Star Sri UK Limited

Cumberland Court

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	Inadequate

Summary of findings

Overall summary

Cumberland Court provides care and support for up to 20 older people with care needs associated with older age. The needs of people varied, some people were mainly independent others had low physical and health needs and others had a mild dementia and memory loss. The care home provided respite care with some people coming back to the home for short stays on a regular basis when they or people looking after them needed a break.

At the time of this inspection 17 people were living in the service. This inspection took place on 16 September 2016 and was unannounced. The inspection only covered the question 'is the service safe.' This was in response to contact from whistle blowers who raised concern about the safety of the service.

The service did not have a registered manager a recently appointed manager had taken up post on the day of this inspection. 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.

Cumberland Court was registered under new ownership in January 2016. A registered manager was in post at this registration. Since registration there has been three changes in the manager. The provider has recognised the need for an established leadership for the service. They have contracted an external professional consultant to establish this.

The staffing arrangement which included one staff member working at night did not ensure the safety of people living in the home in the event of an emergency situation. The Personal Emergency Evacuation Plans (PEEPs) completed identified many of the people needed support and guidance to move to a place of safety if there was a fire in the home.

The provider had not taken account of all possible environmental risks and taken action to minimise them. This included completing an infection control risk assessment and addressing any areas to minimise the risk of infection.

The provider had not ensured staff administering medicines followed clear guidance that maintained safe storage and administration of medicines. Systems to assess people's individual risks were not followed for all people and guidelines for staff to follow to minimise any risk were not in place for all people. Therefore the provider could not be assured people received safe and effective care.

People said they were happy and well looked after. We found people were comfortable and happy moving around the home and spending time where they wanted to. The provider ensured a thorough recruitment procedure was followed when new staff were employed. Staff understood how to recognise any possible abuse and how to respond to any suspicion or allegation of abuse to safeguard people.

We found a breach 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 this report.

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

Some aspects of the service were not safe.

The staffing numbers deployed did not ensure a suitable number of staff were available for people's safety at night.

The provider had not ensured the environmental risks had been fully addressed to ensure people's safety.

People's individual risks were not assessed and measures to minimise these risks and ensure people received safe and effective care were not in place.

Medicine records and practice observed did not ensure all medicines were stored and administered safely.

Staff knew how to recognise different types of abuse and were clear on how to respond to any allegation or suspicion of abuse. Appropriate checks were undertaken to ensure suitable staff were employed to work at the service.

People told us they were happy living in the home and felt they were safe.

Cumberland Court

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.

This inspection took place on 17 September 2016 and was announced. The inspection team consisted of one inspector and an inspection manager.

Before our inspection we reviewed the information we held about the home. We considered information we held about the service which included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. The provider was not asked to complete a Provider Information Return (PIR) as this inspection was carried out in response to concerns raised. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the commissioner of care from the local authority before the inspection. During the inspection we were able to talk with eight people who used the service and three staff members including the new manager. The registered provider was contacted by the manager and arrived at the home in the afternoon.

We observed staff working and how staff communicated with people. We looked at most areas in the home including people's rooms with their consent. We reviewed a variety of documents which included the care records relating to four people. We looked at three staff recruitment files, and records of staff training. We viewed medicine records and looked at policies and procedures, and systems for recording accidents and incidents.

Inadequate

Is the service safe?

Our findings

People said that they were safe and had their care needs attended to well. One person said "Yes I am absolutely safe, staff are available at any time and look after me very well." However, our own observations and records showed people were not always protected from risk of harm.

We found the staffing arrangements at night did not reflect the dependency of people and the assistance people would require in the event of an emergency situation including a fire. One care staff member worked at night and a senior staff member was on call for advice and to travel to the home in an emergency if required. Not everyone had a personal emergency evacuation plan (PEEPs) and the ones completed confirmed that most people would need assistance in any evacuation either because of poor mobility, hearing loss or memory loss. Three people were also identified as not being able to walk unassisted and would need a sled sheet for a prompt evacuation which would require two staff to operate. These needs and risks had not been taken into account as part of the staffing provision to ensure peoples safety.

Fire safety concerns were raised as part of a health and safety report completed by an external consultant in May 2016. An action plan was being progressed by the provider. However it was not clear if areas of concern had been fully actioned appropriately. For example the fire risk assessment was completed by a staff member and it was not clear if they were competent to undertake this task and that all areas had been risk assessed effectively. Records indicated that the fire doors and self-closing devises were not all working correctly. An up to date record of people's PEEPs had not been maintained. The provider was asked to contact the local Fire service for further advice. The CQC also contacted the Fire service and requested a visit to review any possible fire risks in the home.

We found care records were limited and lacked thorough assessment of risk and planning of care to ensure people's safety. One person who had been living in the home for six days had no assessment of their care needs, no risks assessment and no care plan to guide staff on how to meet their needs. The acting manager confirmed the risks associated with their care included limited mobility, pain control, risk of falls and risks associated with isolation. Another person had some behaviour that other people found difficult to deal with. There was no care plan or risk assessment in place to manage the behaviour or other people's responses. This person was also using pressure relieving equipment when sitting and in bed. There was no documentation to indicate why this was used or what risks were being responded to. Another person was living with a health need which needed close monitoring and management by staff. There was no care plan in place to provide guidelines for staff to follow to manage the risks associated with this health need.

Although the home was clean and a recent infection issue in the home had been responded to with the support of a professional contractor. A full and thorough infection control audit had not been completed. Areas that could impact on infection control measures in the home had not been identified and responded to. For example the laundry room had surfaces that were not cleanable including unpainted wooden surfaces, brick walls and broken flooring. Some practice observed indicated clear infection control procedures were not followed. One staff member who was also on duty as a care staff member was emptying bins without any protective clothing and soiled undergarments were being soaked in the laundry.

Staff who prepared the evening meals had not completed any food hygiene training. This meant people were not fully protected against the risk ofharm through risks associated with cross infection..

People told us they had medicines when they needed them and we saw staff respond to people's requests for painkilling medicines. The Medicine Administration Records (MAR) confirmed medicines were administered as prescribed however when 'as required' medicines were administered records were not complete. For example when an 'as required' pain killer was administered the time and number of tablets given was not accurately recorded. How the medicine worked was also not recorded. All three staff working in the home at the time of the inspection administered medicines. The provider had not provided a complete medicine administration procedure that provided clear guidelines for staff to follow. We found medicine stored in the fridge had not been secured in a locked facility. The area where medicines were stored had not had the temperature checked for sixteen days. This did not ensure all medicines were stored and administered correctly and safely.

The provider was not always ensuring care was provided in a safe way to people. This was because they did not consistently assess risks to people and do all they could to mitigate such risks. In addition systems to ensure the safe storage and administration of all medicines had not been established. This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

There was a safe recruitment procedure in place. The provider was responsible for staff recruitment and ensured appropriate checks were completed on staff before they started working in the service. We found staff records included application forms and confirmation of identity. The recruitment process included an interview and the sourcing of references that informed the provider of staff suitability. Each member of staff had a disclosure and barring checks (DBS) completed by the provider.

Staff told us they had received training on safeguarding adults, they understood their individual responsibilities to safeguard people. Staff were able to talk about the steps they would take to respond to allegations or suspicions of abuse. They were confident any abuse or poor care practice would be quickly identified and addressed immediately by the manager and provider. They knew how to access the contact number for the local authority to report abuse or to gain any advice.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not always ensuring care was provided in a safe way to people. This was because they did not consistently assess risks to people and do all they could to mitigate such risks. In addition systems to ensure the safe storage and administration of all medicines had not been established.