take to improve staffing levels immediately, they told us they would use an agency and would also be recruiting more staff.

This is a continuing breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection of 2 June 2015 identified a breach of Regulations relating to concerns that risks to people were not adequately assessed, planned for and monitored by the service.

During this inspection we identified there was a continuing breach of this Regulation, as risks were still not adequately assessed, planned for and monitored by the service.

The service had not taken action to ensure that people felt safe in their own home. For example there were some

Inadequate

Is the service safe?

difficulties in the relationships between people and this resulted in one person becoming upset and feeling harassed. Care staff had no awareness of how they should respond when the relationship between the two people became fraught, and this was clear when we observed staff sitting and watching whilst the two people argued. No attempt was made by staff to intervene, and the incident ended in a physical altercation. The person told us, "They just do nothing. They sit there and watch and I'm miserable in my own home. They don't care."

We looked at the records for two people at high risk of developing pressure ulcers. There was no risk assessment or care plan in place to guide staff on how to reduce this risk of developing pressure areas and staff we spoke with were not aware of the risk. One of these people had a pressure ulcer at the time of our inspection. We also looked at the records of people who were living with diet controlled diabetes. We found that there were no risk assessments or guidance to enable staff to support people to maintain a safe blood sugar level. We witnessed a staff member giving one person a cup of tea, which the person discarded saying, "I'm diabetic, that has sugar in it." The person told us, "They're always giving me things I shouldn't have. Lucky I know what I can't have, isn't it?" We observed another person with diabetes eating two muffins given to them by another staff member. The person could not independently identify that this might be inappropriate for them.

Some areas of the home remained dirty and there was a risk that infections could spread between people using the service. Drawers containing cutlery were dirty and soiled at the bottom, and clean cutlery was coming into contact with this dirty surface. Some of the worktops remained heavily scored in places, which allowed dirt to settle into the recesses, presenting a food safety risk. Dirt remained around the edges of the kitchen floors. Some of the bathrooms still required thorough cleaning. The flooring in two bathrooms still required replacement to ensure there were no rips or gaps around the edges where dirt could settle. The pipes behind the toilets still required cleaning and the bath was still heavily soiled with limescale. One of the carpets upstairs remained heavily soiled and stained, and some furniture downstairs still required cleaning or replacement.

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

Inadequate

Is the service responsive?

Our findings

Our previous inspection on 2 June 2015 identified a breach of the Regulation relating to concerns with people's care records and the way in which staff supported them to maintain their health, safety and welfare.

During this inspection we identified the care records for people were still not fit for purpose and some people were not receiving the care and support they required. This was despite reassurances from the provider that they themselves had reviewed and implemented new plans.

People's assessed needs did not feed into care planning. For example, it was identified in an assessment that one person's risk of pressure ulcers had increased but there was no care planning in place to guide staff on how to support the person to maintain the viability of their skin. A recently completed body map showed that the person had developed a pressure ulcer, but the care staff on shift were unaware of this and were unable to tell us how the person should be supported to ensure the condition of their skin did not worsen. The person was not seated on any pressure relieving equipment during the inspection and was not regularly repositioned by staff. Both these provisions would have reduced the risk but were not planned for.

For another person who was underweight and at high risk of malnutrition, there was no clear care planning in place to guide staff on how they should support the person to reach a healthy weight and eat sufficient amounts. It was noted in a record of input from health professionals that the person now required a supplement drink twice a day, but this was not recorded In the person's care plan. There were inadequate stocks of these drinks in the fridge, and staff we spoke with were unclear whether the person should have one drink a day or two. We noted that medicines administration records (MAR) charts showed that the person had not been consistently receiving these drinks twice per day since they had been prescribed for them.

Revised care plans had been put in place for some people using the service. However, these still did not reflect people's current needs accurately or were contradictory which could cause confusion for staff and lead to people receiving inappropriate or unsafe care. For example, the care plan for one person stated they needed support to visit the toilet. However, we observed the person had a catheter in situ. For another person their care plan stated they required a particular medicine to be administered before breakfast, and in another care plan it stated they required it after breakfast. Staff administering medicines could not tell us which care plan was accurate.

The manager told us the care plans had been completed by the provider, who did not know the people, and without the input of the person or their family. We asked one person if they knew about their care records and they commented, "I don't know what that is. Never seen it before in my life." It was unclear how the person completing these care plans assured themselves that people's needs were reflected accurately.

A visiting health professional raised concerns with us about the timeliness in which referrals were made to other health professionals, such as GP's, when required. They said, "[The service] are not very good at making referrals in time. Sometimes they leave it and the problem gets worse and worse and then they call me when the person is in a bad way. It is not good enough really but I have told them."

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

Inadequate

Is the service well-led?

Our findings

Our previous inspection on 2 June 2015 identified a breach of the Regulation because there were no systems in place to monitor the service or identify shortfalls in the care people received.

During this inspection we identified there was a continuing breach. There were no systems in place to monitor the quality and safety of the service which were robust enough to identify shortfalls in the care people received.

The provider told us that they carried out regular quality assurance checks during their visits, but did not provide records of these checks when we requested them prior to our inspection visit. These could not be provided to us during the inspection.

The manager showed us a written record of some checks they carried out, but these were neither comprehensive nor robust enough to pick up issues such as inaccurate care records, poor cleanliness and shortfalls in staff practice.

Improvements required as a result of inspections by Environmental Health, the Commission and the Infection, Prevention and Control Team had not been completed within the required timeframe, which meant people were placed at continuing risk of harm.

There was not an open and inclusive culture at the service. The manager was not adequately supported by the provider to make the improvements required, and did not have access to sufficient funds to do so. Despite assurances that they would be present at the home twice a week, the provider failed to attend on a number of occasions when they agreed they would come and support the manager. The manager told us that support from the provider came in the form of a telephone call or email, but said that they were often unable to receive a response from the provider at the time the support was required.

A staff meeting which was scheduled to feedback important information about improvements that needed to be made did not take place because the provider arrived approximately two hours late. One of the staff members we spoke with during our inspection said, “I didn’t hear about any staff meeting. I was around then but no one told me.”

People using the service had not been made aware of the ongoing issues at the service, how the provider intended to improve the standards of care they received, and had not been asked for their views on how improvements could be made. One person said, “My [relative] says there are problems here, but I have heard nothing about that.”

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 Safe Care and Treatment** 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— A. assessing the risks to the health and safety of service users of receiving the care or treatment; B. doing all that is reasonably practicable to mitigate any such risks; C. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; D. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; E. ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; F. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 Staffing** 18.— 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 Good Governance** 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

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 18 HSCA (RA) Regulations 2014 Staffing **There continued to be insufficient staff to meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There were no effective systems in place to monitor the quality of the service and identify shortfalls.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Actions were not taken to ensure people's safety and welfare.**