Swallowcourt Limited

Ponsandane

Inspection report

Chyandour Terrace
Penzance
Cornwall
TR18 3LT
Tel: 01736 330063
Website: www.swallowcourt.com

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service responsive?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 3 and 5 of January 2015 and found breaches of legal requirements. This was because systems for recording the administration and recording of medicines were not robust. Risk assessments did not guide staff on how to minimise identified risks.

After the comprehensive inspection the registered manager wrote to us to say what they would do to meet the legal requirements in relation to the breaches. We undertook this focused inspection on 5 May 2015 to check they had followed their plan and to confirm they now met legal requirements.

We saw that daily medicine audits were carried out to identify any errors quickly and ensure actions could be taken to address them. We saw there were new systems in place to record risks which included information on what action staff should take to reduce the risk of avoidable harm.

Following the comprehensive inspection of 3 and 5 January 2015 we received information about concerns in relation to the service. As a result we also looked into these concerns during our focused inspection. The concerns were about how the service identified and responded to people's changing needs.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ponsandane on our website at www.cqc.org.uk.

Ponsandane is a registered nursing home for up to 58 older people. At the time of the inspection 41 people were living at the service some of whom were living with

Summary of findings

dementia. The service is required to have 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 2008 and associated Regulations about how the service is run. At the time of the inspection there was no registered manager in post. The manager had been employed at the service for four weeks and they were planning to apply to be registered.

At our focused inspection we identified some errors in the recording of the administration of medicines. However we found improvements had been made since the previous inspection. Regular audits were being carried out but these had not eliminated all errors. Following the inspection the Head of Elder Care for the provider, contacted us to tell us about additional safeguards they had introduced to protect people from any risk.

Where people had been identified as at risk from poor nutrition and/or hydration they were weighed regularly and food and fluid charts were usually kept to record how much they were eating and drinking each day. The charts did not advise staff as to how much people should be consuming. Following the inspection we received a copy of a revised chart which was being introduced which would record this information.

We looked at records for two people who had been admitted to hospital while at Ponsandane. The records showed people's needs had not been responded to in a timely manner.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The actions we have asked the provider to take are detailed at the back of the full version of the report.

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?

The service was not safe. The arrangements for the recording of the administration of medicines were not robust.

Risk assessments were in place to guide staff as to what action they should take to minimise risks.

Requires improvement

Is the service responsive?

The service was not responsive. People's needs were not monitored effectively or responded to in a timely fashion.

People at risk from poor diet had their food intake monitored.

Requires improvement

Ponsandane

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 5 May 2015 and was unannounced. The inspection was carried out by three inspectors.

Before the inspection we reviewed information we held about the home including previous reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with seven people who used the service, three relatives who were visiting on the day of the inspection, a visiting GP, the manager and the provider's Head of Elder Care and fifteen members of staff. We pathway tracked three people who used the service. This means we looked at a variety of records about their individual care and support and spoke with them about the care they received. We also looked at the care documentation for one other person.

Requires improvement

Is the service safe?

Our findings

At our previous inspection in January 2015 we found the administration and recording of medicines was not robust.

At this inspection we observed part of a medicines round. We saw some gaps in the Medicines Administration Records (MAR). For example we saw one person had been prescribed a pain relieving medicine and a drug to control anaemia to be taken in the morning. When we observed the lunch time medicine round we saw these had not been marked as given. The nurse told us the medicines were; "probably not available." Any errors or omissions such as these were recorded in the daily medicines audit folder following each medicines round. The nurse commented; "It's an improvement, it makes you look carefully." We spoke with the clinical lead who told us this was checked monthly for trends by the manager who would then take the appropriate action to address any identified issues. While improvements had been made, in that any errors in the recording of the administration of medicines were reported and recorded quickly, this had not eliminated errors being made.

This was a continuing breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Following the inspection visit the Head of Elder Care told us stricter audits had been put in place to minimise errors. These included the continuation of daily audits of MARS sheets with a further check at each handover. The introduction of a medication communications book to address any issues with the availability of medication and creams. A weekly in depth audit of five randomly selected resident's medication records and a stock check of creams to ensure all prescribed creams were available. This demonstrated the service was working to improve their systems.

