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Canwick House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service effective?	**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 comprehensive inspection of this service on 2 September 2016. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Canwick House Care Home on our website at www.cqc.org.uk.

This inspection took place on 7 February 2017 and was unannounced. Canwick House provides care for older people who have mental and physical health needs including people living with dementia. It provides accommodation for up to 22 people who require personal and nursing care. At the time of our inspection there were 18 people living at the home.

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. However on the day of our inspection they were unavailable and the provider was unable to tell us when they would be available.

At this inspection we found that the provider had failed to ensure that previous improvements had been sustained. We found that there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of this report.

The provider did not always act in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find.

Records were not accurate. Care plans were not updated consistently and did not reflect the care people required. Five people who were at the home for a short period of time did not have care plans or completed assessments.

Medicine records were inaccurate and not completed consistently.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not act in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Staff had not received training about the Mental Capacity Act 2005 and were unaware of the implications on care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records did not reflect the care people required. Care records were incomplete and inconsistent

Care records had not been completed for people who were staying at the home on a short term basis.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider was not complying with their condition of registration.

The provider had failed to inform us of the registered managers absence from the service.

Systems for checking care records were not effective.

The most recent inspection report was not on display or available in the home.

Canwick House Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Canwick House on 7 February 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 2 September 2016 had been made. The service was inspected against two of the five questions we ask about services: is the service effective and is the service responsive? This is because at our previous inspection we found the service was not meeting some legal requirements. However at this inspection we also found concerns relating to: is the service well led? The details of our findings are included in the report. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

The inspection was completed by an inspector. During our inspection we observed care in the home and spoke with the acting manager and a member of care staff. We spoke with one person who used the service. We also spoke with the provider by telephone. We looked at ten people's care plans and records of audits and medicines.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection on 9 September 2016 we found the registered provider did not act consistently in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At this inspection we found that improvements had not been made.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find. At the time of our inspection it was not clear whether or not people were subject to DoLS authorisations. DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. We observed it was not clear from the records when applications for DoLS had been made and whether or not they had been accepted. For example a request for an urgent authorisation had been made and recorded as being implemented however there was no supporting paperwork to confirm this. When we spoke with the acting manager they were unable to clarify the situation. In addition they were unaware where relevant paperwork was stored.

People were at risk of having decisions made for them unlawfully. At our previous inspection we identified best interests decision had not been made where people required specific equipment such as bed rails to keep them safe. At this inspection we found best interests decisions were in place for bed rails. However, best interests decisions had not been put in place for other equipment such as pressure mats to ensure that staff were providing care in the person's best interest. Additionally five people who were staying at the home on a short term basis had not had best interests assessments carried out. There was a risk decisions were not being made in their best interests.

Two of the people whose care records we looked at had do not attempt cardio pulmonary resuscitation (DNACPR) orders in place. However in one of the records the order stated that the decision had been discussed with the person although their care record stated they did not have the capacity to make complex decisions and an application for a DoLS had been made. Another person who had a DNACPR in place had capacity to make decisions however the DNACPR did not recognise this and had not been discussed with the person. There was a risk that treatment would be denied to the person against their wishes. Additionally best interests decisions were not in place for DNACPR decisions. People were at risk of having decisions made on their behalf which may not have been in their best interests.

We spoke with a member of staff about the MCA. They told us they had not received any training and were unclear about the implications of the act. We saw from the training matrix that the majority of staff had not

received specific training about MCA and DoLS.

We looked at people's records and saw records included consent to treatment forms. However we observed that these were not always fully completed. Where people were unable to consent this was not clearly detailed in the care records or detailed what support people required and why. For example a person who used bedrails to keep them safe did not have a consent form in place.

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

We observed that people were asked for their consent before care was provided. Staff were able to tell us what they would do if people refused care and we observed staff responding to people when they refused care.

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection we found that care records were not updated and did not reflect the care people required. People were at risk of receiving care that did not meet their needs.

At this inspection we looked at care records for 14 people who lived at the home. Care plans had been reviewed but they had not always been updated. For example, one person used a piece of equipment to assist them to move but the care record had not been amended to reflect this. There was a risk the person would be supported to move inappropriately.

