Care Quality Commission

Solway House Limited

Solway House

Inspection report

Solway Terrace
Maryport
Cumbria
CA15 6EL
Tel: 01900 817651

Date of inspection visit: 12 October 2015
Date of publication: 12/02/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 12 October 2015 and was unannounced.

Solway House is situated in a residential area of Maryport, close to the town centre with views over the sea and harbour. It is registered to provide accommodation and personal care for up to 18 people, some of whom may have dementia. The home is an older style property adapted for use as a care home. Accommodation is provided over two floors, in single bedrooms but the home does have one double room.

There is a registered manager at this service.

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.

We spoke to five of the people that lived at Solway House and one of their visitors. Everyone we spoke to told us that they were "very happy" or "very satisfied" living at this home. People told us that the staff were "very good" and looked after them "very well".

Summary of findings

Everyone we spoke to told us that they had never seen anything at the home to cause them concern. They also said that should they have any concerns, complaints or issues, they knew who to speak to about them. People told us they were confident they would be listened to and that actions would be taken by the staff and management.

The home was clean and free from any unpleasant odours. The provider showed us some of the environmental improvements that had been made at the home and told us about the plans for further improvements for Solway House.

We observed staff supporting people who used this service. The staff were kind, polite and acted very discreetly when helping people with their personal care needs. The people who lived at Solway House appeared well groomed and cared for. The staff were very attentive to people's needs without compromising independence. The atmosphere at Solway House was warm and friendly. Visitors were made welcome and people could meet their visitors in private if they wished.

At the time of our visit to Solway House, there were a sufficient number of staff available to support people with their needs. However, we found that there were times when there were not enough staff on duty.

We found that there were a considerable number of unwitnessed falls at the home which had resulted in people being injured. We found that risk assessments lacked information and had not been reviewed and updated following any incidents. These actions would have helped identify and reduce the risks of the accident happening again.

The sample of staff recruitment records we looked at showed that the provider had not followed safe recruitment practices. There were gaps in the pre-employment checks and the manager told us they were not aware of the requirements of this regulation.

We observed some poor practices used by staff during our visit. These included poor moving and handling techniques and infection control practices. We were told that the person carrying out risk assessments did not have the skills and knowledge to carry these out effectively. We spoke to the manager about these matters during our inspection.

The records showed that staff had received some training about the Mental Capacity Act 2005 but we found that there was a lack of understanding. We noted that the principles of the Mental Capacity Act 2005 Code of Practice had not been followed when assessing people's ability to make a particular decision or when placing restrictions on their liberty.

Although staff were able to tell us about the care and support needs of people living at Solway House the care plan records contained little information and guidance in relation to people's needs. Some were out of date and this placed people at risk of receiving inconsistent and unsafe care.

The provider had system in place to help monitor the standard and quality of the service but this was not effective. There were gaps in staff personnel records and people's personal care records were out of date. Accidents and incidents had not been routinely reviewed and evaluated to help identify and reduce potential risks to people who lived and worked at this service.

We checked the information we held about Solway House and compared this with the events and incidents we found recorded at the home. We found that some of the incidents should have been reported to us (CQC) but the provider had not done so. The registered manager told us that they were not familiar with the requirements of this regulation.

We looked at the way in which people were supported with their medicines. We found that medicines were generally well managed and people received their medicines as their doctor intended. The use of when required medicines could be improved to help ensure these types of medicine are used and monitored safely.

The people we spoke to during our visit to the home told us that the food and the cook at the home were very good. We observed the serving of the lunchtime meal and spoke with the cook. People were able to make choices about what they ate. People told us that they had been supported by staff to help manage their weight. However, this type of support was inconsistently provided and where food and fluid intake needed to be monitored, records were poorly maintained.

Summary of findings

People who used this service were able to speak directly to the manager and provider of this service on a daily basis. However, there were no formal processes in place for people to comment on their experiences and of how the service was run.

We have recommended that the service seeks guidance about assessing and managing the nutritional needs of people who use this service.

We have recommended that the service seeks advice and guidance about supporting people to express their views about the quality of services they experience.

We have recommended that the service considers current guidance on the management of some medicines.

We found breaches of the following regulations:

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and support had not been personalised to meet people's individual, changing needs.

Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The provider had not taken adequate action to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014. People who used this service were not protected from improper treatment.

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that the provider did not have systems in place to ensure the quality of the service and compliance with the law.

Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. People who used this service were exposed to the risk of harm because staff did not have up to date skills and knowledge to work safely.

Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The staff recruitment process was not robust and the provider could not be certain that only fit and proper people were employed to work at the home.

You can see what action we told the provider to take at the back of the full version of the report.

