Mrs C Duffin

Freegrove Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Overall summary

This inspection took place on 25 September 2015. The purpose of the inspection was to establish if improvements had been made to people's safety following enforcement action we had taken in June 2015. We found the required improvements had been made and that care was being provided in a safe way. You can read a summary of our findings from this inspection below.

Freegrove Care Home is a small residential care home located in a residential area of Lymington. The home is arranged over two floors and can accommodate up to 17 people. At the time of our inspection there were 13 people living at the home. The home supports people with a range of needs. Most people were quite independent and only needed minimal assistance. Some people were more dependent and needed assistance with most daily living requirements including support with managing their personal care and mobility needs. A small number of people being cared in the home were living with dementia and could display behaviour which challenged.

The home had a registered manager. 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 and associated Regulations about how the service is run. The registered manager was in the process of applying to de-register and the registered provider was now in charge of the day to day management of the service.

We found that the registered provider had taken action to ensure that people had appropriate care plans and risk assessments which helped staff to deliver their care safely. Tools used to assess and monitor people's risk of developing pressure sores or of becoming malnourished were being consistently used.

Summary of findings

Arrangements were in place to ensure that people's medicines were administered safely. Medicine audits were being effectively used to drive improvements and to ensure that people's medicines were being managed safely. Staff were only administering medicines when they had been trained to do so and their competency to do this safely had been assessed.

There were systems in place to reflect upon the nature and cause of incidents and accidents. These were reviewed by the registered provider to identify any trends or patterns so that remedial action could be taken which might reduce the risk of similar incidents happening again.

Food was being stored in line with guidance from the Food Standards Agency. This helped to ensure that people were not given foods that were unsafe or unsuitable to eat.

Arrangements were in place for dealing with emergencies which might reasonably be expected to arise from time to time. Each person had an personal emergency evacuation plan (PEEP) and there was a detailed business continuity plan which set out the procedures for dealing with a range of emergencies.

This report only covers our findings of the inspection on 25 September 2015. You can read the report from our previous inspections by selecting the 'all reports' link for 'Freegrove Care Home' on our website at www.cqc.org.uk.

We could not improve the overall rating for this service because to do so requires consistent good practice over time. We will consider whether it is appropriate to revise the overall rating awarded to this service during our next planned comprehensive inspection.

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 

Action had been taken to improve the safety of the service.

People had appropriate care plans and risk assessments which helped staff to deliver people's care safely.

Food was now being stored in line with guidance from the Food Standards Agency.

Medicines were administered safely by staff who had been trained to do so. Medicine audits were being effectively used to drive improvements.

We could not improve the rating for 'is the service safe' from 'inadequate' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Freegrove 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 inspection was planned to check whether the registered provider had made the necessary improvements following our inspection in June 2015 and that they were meeting legal requirements and regulations associated with the Health and Social Care Act 2008 .

This inspection took place on 25 September 2015 and was unannounced.

The inspection team consisted of one inspector.

The provider had not been asked to complete a provider Information Return (PIR) before the inspection. This 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. However we referred to other information we held about the home to plan the inspection.

We spoke with two people who used the service and two relatives. We spoke with the registered provider, and two care workers. We reviewed the care records of four people in detail. We reviewed the Medicines Administration Record (MAR) for 10 people. Other records relating the management of the service such as audits and incident forms were also reviewed.

Inadequate

Is the service safe?

Our findings

We carried out an unannounced comprehensive inspection at Freegrove Care Home on 22 and 23 January 2015. We found a number of breaches of the legal requirements and as a result we served four warning notices on the registered manager and registered provider requiring them to become compliant by 11 May 2015. We undertook a further unannounced inspection on the 11 and 12 June 2015. We found that although some improvements had been made, some Regulations continued to be breached. As a result we took further enforcement action. We issued a warning notice on the registered provider requiring them to make improvements to ensure people's care and treatment was provided in a safe manner by the 16 September 2015. On the 25 September 2015, we undertook a focused inspection and found that the required improvements had been made.

People told us they felt safe and secure living at Freegrove Care Home. The visitors we spoke with were all satisfied that their relatives were being cared for safely by staff who one relative said were, "Kindness itself". Staff told us that the service had improved and felt it provided a more organised and structured environment, whilst still maintaining its homely feel.

