Central and Cecil Housing Trust

Compton Lodge

Inspection report

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21 September 2018

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Ratings

Overall rating for this service	

Is the service safe?	
Is the service effective?	
Is the service well-led?	

Summary of findings

Overall summary

Compton Lodge is a residential care home for up to 32 older people. At the time of our inspection there were 27 people using the service.

We carried out an unannounced inspection on the 19 and 21 September 2018. At our last inspection on 10 and 12 January 2018 the service was rated as Good. As a result of this inspection the service has been rated as Requires Improvement.

We carried out an unannounced comprehensive inspection of this service on 10 and 12 January 2018. After that inspection we received concerns in relation to the use of medicines at the home due to a controlled medicine having been given in error. As a result, we undertook a focused inspection to look into those concerns. This report covers our findings in relation to this topic and other areas we examined. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for [Compton Lodge] on our website at www.cqc.org.uk

Earlier this year, after our previous inspection, there had been a delay in following up the receipt of a prescribed medicine needed due to sudden illness. Since that time there was a recorded omission from a controlled drug register entry in August 2018, a medicine error where an incorrect medicine had been given and an error by the dispensing pharmacy which was picked up by the service, but not until after the medicine had also been given. These had fortunately not resulted in harm to anyone. Action had been taken as a result of these occasional errors and improvements had been made although errors had still occurred. The provider has changed pharmacy provider since in order to respond to errors being made by the previous pharmacy provider.

There was a registered manager in place at the time of the inspection. There had been a change since our last inspection in January 2018. The previous manager had left the provider organisation in June 2018 and had been replaced by a manager who had previously been the registered manager of another care home operated by the same provider. 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.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The service was clear about obtaining consent to care and had done so in each of the care plans that we viewed. Consent was obtained from people themselves, but if they lacked capacity, and if legally permitted to do so, relatives provided signed consent. One person, of the six currently identified as lacking capacity, had a relative with lasting power of attorney (LPA) noted on their care plan. The Office of the Public Guardian registered number of the LPA was noted on the care plan, but a physical copy of the LPA had not been obtained from the relative, which was being followed up by the service.

There were systems in place to safeguard people and staff had a good understanding of keeping people safe from harm or abuse. Risk assessments formed part of each person's care plan and covered risks that staff needed to be aware of to keep people safe.

People had a Personal Emergency Evacuation Plan on their care record (PEEP) which informed staff how to support the person should evacuation be necessary in the event of fire. The home was undergoing a renewal of the fire alarm system at the time of this inspection, during which the current fire alarm system was still in use.

Recruitment practices ensured staff were appropriately checked prior to employment to ensure they were suitable to work with the people using the service. There were sufficient staff available and deployed to meet people's needs and staff were trained about their work.

People were supported to eat drink and maintain a balanced diet. There were menus on display in pictorial form. People were supported appropriately during meal times which we saw happening during this inspection.

People were supported to keep well and had access to the health care services they needed.

There were opportunities for people's voices to be heard. Meetings and social events were organised for people using the service and their relatives.
As a result of this inspection we identified that the service requires improvement in the areas of safe and well-led. Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People did not always receive their medicines in a safe way as errors being made on occasion. The provider had changed the pharmacy provider since our inspection due to concerns about the standard of service provided by the pharmacy. No harm had come to anyone using the service as a result of the occasional medicines errors.

Staff were recruited in a safe way, with appropriate background checks being undertaken. There were suitable numbers of staff to support people.

Staff had received training with regard to safeguarding.

Day to day risks to people were assessed and managed, not only individually but also environmental risks both inside and outside of the home.

Is the service effective?

Good

The service was effective. The provider had acknowledged and commenced action that was needed to improve the consistency with which daily care records were written in some cases. Recording in most cases was, however, descriptive and gave a good picture of what care had been provided to people each day.

People had their mental capacity assessed and no one was illegally deprived of their liberty.

People had access to a food and drinks that they chose.

People were supported by external healthcare professionals who provided staff with guidance.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider had been transparent with CQC and other statutory agencies about events at the service. However, embedding lessons learnt from previous incidents was not suitably evidenced as occasional mistakes had still been made in connection with medicines.

