Mrs H Green

Devonia EMI Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21 and 27 April 2015. Breaches of legal requirements were found. We served a warning notice to be met by 31 August 2015 relating to good governance. After the comprehensive inspection, the provider also wrote to us to say what they would do to meet legal requirements in relation to medicines management. We undertook this unannounced focused inspection on 9 September 2015. This was to check whether Devonia EMI Home had met the warning notice, followed their plan and to check whether they were meeting legal requirements. This report only covers our findings in relation to those requirements. 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

Devonia EMI Home is a family-run home that has been established for 32 years. It provides accommodation and care for up to 12 ladies, over the age of 65, some of whom are living with dementia. At the time of our visit there were nine people in residence.

It is a condition of the provider's registration that they have a registered manager in place. There had not been a registered manager in post since May 2014 which was in breach of this condition. 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. Since our last visit a new manager had been employed and started in post on 14 August 2015.

Summary of findings

The new manager had improved how medicines were managed. Staff competency in medicines management had been assessed and a new daily check had been introduced. Records were complete and demonstrated that people had received their medicines safely.

The provider had not met the warning notice in relation to good governance.

We found that people were at risk of harm. The provider did not have an effective system to assess, monitor and improve the quality and safety of the service. Known risks to people's safety had not been addressed. There was evidence that people had been placed at risk of harm through a lack of guidance and equipment to enable staff to support them to move safely. People had sustained injuries when distressed but there was no guidance for staff on how to support them when they presented with behaviour that could be described as challenging. The provider had not taken action to improve fire safety at the service.

There were not enough staff deployed to keep people safe or to ensure the smooth running and management of the service. Some staff may not have been supported to carry out their duties safely as there were no records of them receiving training. Recruitment procedures were not effective as pre-employment checks designed to check the character of new staff were missing in some staff files.

Staff understood local safeguarding procedures but did not have access to updated local procedures or contact information.

The provider had failed to take action to improve the quality and safety of the service. They remained in breach of regulations. The provider's audits were not effective at identifying where improvements were needed in the service. Where actions had been identified the provider had failed to make improvements to mitigate risks to people's health, safety and welfare. Some improvements noted at our last inspection had not been sustained.

The atmosphere at the service was not relaxed. Staff were stretched and as a result their contact with people was mostly task-based. The new manager worked mostly as a carer and had limited time to dedicate to managing the service. Before a period of absence, the provider had not supported the new manager by giving sufficient induction or handover. The new manager did not have the freedom to make changes in the service and did not have access to the service's funds to do so.

At this inspection we found several breaches of the Regulations, including some continued breaches from previous inspections. 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.

We found that some action had been taken to improve safety but that there were new areas of concern.

People were at risk of harm because risks were not assessed or managed safely.

There were not enough qualified staff deployed to meet people's needs and keep them safe.

Staff recruitment practices were not robust.

Staff understood the principles of safeguarding but did not have access to up-to-date policies or external contact information.

Action had been taken to ensure that people received their medicines safely.

Is the service well-led?

Inadequate 

The service was not well-led.

The quality assurance system was not effective. The provider had not taken action to mitigate known risks. Actions identified to make improvements in the service had not been completed. There was no system in place to monitor and drive improvements.

The service had a new manager. The manager had not received an induction and had very few dedicated management hours to enable them to manage the service effectively.

People spoke well of the service but the atmosphere was not relaxed. This was due to pressures on staff due to low staffing numbers and a lack of clear leadership.

Devonia EMI 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 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 Devonia EMI Home on 9 September 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 21 and 27 April 2015 had been made. 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 in these areas.

The inspection was undertaken by one inspector.

Prior to our visit we reviewed two previous inspection reports, safeguarding information received from the local authority, the provider's action plan in relation to medicines management, whistleblowing information and notifications received from the service. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we addressed potential areas of concern.

During our inspection we observed care and spent time looking at records. 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 spoke with five people who used the service, the new manager and two care staff. We also spoke with one social worker and one music therapist who were visiting.

