Coate Water Care Company (Church View Nursing Home) Limited

Chapel House Care Centre

Inspection report

Chapel House Care Centre
Horton Road
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Website: www.coatewatercare.co.uk

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service responsive?	Requires Improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8 and 11 November 2014 during which breachs of legal requirements were found. After the comprehensive inspection the provider wrote to us to say what they would do to meet the legal requirements.

We undertook a focused inspection on 17 February 2015 inspection to check that the provider had met one of the legal requirements. This report only covers our findings in relation to the legal requirement: the registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe.

We told the provider they had to meet this requirement by 1 January 2015. This inspection found the provider had not fully met this requirement. However, we also found that some improvements to people's care had taken place.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chapel House Care Centre on our website at www.cqc.org.uk'

Chapel House Care Centre provides care and support for up to 41 people with physical health needs and people who live with dementia. At the time of this inspection 13 people were living in the home.

Summary of findings

The home has a manager who is not yet registered. 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.

People's welfare and rights were not protected in November 2014 and they were not always receiving the care they required. Equipment was in use without an assessment having been completed for its safe use. People's rights had not been upheld and equipment which could restrict people's freedom was in use without people's consent.

At the focused inspection on 17 February 2015 some improvements had been made since November 2014 to ensure people's welfare and rights. Assessments for the safe use of equipment had been completed. In some cases alternative measures had been introduced, for example, the bed rails removed from the bed and other safety measures adopted. However, we found an example of equipment in use without an appropriate assessment having been completed. The person's consent for its use had also not been obtained. This meant there was still potential for people to be harmed from equipment and, restricted through its use without their consent.

Some people had been at risk of developing pressure ulcers and their care had not been planned appropriately to reduce this risk. During this focused inspection we were told people were receiving care to prevent pressure ulcers developing. This included repositioning people to relieve pressure from their skin. We saw relevant care plans in place which guided staff on how frequently this should be done. However, staff were not recording when people received this care, although the home manager confirmed that none of the people using the service had pressure ulcers.

People's care needs had not always been assessed appropriately. During this focused inspection one area of a person's health had still not been assessed by an appropriate health care specialist.

People had not been protected against the inappropriate use of medicines because staff had lacked guidance on the use of some prescribed medicines. During this focused inspection this was still the case in relation to one particular medicine. There was no evidence of a protocol to guide staff in relation to when to administer this medicine. This meant people were not fully protected against its potential inappropriate use.

This was a continuing breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The evidence was gathered prior to 1 April 2015 when the Health and Social Care 2008 (Regulated Activities) Regulations 2010 were in force. These breaches now correspond to breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take 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 fully safe. There were better systems in place for ensuring some people's safety. Although, risk assessments for the use of equipment were still not fully in place.

People were at risk of receiving 'as required' medicines inappropriately due to a lack of guidance for staff.

Inadequate

Is the service effective?

The service was not fully effective. People's rights under the Mental Capacity Act 2005 were not always protected.

Requires Improvement

Is the service responsive?

The service was not fully responsive. People's needs were not always assessed by an appropriate person to ensure the care they delivered was correct.

There were more robust assessments of care and treatment needs as well as care plans.

Requires Improvement

Chapel House Care Centre

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.

The inspection took place on 17 February 2015 and was unannounced. This inspection was a planned focused inspection to follow up whether the provider is meeting one of the legal requirements and regulations associated with the Health and Social Care Act 2008.

One inspector carried out this inspection. Prior to the inspection the actions the provider told us they would take to address this requirement were reviewed. Information sent to us from the care home, about significant events, were also reviewed. We sought an update on some people's care from one health care professional who visited the home. During the inspection we reviewed the records of three people who we reviewed and spoke with in November 2014. We spoke with two of these people and one of their relative's. We spoke with two members of staff who look after these people as well as the home manager and a representative of the provider. We reviewed two people's medicine administration records, one medicine audit and records recording health professionals' visits.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection in November 2014 bed rails were in use without completed assessments for their safe use in relation to the person they were being used for. In one person's case, where an assessment had not been carried out, bed rails had proved not to be safe when the person subsequently injured themselves.