We also found breaches of Regulation18 of the Care Quality Commission (Registration) Regulations 2009. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

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 always safe.

Risk assessments relating to the needs and safety of people who used this service did not provide sufficient guidance for staff to follow. Risk assessments had not been reviewed and updated as people's needs changed.

People were placed at risk of harm or injury because there were not enough staff on duty to provide the care and support required when needed.

Staff recruitment practices at the service were not effectively operated.

Is the service effective?

Requires improvement

The service was not always effective.

Staff at the home, including the registered manager, had limited understanding of the Mental Capacity Act 2005.

Staff did not always ensure safe practices were used when assisting people with their mobility.

People who used the service were not always supported appropriately with their dietary needs.

The service ensured people who needed specialist equipment such as pressure relieving cushions and mattresses, were provided with these items.

Is the service caring?

Good

The service was caring.

Staff treated people who used this service with dignity and respect.

Where possible, people were encouraged to remain as independent as possible, although this was not always well managed.

People who used this service had been consulted about their wishes with regards to their end of their life care.

Is the service responsive?

Requires improvement

The service was not always responsive.

People who used this service did not have their care and support needs reassessed and reviewed in a timely manner.

People who used this service did not always get a timely or consistent response to their care needs.

Staff were aware of people's needs but care plans and assessments were out of date and did not accurately reflect the care and support people needed.

Summary of findings

Is the service well-led?

The service was not always well led.

Quality assurance systems are in place but they are not effective or consistently applied.

The registered persons are not familiar with their registration requirements and obligations.

People who use the service, their families and friends are all able to be involved with the day to day running of the home, although this process is not formalised.

Requires improvement

Solway House

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 12 October 2015 and was unannounced.

The inspection was carried out by a lead adult social care inspector.

As part of the inspection we carried out a review of the information we held about this service, including notifications and information that had been supplied to us by the provider.

The inspection included a visit to Solway House. During the visit we spoke to people using the service, their relatives and friends and spoke to the staff on duty, including the registered manager and the owner of the home. We spent time observing staff working with people who used this service and carried out a review of some of the records kept at the home.

We looked at a sample of care records belonging to three of the people who used this service. We looked at the recruitment and personnel records of three members of the staff team. We also looked at records relating to the running of the home, for example; accident records and maintenance records.

We contacted some of the health and social care professionals who visited the home for their views on the service provided. We did not receive any adverse comments or observations from the people we contacted.

Inadequate

Is the service safe?

Our findings

The people who we spoke to during our visit all told us that they were "very happy" at Solway House. One person told us; "The staff are very good and look after us very well." Another person said; "We are all well looked after here."

All of the people we spoke to told us that they had "never" seen anything at the home to concern them and everyone knew who to speak to if they had any complaints or issues. People told us that they could speak to "any of the girls (staff)" if there was a problem.

We looked at the accident and incident records that had been kept at the home. We found that there were a considerable number of people who had suffered "unwitnessed" falls. The records showed that people had been "found" on the floor by staff and that some of the people who had fallen had suffered injuries such as cuts, bruises and in one case a fractured bone.

We looked at the processes that were in place to help keep people safe from harm or injury. This included looking at risk assessments, staffing levels and the ways in which the provider managed incidents.

The risk assessments did not include sufficient information about the risks identified and the actions staff should take to mitigate the risks. We found that where people's care and support needs had changed, risk assessments and care plans had not been routinely reviewed and updated to reflect those changes.

There were insufficient numbers of staff on duty to help ensure people who used this service were safe from harm. We noted that there were occasions when people were waiting for assistance because both of the staff on duty were supporting individuals, in private, with their personal care needs.

The provider did not take adequate action to improve the safety of the service for the people who lived at Solway House.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not protected from actual harm and were placed at risk of receiving unsafe care, treatment and avoidable harm.

We looked at a sample of staff recruitment records during our visit to the home. We found that the provider did not follow safe recruitment practices and had not ensured that all of the necessary checks had been made prior to employing people at Solway House. We spoke to the registered manager about this matter during our visit and guided her towards the requirements of the regulations.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk of harm because the provider did not have robust processes in place to make sure only fit and proper people were employed at the home.

We looked at the way in which the service supported people with their medicines. We found that where people needed help with applying cream and ointments that these were well managed. Clear instructions and documentation helped staff to ensure these medicines were used safely and appropriately. Medicines that are liable to mis-use (controlled drugs) had been stored securely and were only kept when necessary. The medicines records we looked at had been fully and accurately completed. There was an auditing process in place to help ensure medicines were checked and managed safely.

When required medicines (PRN) had been prescribed and administered this had been recorded on the medication administration record and in the daily notes of the person taking the medicine. However, there were no individual care plans with regard to the safe use and monitoring of these types of medicines.

