Croftwood Care (Cheshire) Limited

Turnpike Court Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 26 July 2017 and was unannounced, which means the provider did not know we were coming. We found the service required improvement with three breaches of the Health and Social Care Act (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.

Turnpike Court Residential Care Home provides personal care and accommodation for up to 30 older people, some of whom may be living with dementia. There were 26 people who were living at the home on the day of our visit.

There was a registered manager in place at the time of our inspection visit; however the registered manager was not available on the day of our inspection visit. A registered manager from the providers other service came to support the inspection visit. We spoke with the registered manager on the telephone on the 1 August 2017. 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 recognised signs of abuse and knew how to report this. Risk assessments were not always completed properly, which meant that actions needed to keep people safe and minimise risks were not always identified and acted upon. People felt that more staff were needed to meet their needs, we found that while this was the case, there were enough staff on duty to keep people safe.

Staff supported people with their consent and agreement. Staff understood and recognised the importance of this. We found people were supported to eat a healthy balanced diet and with enough fluids to keep them healthy. We found that people had access to healthcare professionals, such as their doctor when they required them.

People told us that staff treated them kindly and respected their privacy. However we saw an example where a person was not treated with dignity. People told us that their wishes were not always met as staff did not have the time to devote to them.

People did not always receive care that was responsive to their individual needs as people had to wait for staff to become available to support them. Where people had specific individual needs, staff had not always recognised this to ensure their care reflected their personal preferences.

Information on how to raise complaints was provided to people, and people knew how to make a complaint if they needed to. We looked at the providers complaints over the last eight months and found that two complaints had been received and responded to with satisfactory outcomes.

People did not always feel included and listened to in the way the service was run. There were not effective systems in place to ensure the risks to people were being managed safely. Whilst the provider had identified areas for improvement around risk management, the registered manager had not learnt from this to improve practice, so people received consistently safe care.

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.

Identified risks to people were not always managed or responded to. Whilst staffing levels did not meet people's needs in a timely way, there were enough staff on duty to keep people safe. Staff recognised signs of abuse and how to report this. People received their medicines as required.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the right skills to meet their personal care needs. People received care that they had consented to, and staff understood the importance of this. People had access to healthcare professionals when they required these.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always consistently treated with dignity. The service met the needs of the staffing levels and not the individual needs of the people who lived in the home. People felt most staff were kind and caring towards them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had to wait for staff to become available before they could be supported with their individual needs. Staff had not always identified people's individual needs and wishes, and because of this people's preferences were not being met. People did not always have the opportunity to take part in interests and hobbies they enjoyed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People were not always listened to about the way the service was run. The registered manager's checks did not always identify areas that required improvement. Where the registered manager had identified which staff required support, they had not ensured staff received this.
The provider had completed checks which looked at the experience of people living in the home, where the provider had identified areas of risk to people needed further management, the registered manager had not shown they had learnt from this to improve practice.
Records for people's care were not always clear, complete or accurate.

Turnpike Court Residential Care Home

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 26 July 2017 and was unannounced, the registered manager was not available at our inspection so we spoke with them on the telephone on 1 August 2017 to gather further information. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also spoke with the local authority about information they held about the provider.

We spoke with ten people who used the service and one relative. We spoke with three care staff and one domestic staff. We also spoke with the home service manager, a registered manager from the provider's sister home who supported staff during the inspection, and the registered manager via telephone.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a sample of people's care records and medication records. We also looked at provider audits, complaints and compliments and incident and accident audit.

Requires Improvement

Is the service safe?

Our findings

We looked at how people's individual risks had been assessed in a way that protected them from harm whilst promoting their independence. Our findings showed people's risk of harm was not always managed in a consistent way, to ensure they were kept safe from injury. For example, we looked at one person's care record to see how their care was managed in a way to help reduce the risk of them falling and coming to further harm following a serious injury which had resulted in hospital admission in December 2016.