During this focused inspection the systems for ensuring people's safety when in bed had generally improved. In some cases bed rails had been assessed as not required or they had been found to be inappropriate and were not in use. People were now kept safe through alternative and less restrictive measures. For example, their bed was lowered to its lowest setting and padded mats placed on the floor to prevent injury, if, the person were to roll off their bed.

Instructions in one person's case directed staff not to have bed rails in the upright position. However, when we visited the person in their bed, one bed rail was in the upright position. Staff confirmed that this was always the case. Staff could not explain the discrepancy between the instruction and the upright bed rail. The home manager confirmed that the bed rail should not have been in the upright position. There were additional safety measures in place, for example the bed was in its lowest position and padded mats were on the floor. However, there was no risk assessment for the use of the one bed rail.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (now Regulation 12(1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

At our comprehensive inspection in November 2014 people were not protected against the risks of inappropriate use of medicines and medicine errors. During this focused inspection systems were still not robust enough to protect people from these risks. For example, medicine for one person, prescribed to be used 'as required' had been identified in November 2014 as having no protocol or guidance for staff to follow. This meant this medicine could be used at the staffs' discretion but without clear guidance in place saying when and under what circumstances they should administer it. At the focused inspection this situation was unchanged. There was therefore a risk that this person could be given this medicine inappropriately. One recorded reason for administering this medicine stated that the person was "very anxious, wanting to go downstairs, getting out of bed". However, there was no record of what actions staff took before they administered this medicine, to address this person's wishes and anxiety using a least restrictive method. In this case, a bed rail had been removed but another form of restriction had been used without explanation.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (now Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

At the comprehensive inspection in November 2014 people who were at risk of developing pressure ulcers did not have their levels of risk assessed or care planned to reduce this risk. During this focused inspection people's levels of risk had been assessed and their care records gave staff guidance on how frequently they should be repositioned to avoid pressure damage to their skin. One person's care plan said they had to be repositioned every four hours. The home manager confirmed that no-one had pressure ulcers but, there was no record that this person was being repositioned every four hours.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (now Regulation 17(1) and (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Requires Improvement

Is the service effective?

Our findings

People looked cared for and one person said "I am happy with my care." A relative told us they remained satisfied with their relative's care.

At the comprehensive inspection in November 2014 equipment was in use for some people, without their consent and for others, who lacked mental capacity, without a recorded best interests decision. At our focused inspection there was evidence that consent had still not been obtained from one person in relation to the use of equipment that may restrict their freedom.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (now Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Requires Improvement

Is the service responsive?

Our findings

People had not had their needs appropriately assessed when we visited in November 2014. When health care professionals visited to carry out assessments or reviews their visit and advice had not been recorded. This had subsequently led to people not receiving appropriate care and treatment. At the focused inspection various assessments had been completed. In addition to bed rail assessments, people for example, had been more consistently assessed in relation to the risk of falls and weight loss. This had led to better care planning and care delivery. Reviews and assessments carried out by health care professionals had been recorded.

We reviewed the care of one person who had originally been assessed by a health care specialist and where instructions had been given in relation to the person's diet. At the comprehensive inspection in November 2014 we were told that a qualified nurse had carried out their own assessment and determined that the specialist's instructions were no longer needed. However, during this focused inspection we were told about an incident which demonstrated that a review, or advice, was required from the health care specialist but this had not been sought. People's needs were not always being reassessed by the most appropriate person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (now Regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered persons had not taken proper steps to ensure that each person was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of – Carrying out an assessment of needs and planning and delivering, or where appropriate treatment, that – met people's individual needs, ensured their welfare and safety, reflected good practice and avoided unlawful discrimination, including, where applicable, making reasonable adjustments in service provision to meet people's individual needs. Regulation 9 (1)(a)(b)(i)(ii)(iii)(iv). The above breach corresponds to a breach in regulations 12(1) and (2)(a) and (2)(g), 17(1) and (2)(c), 11(1), 9(3)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
A Warning Notice was repeated. The provider must meet this by 1 April 2015.