Mr J R Anson & Mrs M A Anson

# Tremethick House

## Inspection report

Meadowside
Redruth
Cornwall
TR15 3AL

Tel: 01209215713
Website: www.anson-care-services.co.uk

Date of inspection visit:
06 September 2016

Date of publication:
29 September 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

We carried out an unannounced focused inspection at Tremethick House on 6 September 2016. The previous unannounced comprehensive inspection carried out on 31 March 2016 found a breach of the regulations. We were concerned records held at the service were not always accurate or maintained regularly. Staff did not always record details of care provided to people living at the service each day. Some records were inaccurate. Where staff had identified when people had lost weight, this was not reported and advice was not sought to address the issue. Risk assessments were not always reviewed and updated in a timely manner. Care plans did not always contain sufficient guidance and accurate information for staff about people's care needs. The records relating to medicines that required stricter controls held at the service, were not entirely accurate. Some policies required updating and staff were not regularly provided with supervision. During the last inspection visit some staff passed clothes protectors over people's heads and over their clothes without telling them what they were going to do or seeking permission first. Many bedroom doors were open throughout the day of the inspection when people were sleeping in their rooms. This did not respect people's privacy and dignity.

Following the inspection of 31 March 2016 the provider sent us an action plan setting out the steps the service was taking to address these concerns. We carried out this focused inspection visit to check they had followed their action plan and confirm if they now met the legal requirements.

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 Tremethick House on our website at www.cqc.org.uk

Tremethick House is a residential care home for up to 42 older people. At the time of this focussed inspection visit there were 40 people living at the service, some people were living with dementia.

There was a registered manager in post. 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.

Tremethick House had installed an electronic records system since the last inspection, which had been fully implemented in June 2016 following a period of transition and training for staff and management.

At this inspection we found care plans were regularly reviewed and contained sufficient information to guide staff to meet people's individual needs. However, risk assessments were not always reviewed regularly. Some risk assessments had not been reviewed since April 2016. The registered manager assured us that the new electronic system would be set up to ensure that such risk assessments were all updated when each care plan was reviewed. Some guidance in people's care plans was not always followed by care staff. For example, regular re-positioning was required every 2 hours for some people who were cared for in bed. Staff

did not always record this in a timely manner and gaps of up to 8 hours were seen when there was no record of the person being re-positioned. We were able to establish that there had been no impact on the person's wellbeing due to this gap in recording and that care had been provided but not recorded.

The action plan sent to CQC by the provider stated that a key worker system was in place to help improve documentation and communication. This had not yet taken place.

The Deprivation of Liberty Safeguards policy continued to require to be updated to take account of changes that had taken place to the legislation. The safeguarding procedures in the county had changed recently and this was not reflected in the procedure available for staff. The registered manager and quality assurance manager assured us this would be actioned immediately.

The service has a responsibility to display the latest CQC report showing the rating given to the service. The most recent report was not clearly displayed to the public, with only a summary sheet available in the registered managers office. The service's website did not contain a link to the latest CQC report. We were assured that the service was about the launch a new website and that this would include such a link. The service had not sent a notification to the CQC of a death which had occurred at the service. A notification is information about important events which the service is required to send us by law.

Staff had improved their recording when they had provided care and support to individuals. Where people had been assessed as needing to have their weight monitored regularly we found this was being done and regularly monitored by the registered manager. Actions were taken to address any concerns. People who required regular input from the district nursing service had details of their nurses visits recorded in a new communication book. This meant it was possible to evidence when each person had received such support.

Staff were observed seeking people's agreement to having a clothes protector placed over their clothes during meals if they wished. People were provided with choices and this was respected. People's care records detailed if they wished to have their bedroom doors open at all times or preferred to have them closed to protect their privacy.

Audits of pressure relieving mattresses and medicines held by the service were being carried out regularly and were effective in identifying if any issues needed addressing.