We recommended that the service considers current guidance on the management of these medicines.

Requires improvement

Is the service effective?

Our findings

People who used this service told us that the staff were "very good". One person told us that they "felt safe with staff, they know what they are doing."

People who lived at Solway House commented on the food provided for them too. One person told us; "The food is lovely here. We have a very good cook who makes lovely meals. I had been losing weight but the staff took me to the doctors to get this looked at." Another person said; "We eat well. The food is very good here. I can choose what I want to eat and if I don't want what is on the menu I can choose something else." We observed this to be the case during our visit to the home.

The staff we spoke to, including the cook, told us that they received training to help them carry out their job. They confirmed that they regularly met with the manager and were supervised in their work.

We looked at a sample of staff training and supervision records and the training matrix that was in place at Solway House. We found that staff received induction training when they first commenced working at the home and that this was followed up with further training from external training providers or from within the home. The manager told us that most of the staff had or were working towards national vocational qualifications.

We found that risk assessments relating to the health, safety and welfare of people who used this service had been carried out by a person who did not have the appropriate skills and knowledge to carry out this work.

During our visit to the home we observed some poor practice by staff, including the use of unsafe moving and handling techniques and poor infection control practices, for example not wearing protective clothing at meal times. We spoke to the manager about this at the time of our visit as action needed to be taken quickly with regard these matters.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured staff had the skills and knowledge to carry out their role.

We checked whether the service was working within the principles of the MCA. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider told us that there was no one at the home subjected to authorisation under the Deprivation of Liberty Safeguards (DoLS).

Staff, including the manager had received some awareness training in relation to the Mental Capacity Act 2005. We found that the provider and staff at the home had limited knowledge of the Mental Capacity Act 2005 and the deprivation of liberty safeguards. An application had been made to deprive someone of their liberty, but this had been completed incorrectly and had been returned to the manager for review. The care records we looked at did not always show that people had given consent with regard to the care and support they received.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the principles of the Mental Capacity Act 2005 Code of Practice had not been consistently followed when assessing an individual's ability to make a particular decision or when placing restrictions on their liberty.

The sample of care records we looked at showed that people were not consistently supported and monitored with regards to their nutritional needs.

We saw evidence to support that people had their nutritional concerns monitored but we also saw examples where this was not the case. For example, one person had lost a considerable amount of weight over a three month period but their dietary assessment had not been reviewed and there was no information in their care plan to guide staff with regards to fortified diet, drinks and snacks. However, another person had been seen by the speech and language therapist and their care plan provided staff with guidance about soft diets, use of food thickeners and positioning the person to help reduce the risks of choking.

Requires improvement

Is the service effective?

We also found that where people needed to have their food and fluid intake monitored records had been poorly maintained. It was difficult to tell how much someone had eaten or had to drink.

We spoke to the cook at the time of our visit they provided us with an overview of people's dietary requirements. The cook also told us of the training they had attended to help them carry out their role effectively.

We recommended that the service seeks advice and guidance from a reputable source about the assessment and management of people's nutrition and hydration needs.

The home was clean and free from any unpleasant odours. The provider showed us some of the environmental improvements that had been made at the home and told us about the plans for further improvements for Solway House. Where people had been identified as needing specialist equipment such as pressure relieving mattresses or cushions, this had been provided. There was equipment in place to help people who used this service with their mobility and to access the bathing facilities at the home.

Good

Is the service caring?

Our findings

Everyone we spoke to during our visit to Solway House were very happy with the care and support they received. We did not receive any complaints about the staff approach or the care people received.

One person described the staff as; “Lovely, they are very, very good. They have taken me to the doctors, the clinic and they are taking me out shopping later this week. I am very happy here and the staff look after me well.”

Another person told us; “I am very well cared for here. The staff are very kind and this is a pleasant environment to live in.”

We observed staff supporting the people who used this service. There were times when people had to wait for staff assistance because they were helping another person. However, we noted that staff were very attentive to people’s needs without compromising people’s independence. The atmosphere at Solway House was warm and friendly and everyone joined in the conversations and friendly banter observed in the communal areas. The people who used this service and the staff who worked there knew each other very well.

People were treated with dignity and respect. The people that lived at Solway House appeared well groomed and cared for. The staff we spoke to were able to give a good account of people’s needs and individual personalities. Staff were mindful of people’s privacy and ensured that people were asked about and supported with their personal care needs discreetly. Where people needed assistance with their mobility, staff provided clear information and explanations of what was happening.

People were able to spend their time in one of the communal areas or, if they preferred to stay in their own room. People had been able to bring into the home some of their own personal possessions to help make their bedrooms more personal. Visitors were made welcome at the home and people were able to see their visitors in private if they wished.

