The Huntercombe Centre - Sherwood

Quality Report

8 First Avenue
Sherwood Rise
Nottingham
Nottinghamshire
NG7 6JL
Tel: 01159 246220
Website: www.huntercombe.com

Date of inspection visit: 6th October 2016
Date of publication: 21/11/2016

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good

Overall summary

We have changed the rating for Safe from requires improvement to good because;

- The environment was visibly clean and records showed it was cleaned regularly. Environmental risk assessments were up to date. All of the staff had personal alarms. There were enough staff for all of the residents to have one to one time. Activities and visits were never cancelled due to lack of staff.
- The medicines management was good; we looked at all of the medication cards and they had all been signed and completed correctly. We saw records showed staff recorded fridge temperatures daily and all of the medication was stored safely and securely.
- We saw records showed the staff had checked all of the safety equipment including the defibrillator regularly.
- Staff completed risk assessments when a resident was admitted and updated them regularly. All of the staff we spoke to could explain how and when they would make a safeguarding referral.
- All of the staff we spoke to knew what and how to report an incident. Staff had reflective meetings at the end of every shift to help support learning from incidents.

Summary of findings

- This meant the service now met Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Safe care and treatment. During the last inspection, the service was in breach of this regulation.

Summary of findings

Contents

Summary of this inspection	Page
Background to The Huntercombe Centre - Sherwood	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	6
What people who use the service say	6

Good

The Huntercombe Centre-Sherwood

Services we looked at;
Long stay/rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to The Huntercombe Centre - Sherwood

The Huntercombe Centre – Sherwood is a specialist care home with nursing. The service is for men with mental health needs, challenging behaviour, or complex needs. Some individuals may also have intellectual disability and some may have a forensic background with associated risk and be on a Community Treatment Order. The service has 18 beds, 14 in the main building and four individual flats on site but in a separate building. On the day of inspection, 16 people were at the service.

The service is regulated to provide accommodation for persons who require nursing or personal care, diagnostic and screening procedures and for the treatment of disease, disorder or injury.

There was a registered manager at the time of inspection. The registered manager was also the accountable officer for controlled drugs.

The service was last inspected 18 April 2016. This inspection rated the provider as good overall. The safe domain was rated as required improvement because; staff had not signed all medication administration records, which could have led to medication errors and records did not evidence that staff had checked the defibrillator as regularly as planned. This was a breach of Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014 Safe Care and Treatment. CQC issued a requirement notice to ensure improvements would be made.

This inspection was unannounced and focused on ensuring the improvements had been made.

The provider has now met the requirement notice.

Our inspection team

The team that inspected the service consisted of two CQC inspectors. The lead inspector was Nicky Mountford.

Why we carried out this inspection

We inspected this service as part of our follow up from the previous comprehensive mental health inspection to check regulatory breaches had been met

We undertook this inspection to find out whether The Huntercombe Centre-Sherwood had made improvements since our last comprehensive inspection of the service on 18th April 2016.

When we last inspected the service, we rated it as good overall. We rated the service as requires improvement for Safe, good for Effective, good for Caring, good for Responsive and good for Well-led.

Following this inspection we told the The Huntercombe Centre- Sherwood that it must take the following actions to improve;

- The provider must ensure that staff sign all medication administration records when they dispense medication to prevent medication errors.
- The provider must ensure staff check and record the defibrillator to be in good order, on a regular basis so that it would be fit to use if needed.

We also told the trust that it should take the following actions to improve:

- The provider should ensure all staff complete clinical supervision when planned as per the providers policy.
- The provider should ensure staff are clear which legislative framework they are using to support people. There was confusion between the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.

Summary of this inspection

We issued The Huntercombe Centre-Sherwood with one requirement notice.

This related to:

Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Safe Care and Treatment.

How we carried out this inspection

We asked the following question of the service:

- Is it safe?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- Visited the unit and looked at the quality of the environment.
- Spoke with three residents who were using the service.
- Spoke with the nurse in charge
- Spoke with five other staff members; including, nurses, support workers and activity coordinator.
- Looked at nine care records of residents.
- Carried out a specific check of the medication management on the unit and looked at 16 medication charts.
- Looked at a range of policies, procedures and other documents relating to the safety of the service.

What people who use the service say

The residents we spoke to said they felt safe and well cared for by the staff. They said there was always enough staff and activities and visits were never cancelled. They felt they had enough support around managing their physical care needs and attending appointments. They had a key for their own rooms and felt their belongings were safe. They felt confident the staff dealt with incidents in a timely manner.

Long stay/rehabilitation mental health wards for working age adults

Good

Safe

Good

Summary of findings

We rated safe as good because;

- The environment was visibly clean and records showed it was cleaned regularly.
- We saw environmental risk assessments were up to date.
- Staff all had personal alarms.
- There were enough staff for all of the residents to have one to one time and activities and visits were never cancelled due to lack of staff.
- Staff completed risk assessments upon admission and updated them regularly.
- All of the staff we spoke to could explain how and when they would make a safeguarding referral.
- All staff knew what and how to report an incident.
- There was good medicines management because all of the medication cards had been signed and dated.