We looked at care records for five people, Medication Administration Records (MAR), staff recruitment and training records, staff rotas, accident records and audits used to monitor the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection, we identified that the provider had not fully assessed risks to the health and

safety of people using the service and others. We found that risk assessments were missing or inconsistent and that this had not been picked up in the audits conducted by the provider. At this visit we found that the provider had failed to make improvements. Furthermore, the lack of risk assessment and consistent approach to managing risk was impacting on people's safety and putting them at risk of harm.

Where people presented on occasion with behaviour that could be described as challenging there were no risk assessments or care plans in place. In one person's care plan we read, 'Does tend to hit out when frustration sets in' and, 'Requires full assistance to wash and dress can become agitated and lash and kick out during the process'. There was no further guidance. This meant that staff did not have information regarding known behaviours, what might trigger them and how they should respond to support the person and keep others safe. Accident records showed that people had sustained injuries such as skin tears when they were distressed.

Staff had started to complete a behaviour monitoring chart for one person following our last visit but had not continued. There was no evidence to suggest that the information had been used to identify triggers for the behaviour the person displayed. The last entry on the chart was in June 2015. In the daily notes we saw that there had been further incidents. From July, we read, 'Thrashing around, caught elbow on chair', from August, 'Ate all lunch then started to become agitated'. In the daily notes of another person we read that they had 'lashed out' at a staff member, thrown their belongings and been 'Very agitated and angry'. There was no written guidance to describe how staff should respond to each individual when they became upset or distressed. Staff had not received training in managing behaviours that challenge. People were at risk of injury or harm because the provider had not taken steps to mitigate risks relating to behaviours that challenge.

We also identified concerns around how staff supported people to move, for example to stand from a seated position. Staff told us that there were two stand-aid hoists but that these were not currently used with any of the people who lived at the home. At lunchtime we observed that one person was unable to get up from their chair in the lounge. They waited for 45 minutes until they were able to stand before going through to have their lunch in the dining room. One staff member explained, "They have to wait until they can get up". Throughout our visit another person remained seated in the lounge. This person's care plan stated, 'Depending on mood will stand with two carers and take weight well'. There was no guidance on how staff were to assist this person if they could not take their weight. Staff told us that they had assisted this person to the toilet and back but we did not observe this. Due to concerns a specialist moving and handling assessor from the local authority had visited on 1 September 2015. In their report we read that staff had used a drag lift to support this person to transfer. A drag lift is a controversial moving and handling technique which puts the person and staff at risk of injury.

In the accident record of one fall we read that staff, 'lifted' a person up from the floor. The home did not have a full body hoist. This meant that if a person was unable to get up independently, staff would not have a safe method of assisting the person to their feet. We found that the provider had not adequately assessed people's moving and handling needs. This put people and staff at risk of harm because there was a lack of appropriate guidance and equipment to meet people's mobility needs safely.

Known risks were not managed consistently. For one person who was assessed as being at high risk of falls, a weekly review of the risk assessment was recommended. This frequency had not been maintained. Another person had been referred to the GP following unplanned weight loss. Guidance from the GP to maintain a food record chart had not been followed. This same person had started to use bedrails to stop them falling from bed. Although the care plan stated that padding was used to avoid bruising, the risk of entrapment in the bedrails had not been assessed. For people at risk of constipation bowel monitoring records were maintained but these were not used effectively to safeguard people's health. The last recorded bowel movement for one person was eight days earlier. There was no evidence that action had been taken to check whether the record was accurate or to meet the person's needs in this area. People's care records did not demonstrate that action had been taken to mitigate risks.

Inadequate

Is the service safe?

The provider had not taken action to mitigate the risks associated with fire. Following our last inspection we made a referral to the West Sussex Fire and Rescue Service who visited the home in May 2015. The provider received a notice of deficiencies relating to fire safety arrangements in the home. These included the lack of an updated fire risk assessment, the need to provide emergency evacuation plans specific to the people living at the home and the fact that a fire evacuation drill had not been completed. The manager was unable to provide evidence that action had been taken to address these issues. Staff confirmed that they had not carried out a fire evacuation drill. The provider had not taken action to mitigate the risk of fire. We shared our findings with the West Sussex Fire and Rescue Service.