Medicines were kept in locked trollies which were attached to the wall on landings. The nurse responsible for the medicines round took medicines for individuals and locked the trolley while they were away. They checked with the person that they were happy to take their medicine and that it was the correct person. Creams and liquid medicines and products such as eye drops had been dated upon opening so the nurse could be assured it was not being used after it's effective use date had been passed. Entries that had been handwritten on the MARs had been double signed; this meant people were protected from risks associated with receiving the wrong medicine. Where the MAR indicated it was appropriate people were offered medicines as required (PRN), such as paracetamol. If they declined this was recorded clearly on the MAR. People told us they received their medicines when they needed them.

At our previous inspection in January 2015 we found risk assessments did not always guide staff as to how they could protect people from risk. Where risks had been identified appropriate actions had not always been carried out to help protect the person from harm. At this inspection we saw new ways of recording identified risk had been introduced. These contained sections on how staff could minimise the risk and what action they could take if this was not effective. Nursing staff had received training on how to complete the new format.

Requires improvement

Is the service responsive?

Our findings

At our previous inspection in January 2015 we found records to monitor changes in people's health needs were not consistently completed. We found the service was in breach of Regulation 9(1)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we saw charts were in people's bedrooms to monitor and record various aspects of their health care. For example we saw turn charts were in place and food and fluid charts were being completed for some people who had been assessed as being at risk due to poor nutrition and/or hydration. However the charts did not give any indication of what the ideal amount to be consumed was for each individual person. Therefore staff would not be able to identify when someone was at increased risk due to poor intake. Following the inspection we received a copy of a revised food and fluid chart which had been introduced at the service. This had a section to record ideal intake and a space to total the amount taken during the day. This meant the risks associated with poor nutrition and hydration were minimised.

One person had been identified as losing weight and therefore needed to be weighed monthly to monitor this. This had been completed; however there were no food charts in place to assess if the person was consuming enough to maintain a healthy weight. We discussed this with the manager and head of care who assured us that they would take immediate action to minimise the risk.

Before our inspection we had received a notification from Ponsandane informing us one person had been admitted to hospital. On their return to the service the following day the hospital had contacted the service to inform them the person had a grade 4 severe pressure sore. During the inspection we looked at the persons care records and spoke with the clinical lead and the manager. The clinical lead assessed the person as having a grade 3 moderate pressure sore. Care records in the person's bedroom showed on the 20 April the person had been examined and found to have no pressure sores. On 30 April they were assessed as having a grade 2 pressure sore, this was also noted on 1 and 2 May, the two latter records were not signed. On the 30 April it was recorded; 'Dressing intact on sacral area'. Up until the day of the inspection this was the only reference we saw to a dressing. On 3 May the person was admitted to hospital. On the 4 May it had been recorded and signed that the person had a grade 2 pressure sore. This was incorrect as the hospital and the clinical lead both agreed it was at least a grade 3. The body map in the records had not been completed to indicate the position of the sore.

We also looked at the records contained in the persons care file in respect of the pressure sore. On the 13 February it stated the person was at; 'mild risk of pressure damage.' On the 23 April, three days after records in the person's room stated they had no pressure sores, they were recorded as having a grade 2 pressure sore and on 3 May it was rated as between grade 2 and 3. The information recorded was not detailed enough to give a clear picture of the development of the sore or how staff had been directed to treat and monitor it. We could not be confident that, had the person not been admitted to hospital, the pressure sore would have been assessed correctly or treated appropriately.

Before the inspection we had received a notification to inform us one person had fallen whilst in their room resulting in a broken hip. We looked at the records relating to this incident. We saw recorded in the person's daily notes that they had been found on their bedroom floor at 8:00am. The member of staff who had found them recorded that they were 'complaining of back and hip pain. Checked over for injury, right leg painful and query slightly turned in. Hoisted off the floor and made comfortable.' At 9:00 am another member of staff had re-assessed the person and called 999. Following this action the person had been taken to hospital. We asked the manager why there had been the delay between finding the resident and calling for an ambulance. They told us the member of staff concerned had not thought the person was in pain. However, this was not consistent with what was recorded in the notes. The person's needs, in terms of their care and treatment, had not been met.

This was a breach of Regulation 13(1)(4)(d)&(6)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people who used the service because the systems for managing medicines were not robust. Regulation 12(1)(2)(g)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who used the service were not protected from abuse and improper treatment because the care and treatment needs of service users had been significantly disregarded which amounted to neglect. Regulation 13(1)(3)(d) & (6)(d)

The enforcement action we took:
We have issued a warning notice