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

- The main lounge and dining area allowed staff to observe residents. There were mirrors on the stairs so you could see around the corners. There were fixed ligature points present in the building that could pose a risk to individuals' intent on self-harm. (ligature points are fixtures, which someone might tie something to so they can strangle themselves.) Staff used observations of residents to mitigate this risk. We saw an up to date environmental risk assessment that identified the ligature points and the staff we spoke to were aware of them. All of the curtain rails and door handles were anti ligature.
- The environment was visibly clean and we saw cleaning schedules demonstrating it was cleaned regularly. There was a full time housekeeper who kept records and audited the general cleaning. The support workers supported the residents in cleaning their own rooms and the residents' kitchen.
- Nottingham City Council rated the service kitchen as five star (very good) for food hygiene in October 2015.
- The service employed a full time maintenance person who completed checks including; fire alarm systems, water testing and health and safety and ensured the fixtures and fittings were well maintained.
- We saw posters up reminding staff of infection control principles and observed the nurse wash their hands prior to dispensing medication.
- Staff carried personal alarms to summon assistance if needed and there were nurse call buttons in each of the residents' bedrooms.

Safe staffing

- The service based the staffing need on bed occupancy. The establishment for the service was one qualified

nurse on duty day and night and five or six support workers on duty during the day, depending on need and four at night. The manager could increase this if required.
- The service had one vacancy for a support worker at the time of inspection. There were no vacancies for qualified nurses.
- The turnover rate in the 12 months prior to inspection was 46%. Staff told us the reasons for leaving were mainly that the staff had left for senior positions or to go to university.
- The sickness rate in the 12 months prior to inspection was 6.7% and we saw the manager had sickness and absence management plans in place for some staff.
- There were enough staff so residents could have one to one time with their named nurse or key worker.
- The service rarely used agency staff and relied on their own bank staff to cover shifts. In the four months prior to inspection, agency staff had been used on five occasions. Bank staff were a group of regular staff who worked when needed and they were used to cover shifts every week. This was deliberate by the manager and was to ensure they had current knowledge of the service.
- There was an experienced member of staff present in the communal areas at all times.
- We were told by residents' and staff that activities and leave were never cancelled due to not enough staff.
- The service did not have a doctor within the team. If a doctor was required, the staff supported the residents in accessing their local GP, community team, or hospital. In an emergency, the staff would call 999.
- Staff received mandatory training, which included, safeguarding children and adults, information governance and fire safety. At the time of inspection, training figures were 82%; this was because there had been a number of new starters who were yet to complete all of their training.

Assessing and managing risk to patients and staff

- The service did not use seclusion or long-term segregation.
- The service does not carry out physical interventions but uses de-escalation techniques to manage any verbal or physical aggression. All of the staff we spoke with could explain what de-escalation interventions they would use, for example, talking to the patient, distraction techniques.
- We looked at nine care records, all of the patients had received a risk assessment upon admission, and these were updated regularly. Staff used the short-term assessment of risk and treatability (START) risk assessment, which is a nationally recognised tool.
- The service had a list of prohibited items including weapons and drugs. There were restrictions in place regarding mobile phones with internet access and cigarettes and lighters. Staff risk assessed each resident to determine if it was safe to allow the restricted items.
- There were no restrictions in place to prevent residents from leaving the service. We saw residents coming and going at their own will.
- There were policies and procedures in place for use of observation. Staff completed hourly observations and one resident was on one to one at the time of inspection.
- Staff did not search residents. If there was suspicion a resident had an item on themselves that could cause harm the police were called.
- The service did not use rapid tranquilisation.
- Staff were trained in safeguarding adults and children and could explain how they would identify potential abuse and explained the procedure for reporting it. There were safe areas identified where children could visit the unit.
- There was good medicines management practice. We saw staff checked fridge temperatures daily. We looked at 16 medication charts and all were signed and completed correctly. Following the inspection in April 2016, staff had introduced checks of the medication charts between shifts to ensure all of them had been signed. When nurses dispensed controlled drugs, a support worker checked the medication with the qualified nurse before giving it to the resident.
- We saw staff regularly audited clinic room medications and equipment and records showed the defibrillator was checked weekly.

Track record on safety

- There had been 119 incidents recorded as moderate and minor in the 12 months leading to inspection. There were no serious incidents reported.
- There had been a recent incident where an unknown person had entered the service via the back fire door.

Long stay/rehabilitation mental health wards for working age adults

Good

The police were called and the person left of their own accord. The outcome of the investigation was to get a lock fitted to the outside of the door so it can only be opened from inside.

Reporting incidents and learning from when things go wrong

- The staff knew what and how to report incidents via an electronic reporting system. They described the process of how they received feedback following investigations. One of the examples given was moving the locked box that residents lighters and cigarettes were in to the lounge. It was previously in the office but this blocked access to the front door and made the office entrance crowded and there was a risk residents could have seen confidential information.
- The service was aware of the duty of candour but had not had any incidents where this applied.
- Staff had handovers for nurses and support workers between every shift and morning meetings every day to include the rest of the staff. These meetings included feedback from any incidents or actions learnt.
- Staff also had a reflective meeting at the end of their shifts. This was to ensure staff were able to raise any concerns or discuss ways in which things could have gone better or celebrate how well things went during the shift. They also identified any actions the following shift needed to take.
- We saw records of debriefs having taken place for staff and residents and staff said they felt very supported after any incidents.

.