People were consulted about their care and the provider listened to what people said.

Care Quality Commission

Compton Lodge

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 focused inspection took place on 19 and 21 September 2018 and was unannounced. The inspection team comprised of an inspector and specialist professional advisor who was a pharmacist.

During the inspection we spoke briefly with three people who used the service. These people did not make specific comments about the service but all said they were cared for well. We spoke with three members of staff, the Deputy Manager and Registered Manager of Compton Lodge, the Quality and Compliance Manager of Central & Cecil Housing Trust (the Provider) and the Head of Care.

We reviewed four care plan records, one new member of staff recruitment process as well as policies and procedures relating to the service. We observed interactions between staff and people using the service.

Requires Improvement

Is the service safe?

Our findings

The inspection was undertaken because we had received concerns about medicines care at the service which suggested there might be current risks presented to people using the service..

We identified that there had been a failing at the service earlier this year in the following regard. The practice at the service was that, care workers, not responsible for administering medicines, were not permitted to provide the second signature required in the controlled drug register. However, despite this, a care worker had, on the instruction of a team leader, been asked to sign the controlled drug register as the second signatory when a medicine patch had been applied. The provider accepted that this was not their policy and should not have occurred. The provider advised us after the inspection that the investigation into this had concluded and action had been taken. This issue was discussed with the home manager, who has clarified that she and other senior staff from the home were now available to attend if controlled drugs needed handling. This would be in the absence of two team leaders being on duty at any given time and that this had always been the practice."

We noted on the Controlled Drugs Register that there was a missing quantity administered amount (1 patch) in August 2018 that had not been entered correctly on the controlled drug record at the time, although the total remaining and the MAR chart had been correctly recorded. We discussed this with the worker who had made the entry. They said it was due to distractions when making records and that it would be rectified, which it was. However, the provider's policy was that when medicines are being administered the staff member doing so should not be distracted, which clearly wasn't the case at that time. Other controlled drug register entries were correct, however, it was of concern that the particular error in fully recording on the register had not been identified prior to our inspection visit.

One of the team leaders responsible for administering medicines that we spoke with was unclear how to rectify errors or omissions in the controlled drugs register. We did, however, note that an error in November 2017, had been quickly identified and rectified which was documented.

The two team leaders we spoke with during this inspection were able to describe the way in which controlled drugs were administered. They told us that they would check the medicines administration record [MAR] as well as the controlled drug record to verify if a controlled drug was still being administered.

In February 2018, there had been an outbreak of vomiting for some people living at the home. The GP had sent an electronic prescription to the dispensing pharmacy requesting a medicine for people but it was not delivered for over 24 hours. The medicine in question would not have prevented further vomiting but was a rehydration medicine.

There had been a medicine error where an incorrect medicine had been given and an error by the dispensing pharmacy which was picked up by the service, although after that medicine had first been given. No harm had arisen by the errors noted, however, the fact remains that occasional errors in in the management of medicines had occurred.

There was concern expressed by the home manager and other senior provider staff about the quality of service received from the pharmacy provider, including the receipt of medicines in a timely manner and sometimes excessive receipt of bulk medicines that had not been ordered. The provider had, since this inspection, changed the pharmacy provider that was being used at the time of this inspection.

All medicines checked during this inspection were appropriately stored and recorded when administered. Audit forms for medicines were being completed on a weekly basis. Staff competencies were being assessed and documented appropriately. Training records for staff were being maintained. All staff responsible for medicines administration had up to date training delivered by an external pharmacist. There was a comprehensive list of policies/procedures available that staff could refer to. The provider had reviewed the medicines policy in July 2018, we were informed by the operation's manager that there was a further review of medicines policies being undertaken by the provider.

People were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening. The staff we spoke with were clear about their responsibilities to report concerns, including one new member of staff who was still undertaking their induction into the home. Training records confirmed that staff underwent safeguarding adults training.

One safeguarding concern had been raised since our previous inspection. The provider had co-operated fully with the investigation into this as well as two other incident notifications that had also been reported to CQC.