We found that people were at risk of harm. The provider had not assessed the risks to the health and safety of people receiving care and had not taken reasonably practicable action to mitigate risks. The provider failed to respond to known risks that had been identified at the last inspection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough suitably qualified staff on duty to meet people's needs at all times. There were no training records available for three of the staff employed as carers. Two other carers were overdue refresher training. There was a risk that staff were not supported by training to carry out their duties safely.

The staffing rota contained gaps in staff deployment. On three days in a fortnight there were hours with just one carer on duty; once from 1-2pm, once from 8-9am and once from 4-8pm. This was of concern because at least one person who lived at the home needed the assistance of two staff to mobilise. On one day there were no staff on the rota from 8-9am. We raised our concern with the manager who was able to confirm following our visit that arrangements were in place to have at least two carers on each shift. At our last visit, the provider told us that they intended to have three staff on shift in the morning. Staff told us and rotas confirmed that this was rarely the case. The current rota indicated that on just one afternoon a week and one hour on one morning a week the home was staffed by three carers. On the afternoons with three carers this included the manager.

On the day we visited there were two carers on duty and one carer who was working in the kitchen for four hours over the lunchtime period. The service had employed a cook since our last visit and the kitchen shift was covered daily. During the morning we observed that the lounge was often unattended by staff. People did not have call bells in the communal area to request assistance. We sat with people in the lounge for a half an hour. There was a continuous period of 15 minutes when no staff were present, despite eight of the nine people who lived at the home being in the room. Some people were at risk of falling. In the accident records from July and August 2015, five of the six recorded falls were unobserved, meaning that staff were not present at the time of the fall. Staff may not be alerted when a person tried to get up or walk, which could put the person at increased risk.

The manager was usually included as a carer on shift but would also need to attend to phone calls and administrative tasks in the office. As the manager regularly undertook care tasks, this did not leave sufficient time for the management and quality assurance of the service. Four times a day one staff member was responsible for administering medicines. Staff were also responsible for laundry and cleaning as a cleaner was employed for just four hours each week. This meant that there was often just one staff member available to provide care and to engage with people. A music therapist visited the home on a weekly basis for one session. This took place on the day we visited and appeared to be enjoyed by all. For the remainder of the time staff were relied upon to provide stimulation and activity for people. During the morning care staff did not appear to have time to engage with people other than regarding tasks relating to their care, such as offering drinks, administering medicines or assisting them to the toilet. One person told us that staff often came in, asked a question and went out again. On one occasion when a staff member left the room one person said, "Off she trots". Another told us, "It would be nice if there was someone that was interested, that wanted to know all about us, what we were hoping to do, what we were going to do all day". A staff member said, "The morning is the busiest time, in the afternoon we sit and chat" but we did not observe this on the day of our inspection.

We found that there were not enough staff to ensure that people received safe care at all times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

At our last inspection we found that a compliance action around staff recruitment had been met. At this visit we found that improvements had not been sustained. Of the five staff who had commenced employment in 2015, we were unable to find criminal records checks for two. Two references had been received for each of the five staff members. The manager told us that the criminal records checks might be with the provider and not yet in the files. We gave the manager 48 hours to send evidence that the checks had been completed before the staff members began to work with people who lived at the home. No further documentation was received.

The service was unable to demonstrate that their recruitment procedures operated effectively to ensure that staff were of good character and safe to work with adults at risk. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that medicines were not administered safely. We had identified gaps in the records for medicines administered and signatures for medicines that remained in the blister packs. The manager had sent us an action plan setting out the measures they would put in place to address the issues. At this visit we found that steps had been taken to address the problems and that the breach in regulations had been addressed.

Medicines were administered safely. Of the seven staff who administered medicines, six had undergone competency checks. One staff member said, “We’ve had (the new manager) stand by us and watch us give them out”. One competency check was outstanding for a member of night staff. The manager had also introduced a new daily check to ensure that medication administration records (MAR) were completed and that no medicines remained in the blister pack for the day without explanation. A record of the stock held by the home had been introduced on the MAR charts. New documentation had also been introduced to monitor topical creams and ointments. This detailed the date of opening, the recommended storage period after opening and the consequent expiry date. Where a medicine had been refused, a reason was given. We read, ‘Turning head from side to side so impossible to apply. Went back x3 times’ for an eye drop and ‘loose bowels’ as the justification for not giving a dose of laxative. The records were complete and demonstrated the people had received their medicines safely and in accordance with the instructions of the prescribing GP.