At this focused inspection the registered provider had met the requirements of the regulations. However, we could not improve the rating for Responsive and Well-Led from Requires Improvement because to do so required consistent good practice over time. We will check this during our next planned comprehensive inspection.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service responsive?

**Requires Improvement**

The service was responsive. People received personalised care and support which was responsive to their changing needs. Although some risk assessments had not always been reviewed regularly.

Care plans provided information to guide and direct staff to meet people's individual needs.

People were able to make choices and had control over the care and support they received.

### Is the service well-led?

**Requires Improvement**

The service was well-led. There were systems in place to monitor the service provided. Although, some systems, policies and procedures still required further improvement.

Audits were being carried out to monitor the service provided. However, some issues found at this inspection had not been identified through such audits.

Staff were supported by the management team.

# Tremethick 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.

We carried out an announced focused inspection of Tremethick House on 6 September 2016. This inspection was completed to check that improvements had been made to meet legal requirements after our comprehensive inspection on 31 March 2016. We inspected the service against two of the five questions we ask about services; is the service responsive and well-led? This is because the previous concerns were in relation to these questions.

The inspection was carried out by one adult social care inspector. Before our inspection we reviewed the information we held about the home. This included the information from the service regarding what steps they would take to meet the legal requirements.

We looked at care documentation for four people living at Tremethick House, medicines records and other records relating to the management of the service.

We spoke to the registered manager, the quality assurance manager, five people who lived at the service and two staff.

Requires Improvement

# Is the service responsive?

## Our findings

At the inspection visit on 31 March 2016 we found there were gaps in people's care records when no care and support had been recorded by staff. These varied between three and seven days. Staff did not always record when they re-positioned people. This meant there were not records to help ensure people always receive the care they required to meet their needs. Care plans did not always contain sufficient information and guidance for staff to meet people's individual needs. Some records were inaccurate. For example, weight recordings did not always show accurate calculations when a person had lost weight. Records did not demonstrate what action had been taken to address any concerns. Records relating to the management of medicines that required stricter control were not entirely accurate.

At the last inspection visit some people were having dressings applied by the district nurses who visited the service regularly. Care plans did not clearly indicate what care was needed and when visits were carried out by the nurses. This meant that staff were not informed about people's dressing requirements

During the last inspection visit some staff passed clothes protectors over people's heads and over their clothes without telling them what they were going to do or seeking permission first. Many bedroom doors were open throughout the day of the inspection when people were sleeping in their rooms. This did not respect people's privacy and dignity.

At this inspection visit we found the service had installed an electronic records system. This had become fully implemented in June 2016 following a transitional period during which staff and management had training in its use. Staff now recorded care and support provided on to computer screens provided throughout the service and smaller hand held devices. Staff had improved their recording of care and support provided since the last inspection. Daily progress notes were made by all staff. Care plans contained appropriate information for staff to provide personalised care to people. However, some guidance was not always followed. For example, one care plan directed staff to re-position a person every 2 hours. We found this person was being re-postioned but it was only being recorded between 3 and 8 hourly. We were able to establish there had been no impact of the person's wellbeing due to this gap in recording and that care had been provided but not recorded.

Care plans were being regularly reviewed. However, risk assessments were not always routinely reviewed at the same time. Some risk assessments had not been reviewed since April 2016 when first put on to the new electronic system. The registered manager assured us that the electronic system would be set up to prompt staff to review risk assessments when updating care plans. Risk assessments were reviewed if there had been a change in a person's needs.

Where people had been assessed as requiring to have their food and drink intake monitored, we found this was being recorded by staff. However, there were some gaps of evening meals which were not always recorded on some files. People who were having their weight monitored had regular recordings on their care files. If a weight loss had been noticed this was reviewed by the registered manager and action was taken, such as repeated check weights or referral to a dietician or GP for support.

A new communication book had been set up for district nurses to record when they provided care for people living at Tremethick House. The booked helped ensure all staff were able to see when the nurse had visited and what the outcome of the visit was. This helped to inform any updating of care plans.