The care records for this person showed a decision was made in February 2017 by an external health care professional visit that the person was to be supported by two care staff member with the use of a hoist. We spoke with staff to understand if this was still happening. Three care staff told us the person was supported with one staff member to mobilise from their chair to bed or to the toilet. Staff told us that the person's ability to hold their own weight varied. They told us that if they thought the person was unsafe and could not support their own weight, they called for further staff support. When we looked at when and why the decision had been made to stop using the hoist, the records were not clear when and for what reason this decision was made. The mobility assessment tools that had been used had not taken into consider the person's previous falls, current mobility needs and underlying health conditions, which could have a potential significant impact to the person if they had a further fall. We could see from in accident form in the person's care record the person had been assisted by a staff member and had fallen when being assisted onto the toilet in April 2017. This had resulted in an ambulance being called and a minor injury being sustained. This further fall had not been considered at the time it had happened of when the person's mobility support needs were reviewed.

The supporting manager raised their concerns with staff about the person's safety if mobilising with one staff member. After they had reviewed the risk assessment and watched how staff demonstrated the support to assist the person with their mobility, they requested that two staff should support the person. After our visit we spoke with the registered manager about our concerns for the safety of this person. They told us they were unaware of the person's fall in April 2017, and told us the person had also had a further two falls with staff supporting them in June 2017. The registered manager agreed that the assessment tool did not reflect the previous falls, injuries and underlying healthcare conditions. Therefore they could not be assured the person was receiving safe care and was being protected from harm and the risk of further potential injury. The lack of appropriate risk assessment to the person's mobility needs had put the person at potential risk of further harm.

We spent time in the communal areas of the home to understand how staff supported to stay safe. We found that staff did not always identify and respond to potential risk. We saw one person walking with the use of a frame and slippers which were too large for their feet causing the slipper to catch under their heels. We raised this with staff, as we were concerned about the person's safety. A staff member told us the person preferred slippers that were too large for them, however when a further staff member saw the slippers were inappropriate they assisted the person to change their footwear into better fitted shoes. We spoke with the person following this who was happy with their shoes they were now wearing.

We found at inspection the safe handling of medicines was not always consistent. We observed the staff member who was giving the medicine to people did not always have the medicine trolley in their view and had left the doors open, with medicines also on top of the trolley. The supporting manager identified this and reminded the staff member of the risks with leaving the trolley open and unattended.

All of the above information demonstrates there was a breach in regulation which was Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Safe care and treatment.

People we spoke with told us they felt staff supported them in a way which kept them safe. One person told us, "You're safe. Carers are always here." A relative we spoke with felt their family member was safe living in the home as when they needed further medical input staff had sought this promptly.

We spoke with staff about how they protected people from harm, they showed a good awareness of how they would protect people. Staff were aware of different types of abuse and what action they would take if needed. We found the registered manager had a good awareness of the safeguarding procedures and where they had identified potential safeguarding concerns had worked with the local authority to ensure people were kept safe.

We received a mixed response from people about staffing levels in the home. Six people we spoke with did not raise any concerns about staffing levels, however five people we spoke with did. These people felt the staff levels supported them to stay safe. We spoke with staff who told us they had busy periods of time but felt they were able to keep people safe with the staffing levels that were in place. Staff were able to tell us about people's usual routines and how they knew people well to know when they would need support.

All people we spoke with did not raise any concerns about how their medication was managed. One person told us the staff were, "very particular about checking" their medicines. We spoke with a staff member who administered medication. They had a good understanding about the medication they gave people and the possible side effects. The supporting registered manager told us a medication error had been reported to them. We saw that staff had sought guidance from the person's doctor who confirmed the person would not come to any harm. The supporting registered manager showed us how they followed the provider's procedure to ensure the medication error was investigated with action taken where necessary.

Good

Is the service effective?

Our findings

People we spoke with felt staff who cared for them knew how to look after them well and in the right way. One person said, "They are pretty good actually". A further person told us how they felt confident that staff were able to support them with their specific care and treatment. Relatives we spoke with told us that staff were good and had no concerns. One relative who we spoke with told us staff had supported their family member with their anxiety. They continued to say staff were aware of the person's health conditions and were meeting their needs.