People told us that they felt safe at the home. One said, “Of course, who is there to hurt us here?” Staff described the action they would take if they were concerned about someone’s safety or welfare. They understood that they could raise concerns with external agencies such as the local authority safeguarding team or CQC. At our last visit, the provider told us that they intended to display the relevant contact telephone numbers. This was to ensure that staff had easy access to information should the provider be absent or if they felt that their concerns had not been satisfactorily addressed. This had not been completed. Staff did not have access to the updated multi-agency safeguarding policy and procedures; furthermore the provider’s policy had not been updated since 2012. This presented a risk that, while staff understood their responsibilities, they did not have access to updated guidance and relevant contact information.

Inadequate

Is the service well-led?

Our findings

When we inspected in April 2015 we found that the provider had not taken action to improve how they assessed, monitored and improved the quality and safety of the services provided. This was a continued breach of the regulations from the September 2014 inspection. We issued a warning notice to be met by 31 August 2015. At this visit we found that the provider was continuing to breach the regulations and that people were at risk of harm.

The provider did not have an effective system to assess the quality of the service. There was a list of audits that were marked as completed each month. These included complaints, moving and handling, infection control, cleaning, risk assessments in care plans and accidents. The list of audits stated, 'Reviewed all' and, 'No issues' but it did not describe what had been reviewed, what the findings were and if any action needed to be taken as a result. Where further information was available we found that the audits had not always been completed at the monthly frequency stated on the provider's list. For example, although marked as completed on the monthly list, there was no record of a cleaning audit in June or July.

At our last visit, we saw that the provider had started to complete a self-assessment of their compliance with the regulations. This followed the domains of Safe, Effective, Caring, Responsive and Well-led. The sections completed were dated January and February 2015. There had been no further work on this since our last visit. We found that the provider was in breach of a number of regulations. The system in place was not effective in assessing the quality of the service in order to identify where improvements were needed to ensure compliance with the requirements of the regulations.

The audits that had been completed were not effective at identifying issues. During our visit we observed that the bathroom windows were full of cobwebs and that in the upstairs toilet the paintwork was cracked and the flooring not sealed. This meant they were not easily cleanable and did not promote good infection control measures. These issues had not been picked up by either the cleaning or infection control audits. The monthly accident audit consisted of a list of incidents. There was no evidence to suggest that the information had been interrogated to determine whether there were any patterns in when or why individuals might have fallen or injured themselves.

The provider had not taken action in response to known risks. Issues that had been identified were not acted upon to improve the quality and safety of the service. The monthly infection control audit dated 31 July 2015 identified that blue gloves were needed in the kitchen. A staff member told us that they had run out of these blue gloves two to three weeks ago. There were no disposable gloves available in the kitchen on the day we visited. At our last visit we identified that risk assessments including those for behaviour that challenged and the use of bedrails were missing from some care plans. We also identified that action needed to be taken to promote fire safety at the service and that policies including the safeguarding and complaints policies needed to be updated to include key contact information. We found that these action points remained and that the provider had not taken action to improve the quality and safety of the service. Where the provider had made improvements, such as to recruitment practices, these had not been sustained as we found that pre-employment checks were again missing from newly recruited staff files.

During our visit we identified some environmental hazards, such as rucked lino in one person's bedroom and a patio door that had a broken lock meaning that it could not be closed or secured. We asked when these issues had been reported and when they were due to be addressed. The staff on duty were unable to show us where maintenance tasks were recorded or provide any assurance as to when the issues would be resolved. In the report from a specialist moving and handling assessor who visited on 14 August 2015 we read that one stand-aid hoist had not been checked in line with Lifting Operations Lifting Equipment Regulations (LOLER). Staff were advised that it must not be used until the checks were complete. On the day we visited, the stand aid hoist was stored in an unused bedroom. The manager told us that no further checks had been completed since the specialist's visit. There was a risk that staff could use the equipment as there was no signage to say that it was out of order.