Improvements had been made to how risks were identified and managed in order to keep people safe. For example, people had a 'maintaining a safe environment' care plan which described the support they needed to stay safe whilst in their room. These plans considered whether the person had the capacity to judge risks for themselves and how this might impact on their safety. In each of the care plans viewed there was a range of individual risk assessments which had been evaluated regularly. For example, moving and handling risk assessments were in place as were assessments which helped predict whether people were at risk of falls or of developing pressure ulcers. The risk assessments had corresponding care plans which described how the identified risk was to be managed. We saw that two people now had a detailed behaviour care plan which included information about the distraction and calming techniques staff could use to effectively manage any incidents of behaviour which challenged others. The registered provider told us that these techniques were being used with good effect and had led to a reduction in incidents of behaviour which challenged.

Tools used to assess and monitor risks to people's nutrition were being used more consistently. Nutrition care plans were in place which included information about people's dietary preferences and the help they needed to eat and drink. People were being were being weighed regularly and where there was an increasing risk of weight loss staff were weighing people more frequently. Another person had a detailed diabetic care plan which contained a clear escalation plan that described the signs and symptoms which might indicate that the person's diabetes was becoming unstable and required a medical review. Another person who was at risk of leaving the building without staff being aware had a 'missing persons' care plan in place and information was highlighted around the home of the importance of maintaining the security of the home.

Action had been taken to ensure there was a more robust system in place to reflect upon the nature and cause of incidents and accidents and risks to people's health and wellbeing. Records were being maintained of incident and accidents within the home and these were being reviewed by the registered provider each month so that any trends or patterns could be identified and remedial action taken to prevent any reoccurrence happening. We saw that the registered provider had acted promptly to report and investigate a safeguarding matter. They had done this in an open, transparent and objective way. This all helped to ensure that risks to people's safety and wellbeing were being more effectively managed.

The warning notice issued following our inspection in June 2015, had cited that the available personal emergency evacuation plans (PEEPS) did not reflect the people currently living in the home. This was of concern as it could impact upon the safe evacuation of the home. At this inspection we found that action had been taken to address this. The available PEEPS reflected the people living in the home and a system had been put place to undertake weekly checks of the plans. We also saw that the registered provider had taken action to put in place a more detailed business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home. This helped to ensure that there were effective procedures in place dealing with a range of emergencies which could impact on people's safety.

At our inspection in June 2015, we had found that food was not always being stored in the fridge in line with guidance from the Food Standards Agency. At this inspection we

Inadequate

Is the service safe?

found that food was being stored safely. All of the opened food in the fridge was labelled with the date it was opened. This meant that people were being protected against the risk of being given foods which were unsafe or unsuitable to eat.

At our inspection in June 2015, we found that the registered provider did not have suitable arrangements in place for safe and effective use of medicines. This was because there was no system in place for reporting, reviewing and learning from medicines errors. Medicines audits were not being effective at driving improvements. We could not be assured that appropriate action was being taken when people refused their medicines or that staff were adequately trained to administer people's medicines. Staff were not following best practice guidance in relation to how the administration of controlled drugs was recorded. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures to prevent them being misused or diverted. At this inspection we found that the required improvements had been made.

Each time a staff member administered a CD, the CD register had also been signed by a second suitably trained member of staff. People had a medicines care plan which described how the person liked to take their medicines or any difficulties associated with this. For example, one person's medicines plan explained that the person could at times refuse to take their medicines. The plan advised staff to try again in 30 minutes and fully explain what each medicine was for. The plan prompted staff to seek medical advice if the refusal was on-going. We did note that there was no specific guidance as to after how many refusals staff should seek medical advice and this would improve the plan further. All of the medicines administration records (MARs) viewed had been completed accurately with no gaps which indicated people were receiving their medicines as prescribed. Staff had received training in the safe administration of medicines and had undergone competency assessments which helped to ensure that they continued to demonstrate they had the right skills and knowledge to administer people's medicines safely.

Regular medicines audits were being undertaken and where these identified that improvements were required, there was a clear action plan in place which identified who was responsible for overseeing the improvements and the timescale within which these were to be made. This meant that the audits were being effectively used to drive improvements and to monitor the safety of the how medicines were managed within the service.

We were able to see that the registered provider had made a number of improvements. It was clear that both the registered provider and the staff team had been working hard to ensure that people had more detailed and specific risk management strategies and support plans in place. People's medicines were being managed safely. There was a developing culture within the service of learning from mistakes, incidents and accidents. However, we could not improve the rating for 'is the service safe' from 'inadequate' because to do so requires consistent good practice over time. We will check that these improvements have been sustained during our next planned comprehensive inspection.