We observed lunch being served to people in the dining room. People we spoke with were very complementary about the food and told us they were able to choose what they wanted to eat and drink. Staff asked people what they would like to drink and if they would like any assistance with their meals. Clothing protectors were offered to people and they were asked if they would like to have one put on. People's dignity and choices were respected by staff.

People told us they were provided with care and support that met their needs, and that staff responded quickly when they required assistance.

We reviewed the records held for medicines held by the service, that required stricter controls. The records tallied with the stock held.

Requires Improvement

# Is the service well-led?

## Our findings

At the inspection of 31 March 2016 we found the service remained in breach of the regulations regarding the management of records. The action plan had not been fully carried out. Staff supervision and appraisal was not consistently provided, recorded and monitored by the registered manager. Policies had been reviewed but did not always take account of changes to the legislation and local procedures which had changed. For example, the safeguarding adults process and the criteria for when a person should be considered for a potential deprivation of liberty under the Mental Capacity Act 2005.

At the last inspection we found audits carried out at the service were not always effective. This meant that issues found at inspections were not always identified and improvements were not always made. Records held at the service were not adequately monitored and managed. This meant people's care and support was not always appropriately assessed, monitored and managed safely.

At this inspection visit regular audits were being carried out. For example, pressure relieving mattresses were checked daily to help ensure they were operating correctly related to the weight of the person using the mattress. Accidents and incidents were being audited monthly by the registered manager.

An external pharmacist had carried out a medicine audit at the service in July 2016 and the actions required from that audit had been actioned by the service. Internal medicine audits were also being carried out regularly. Records relating to medicines that required stricter controls tallied with the stock held at the service. However, some concerns identified at this inspection had not been identified by such audits. For example, prescribed creams and liquids were not always dated upon opening. This meant staff were not advised when the item would not longer be safe to use and need to be disposed of and replaced.

Supervisions were being provided more regularly to most staff. However, two night staff had not received any supervision since the last inspection. No appraisals were being provided to any staff. The registered manager assured us this would be addressed immediately. Staff meetings were being held regularly and group supervisions were being provided to address specific subjects such as documentation.

The deprivation of liberty safeguards policy remained inaccurate as found at the last inspection. It did not reflect the legal changes in the criteria for when a person should be considered for an authorised deprivation of their liberty. The safeguarding process in the county had recently changed. The quality assurance manager had attended a presentation on this change. The service had not amended its process and procedure to take account of this change. This meant staff were not provided with accurate current guidance on their practice. The quality assurance manager assured us this would be addressed immediately.

The action plan sent to the Care Quality Commisision in May 2016 stated that a key worker system would be in place by the end of June 2016 to allocate each person living at the service with a named member of staff. This was to, 'ensure continuous monitoring and ensure person centred care at all times.' This system had not yet been put in place. The action plan also stated that re-positioning charts in people's bedrooms were,

'being audited by a senior member of staff on a regular basis.' There was no recorded evidence of this taking place. The registered manager told us it was done but not recorded. The gaps in the re-postiioning charts found at this inspection had not been identified by the service prior to this inspection. This meant that the audit process was not entirely effective and robust in identifying concerns.

The service has a responsibility to display the latest CQC report showing the rating given to the service. The most recent report was not clearly displayed to the public. There was a summary sheet available in the registered managers office. The service's website did not contain a link to the latest CQC report. We were assured that the service was about the launch a new website and that this would include such a link. The service had not sent a notification to the CQC of a death which had occurred at the service. A notification is information about important events which the service is required to send us by law. The registered manager assured us this would be done immediately.

A survey of people's views and experiences had been carried out and responses were in the process of being collated and responded to.

The service had improved its recording of care and support provided to people living at Tremethick House. However, we identified issues which the service required to improve further. The registered manager and the quality assurance manager were working together to further improve the records held at the service and told us it was, "Work in progress."