Records relating to the management of the service, such as staff training information were not fit for purpose. The manager was unable to update us on the status of staff training. We looked through all the staff files to establish which staff training had taken place. We found that three staff employed as carers did not have any training recorded. Two other carers were overdue refresher training and there was no plan for addressing this gap.

Inadequate

Is the service well-led?

Since our last visit, a new manager had been appointed but had not yet registered with the Commission. The new manager had been in post since 14 August 2015. The new manager explained that they were due to have 16 hours dedicated to management time each week. The rota indicated that they had 15 hours of management time in a fortnight. This equated to two afternoons 2-8pm and one three hour period of 2-5pm when they were not included on the rota as one of the two care staff on shift. One staff member said, "There is no time to do management" and, "She's got to be given time to do the job".

At the time of our visit the provider was not available. Staff told us that they were not due to return until early October 2015. There was no evidence that the provider had given the new manager an induction or sufficient handover to support them to run the service safely. The manager had not been fully briefed on the known risks that had been identified at the last inspection and by visiting professionals. The provider had completed the staff rotas prior to their departure and had left a note to say that they must not be altered. We asked the new manager how they would be able to respond to changes in people's needs that might require an increase in staffing. The manager told us that they were not able to increase the staff numbers and that they had purchased staff uniforms from their own money as they did not yet have access to the service's funds. We found that, although the manager was in principle in control of the running of the service, but this control was limited by the provider. The manager said, "When I put something in place, it is whipped from under my feet".

The systems and leadership in place did not ensure that all areas of service delivery were monitored or that actions were taken to improve poor practice. The provider remains in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had been in breach of the regulations relating to good governance since September 2014. They had failed to take action in response to a compliance action set under the former regulations and a warning notice.

In the absence of a manager, the provider had failed to take action to respond to the warning notice served on 28 May 2015. The provider had also failed to notify us when authorisations had been made to deprive people of their liberty (DoLS) and when the police had been called in relation to a person who had gone missing. The law requires that services notify the commission of these incidents without delay. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The manager had taken action to improve the way that medicines were managed at the service. They had completed staff competency checks and introduced a new daily check of the MAR and blister packs. This had been effective. One staff member said, "She knows her stuff".

During our visit staff were busy and the atmosphere was not relaxed. Staff expressed mixed views regarding the provider. Some were positive while others expressed fear that they may be denied hours or lose their jobs if they spoke of any concerns at the service. Leadership within the service was weak and inconsistent. Prior to the appointment of the new manager, the provider had not had a registered manager in post since May 2014 which was a breach of their registration conditions. The new manager was trying to make improvements in the short time they had been there but was hindered by a lack of freedom to make changes and a lack of time to focus on management tasks.

Most people spoke well of the service. One said, "It's quite nice. It's cosy. Everybody's friendly". Another told us, "It's quite reasonable really". One or two were unsettled on occasion during the day and spoke of wanting to leave. One said, "I'd be gone like a shot". We observed that staff were kind to people but due to time pressures caused by the low staffing numbers, many of their contacts with people were task-based. They did not appear to have time for social interaction.

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 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had failed to notify the Commission without delay of the incidents specified.** Regulation 18 (1) (2)(f)(4B)

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 was not provided in a safe way for people because risks to their health and safety had not been assessed or mitigated. Equipment for safe moving and handling had not been provided. Regulation 12 (1) (2)(a)(b)(f)

The enforcement action we took:
We have served a warning notice to be met by 20 November 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes to assess, monitor and improve the quality and safety of the services provided were not operated effectively. Risks to the health, safety and welfare of service users and others were not effectively assessed, monitored or mitigated. Records in respect of each service user were not always accurate or complete. Regulation 17 (1)(2)(a)(b)(c)

The enforcement action we took:
We have served a warning notice to be met by 20 November 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of suitably qualified staff on duty at all times. Staff had not received appropriate support and training to enable them to carry out their duties.

This section is primarily information for the provider

Enforcement actions

	Regulation 18 (1) (2)(a)

The enforcement action we took:
We have served a warning notice to be met by 20 November 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures had not been used effectively to ensure that staff were of good character. Regulation 19 (2)(a)

The enforcement action we took:
We have served a warning notice to be met by 20 November 2015.