The provider continued to follow safe recruitment procedures to ensure that staff were not employed unless they were suitable to work with people. The provider's central personnel department carried out these checks and then informed the service once satisfactory checks had been received. We looked at verification of checks for the most recently recruited staff member and this showed the necessary background checks, for example disclosure and barring and references, had been undertaken. This meant that people were protected by a provider who was diligent in ensuring that staff were safe and appropriate people to support them.

The rota and staff on duty matched the staff rostered for the days of our inspection and there were a suitable number of staff on duty to attend to people's needs. In addition to this there were two domestic staff, a chef and an assistant chef working throughout each week. At night there was always a senior care worker and two care assistants.

Care plans included risk assessments that identified any risk associated with people's care. Risk assessments were reviewed regularly and were updated if people's needs changed.

Renewal of the fire alarm system was underway during our inspection. The previous alarm system was still in use and would, we were told, not be decommissioned until the new fire alarm system was checked and verified as fully operational after installation. There were Personal Emergency Evacuation Plan (PEEP) on people's care records. Their PEEP identified the level of support they needed to evacuate the building safely in the event of an emergency.

Systems were in place to ensure that all equipment was maintained and serviced. A regular programme of safety checks was carried out. For example, gas safety, fire alarm detection and warning systems, electrical safety and day to day building safety checks were all carried out. There were arrangements in place to deal with foreseeable emergencies.

Good

Is the service effective?

Our findings

The sample of people's daily care notes we looked at during this inspection showed that entries were made for each day and night, indicating what care and support was provided to people. The standard of this recording varied in terms of detail and consistency and it was acknowledged by the provider's representative as lacking consistency in some cases. The registered manager and other senior provider managers we spoke with told us about the action they have taken to make further improvements that had already been recognised. This included further training around care notes recording to ensure continuous learning and to support staff.

People who lacked mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this was in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS].

The service undertook best interests decision making procedures where a person was thought not to be able to make an informed independent decision. This was documented and the necessary consultation with other people, including relatives and other health or social care professionals, was undertaken. The service was clear about obtaining consent to care and had done so in each of the care plans that we viewed. Consent was obtained from people themselves, but if they lacked capacity, and if legally permitted to do so, relatives provided signed consent. One person, of the six currently identified as lacking capacity, had a relative with lasting power of attorney and this had been recorded on the care plan and included the confirmation reference of this. This was noted on their care plan but a written copy had not been obtained from the relative, which was being followed up by the provider.

Where people had their liberty restricted this was assessed and if approved by the local authority under DoLS procedures and the provider had then notified the commission as required.

People were supported to have their assessed needs, preferences and choices met by staff that had the necessary skills and knowledge. Training records showed that staff were trained and attended courses relevant to their role.

Requires Improvement

Is the service well-led?

Our findings

The previous registered manager left the service in June 2018, and a new manager transferred from another home operated by the same provider. There was a clear management structure in place.

Staff we spoke with were not critical of the way the service was managed. They told us that the issues around the way in which medicines were managed and how they used procedures, such as night checks for people when unwell, had been discussed in detail.

Care staff we spoke with told us they felt encouraged and valued in their role as they felt it was central to providing person centred, good quality care.

There was evidence of regular audits and spot checks undertaken by the management team, including checks of care records, medicines, communication and staff practice. These audits were, however, being reviewed. The provider had been transparent with CQC and other statutory agencies about events at the service. The provider representatives we spoke with stated that lessons had been learnt and that improvement had been made and this was being monitored to evaluate the effectiveness of these improvements. Outcomes and learning from audits as well as incidents and investigations were shared with the staff team in one to one supervision and team meetings. However, occasional medicines errors were still being made and the practice to avoid such mistakes was not embedded in the service at the time of this inspection.

There was a daily management meeting held, which we observed, which included care staff and senior [internal] management. The current needs of people using the service, significant events, activities and day-to-day matters were discussed and the action needed was agreed. The provider had effective systems in place for communication among the staff team, however, there was acknowledgement that further improvement was needed.

The provider continued to listen and responded to the views of people who used the service, relatives and other health and social care professionals.