We saw that body charts had not been consistently completed where people had ongoing skin care issues and required the application of creams to maintain their skin. In addition when people had patches applied records were not consistently maintained to ensure that the patches were applied to different parts of the body in line with the manufacture's guidance. this is important to maintain skin integrity and ensure the medicines work effectively.

We looked at medicine administration records for eight people. In all of the records we observed that care plans were not in place for 'as required' (PRN) medicines to indicate when people required these medicines. For example a person was prescribed an inhaler for asthma and required support to administer this. However, it was not clear from the records what support they required and when. People were at risk of not receiving the care they required because care records did not specify people's needs.

Records did not consistently record people's allergies. We saw in three care records the allergies recorded did not match those recorded on the medicine administration record sheets (MARS). People were at risk of receiving medicines they were allergic to.

This was a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed care plans and risk assessments were incomplete. For example one person required support with moving and neither an assessment or care plan were in place to explain to staff how to support the person safely. This person also required support to prevent sores developing on their skin and had a sore which required dressing. However, the assessment to assess skin integrity had not been completed since December 2016. Additionally a nutritional risk assessment had not been completed despite nutritional needs being important in the management of skin integrity. There was a risk the person would not receive appropriate care to maintain their wellbeing.

In addition five people who were staying at the home on a short term basis did not have any completed documentation to assess whether or not the home could meet their needs. In all five of the care records the pre-assessment documentation had not been completed. It was unclear from the records how the registered manager had made the decision that the home could meet people's needs because there was insufficient information available about their care needs. In addition care plans and risk assessments had

not been completed. It was unclear from the records how they required staff to care for them in order to meet their needs. We were unable to discuss this with the registered manager because they were unavailable at the time of our inspection. Despite two of the people being admitted following falls, risk assessments had not been completed to ensure they were cared for safely. Where people had specific needs such as a visual impairment or used a catheter it was not clear from the records how this impacted on their life and how staff should respond to their needs. Care plans were not personalised and did not include people's likes and dislikes.

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

The acting manager and provider informed us that they were working on implementing a new care planning process and format which would improve the quality of documentation.

Requires Improvement

Is the service well-led?

Our findings

Effective systems and processes were not in place to ensure the quality of service was maintained and improved. For example we found gaps in care records and MARs, however these issues had not been identified and addressed as part of the regular checks the provider had in place.

At our inspection on 2 September 2016 we found there were inadequate systems in place to ensure that the service was well-led. We found shortfalls in records relating to the care of people. At this inspection we found progress had not been made owing to the lack of oversight and effective audit. People were at risk of receiving inappropriate care because records did not reflect the care which they required.

The provider did not have arrangements in place to ensure that the regulated activity was being carried out in a manner which met the regulations. In addition as part of their condition of registration the provider was required to have a registered manager at the home managing the day to day arrangements of care. On the day of our inspection we found the registered manager was absent from the building and the acting manager and the provider were unclear about when they would return if at all. This meant the registered manager was no longer available to manage the service. The registered manager is the 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.

There was a breach of regulation17 (1)(2)(a)(b) Care Quality Commission (Registration) Regulations 2009 (part 4).

The provider had failed to inform us of the absence of the registered manager as part of the notification arrangements with CQC. Notifications are events which have happened in the service that the provider is required by law to tell us about. There was a breach of regulation 14(1) (b) (2) Care Quality Commission (Registration) Regulations 2009 (part 4).

On the day of our inspection a sign detailing the most recent CQC rating was not on display. The acting manager was unable to locate a copy of the report published following our inspection in September 2016 and told us that they had not been informed of the content.

There was a breach of Regulation 20A (3) 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	Regulation 14 Registration Regulations 2009 Notifications – notices of absence The provider had failed to inform us of the absence of the registered manager

The enforcement action we took:

NOP to suspend admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not act consistently in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). It was not clear from the records whether or not people had capacity. Best interests assessments had not been consistently completed.

The enforcement action we took:

An NOP to suspend admissions was served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment care plans did not reflect the care people required. there were gaps and inconsistencies in care plans. Pre admission assessments and risk assessments had not been completed.

The enforcement action we took:

NOP to suspend admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Documentation was not complete. Systems and processes were not effective in identifying gaps in

documentation and improving the quality of care.

The enforcement action we took:

NOP to suspend admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display and make available the most recent CQC inspection report.

The enforcement action we took:

NOP to suspend admissions