We saw from the care plans we looked at that people had been asked about their wishes and preferences for when they reached the end of their life.

Requires improvement

Is the service responsive?

Our findings

The people we spoke to during our visit to Solway House were all very satisfied and happy with the service they received. No one we spoke to raised any concerns or complaints with us. People told us that they had never had to make a complaint about the home. However, they did know who to raise any concerns with and told us that they were confident they would be dealt with properly.

As well as speaking to people who used the service and the staff supporting them, we looked at a sample of care records. We found that care records and plans contained limited information about people's needs. Some were out of date and did not accurately reflect people's current needs. This placed people at risk of receiving inconsistent care or of receiving care that was not personal to them and did not fully meet their needs.

The accident records kept at the home showed that a number of people had experienced falls, some of them on more than one occasion. Their risk assessments and mobility care plans had not been reviewed and updated to help identify the cause and develop solutions to help reduce the risks of falls in future.

Two of the care records we looked at, recorded that these people were at risk of developing pressure ulcers. Whilst it was evident community nurses were involved in the care of these two people and pressure relieving equipment was in place, there were no care plans to help ensure staff monitored and managed their skin care effectively.

The service had developed care plans to accompany people to hospital should they need to be admitted. However, these had not been routinely completed and information about people's individual needs and routines had not been included.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and support had not been personalised to meet people's individual, changing needs.

The provider had a complaints procedure in place that described the process people could expect to investigate any concerns they might raise. We had not received any complaints about this service and the provider confirmed that they too had not received any complaints. People who used the service and staff that worked there told us that the manager and the provider were "approachable" and both spent time in the home alongside staff and people who lived at Solway House.

We noted and people told us of the social and leisure activities that were available in the home. People told us that they went out with staff to go shopping. Contact with the local community was maintained and the home had regular visits from the clergy. Social events were held and people could invite their friends and families to attend if they wished.

Requires improvement

Is the service well-led?

Our findings

People who used the service and their visitors told us that they were very happy with the service. No one who we spoke to during the inspection of this service raised any concerns with us.

We checked the information we held about Solway House and compared this with the events and incidents we found recorded at the home. We found evidence in the sample of records we looked at during our inspection visit, of accidents and incidents that should have been reported to CQC, two of which should also have been referred to the local authority.

The manager told us at the time of the inspection that they were not familiar with the requirements of this regulation.

This is a breach of Regulation18 of the Care Quality Commission (Registration) Regulations 2009. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

There were gaps in the auditing and governance systems in place, which meant that the safety and well-being of people using this service was compromised. For example: risk assessments and care plans were not reviewed as needs changed; gaps in staff recruitment processes meant that proper checks on prospective staff were not completed; staff practices were not routinely monitored to help ensure they were working safely.

Accidents and incidents, although recorded, had not been reviewed and evaluated to help identify the cause and develop solutions to make improvements.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have an effective system in place to monitor compliance with the Regulations and drive improvement in the quality and safety of the service provided.

There was a registered manager in place at Solway House.

We found that records relating to staff and people who used this service had been kept securely in order to maintain confidentiality.

Staff discussed and showed us the process in place for auditing and checking that medicines were accounted for safely at the home.

We found that equipment such as hoists and fire fighting equipment had been regularly inspected and serviced. Visual audits of the premises had been carried out by the provider and where necessary, improvements to the environment had been made. The environmental improvements that had been made at Solway House helped to make the home more pleasant. The provider also told us of improvements that were planned over the next few months.

There were no formal processes in place for people to comment on how the service was run or how improvements could be made, but we found that people were able to make comments and suggestions directly to the provider or registered manager as they were frequently in direct contact with them.

People using the service told us that they felt comfortable in approaching any of the staff or the managers in order to discuss issues, concerns or ideas. People told us that they were confident that they would be listened to and actions would be taken.

We recommended that the service seek advice and guidance from a reputable source about supporting people to express their views about the quality of services they experience.

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 This is a breach Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment. How the regulation was not being met: People who use services were not prevented from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed This is a breach Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Fit and proper persons employed. How the regulation was not being met: The staff recruitment process was not robust and the provider could not be certain that only fit and proper people were employed to work at the home. Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Staffing How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

People who used this service were exposed to the risk of harm because there were insufficient numbers of staff and staff that did not have up to date skills and knowledge to work safely.

Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment This is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. How the regulation was not being met: People who used this service were not protected from improper treatment. Regulation 13(4)(b)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. How the regulation was not being met: People who used this service did not receive care and support that was personalised to meet their individual and changing needs. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

How the regulation was not being met:

The service did not have effective systems in place to ensure the quality of the service and compliance with the law.

Regulation 17

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.