Staff told us the training they had was appropriate to the people they cared for, such as continence care and medication training. Staff told us they had the opportunity to develop their learning. One staff member told us they felt supported in their role to be able to provide care to people in the right way. When we spoke with staff it was clear they knew people and their needs well. This understanding meant they provided people with care that was in-line with best practice for the person's health condition. Staff told us that they worked together as a team and that communication on all levels was good. All staff we spoke with told us they knew where they were expected to work within the home and received detailed handover from the previous staff on shift.

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.

People we spoke with told us that staff sought their agreement before carrying out any personal care and staff respected their wishes. One person told us "You get a choice". While a further person told us staff respected their wishes to remain in their room. Staff we spoke with understood their roles and responsibilities in regards to gaining consent and what this meant or how it affected the way the person was to be cared for. Staff told us that the person had wished to remain in bed, we saw they respected this and told us they would ask them later if they were ready to get up. We saw that people's capacity had been considered when consent was needed or when risk assessments were carried out. Where one person lacked capacity we saw the family had been involved around decision making for the person's care. We found the provider ensured people received care and treatment with their consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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.

The supporting manager was unable to advise us which person's living in the home had a DoL in place so we could understand how this affected the person's care. Staff were aware who had a DoL in place and how this affected their care. We had seen that the registered manager had applied for one person was receiving

restrictive care and had worked with the local authority for the correct authorisation for this person so they were being restricted lawfully.

People who we spoke with told us they enjoyed the food at the home. One person said, "The food is good and you get a choice". Another person said, "The food is wonderful with a roast every day and I get a choice". People told us staff ensured they had enough to eat and if they were happy with their meal. A relative told us, "The food is very good, always enough, and they come round with lollies and ice-creams on hot days".

We saw people were offered hot and cold drinks throughout the day and staff ensured people had drinks to hand. People confirmed staff offered them enough to drink throughout the day. We spoke with staff about what steps they took to ensure people received adequate fluids. Staff knew who was at risk of de-hydration and the importance of recording how much fluid people had drank. A staff member told us it was so that checks could be made to ensure people were drinking enough fluids to keep them healthy.

People we spoke with told us they had access to healthcare professionals when they needed to and that visits were arranged in a timely manner when they requested these. One person we spoke with said, "I see my doctor when I need to". Another person told us that when they had become ill, staff had contacted the doctor who prescribed them medication. They told us that staff were aware of this and provided them the medicine.

A relative told us that staff always informed them if their family member had become unwell and needed the doctor or hospital treatment. One relative told us when their family member's health had declined and staff had contacted the doctor. Staff knew people well and told us they recognised when a person became unwell and would contact the relevant health care professional where necessary. For example, where one person mood had become low staff had arranged a doctor's appointment. A staff member told us they had continued monitoring the person to see if the medication was working and would contact the person's doctor again if necessary.

Requires Improvement

Is the service caring?

Our findings

During our inspection we saw one person was not supported in a caring or dignified way. We heard a care staff member ask an activities staff member to, "Put [the person] in the bathroom". And told the activities co-ordinator they were going to support another person first. After five minutes, we went to check to see if the staff member had attended to the person. We found the person was asleep in the bathroom in their wheelchair. We notified the supporting manager about what we had seen. They sat in the bathroom with the person to ensure the person was safe as they did not have a call bell to hand, until a staff member arrived. After a further 10 minutes the supporting manager sought staff assistance for the person. After a further five minutes the staff member that had asked the person to be "put in the bathroom" arrived. Which had meant the staff member had left the person in the bathroom for 20 minutes before they had arrived to support them. After 10 minutes the staff member walked through the dining area and announced loudly to the senior carer "I've just been airing [the person]". The senior staff member did not raise this with the staff member as being inappropriate and undignified. We discussed this with the registered manager after our visit, who told us they would speak with the staff member involved.

We had seen however, throughout our visit most staff were kind and caring towards the people they cared for. One person told us, "Most staff are very kind". While a further person said, "they haven't the time to devote to you". The relative we spoke with were complimentary about the staff who supported their family member. People were supported and encouraged to maintain relationships with their friends and family. A visiting family member told us they visited regularly and were made to feel welcome.
People told us that decisions they made about their care did not always happen. People's preferences, such as what time they got up in the morning and what time they went to bed did not always happen. The service was run to the staffing levels and not to the people who used the service.

People had the choice to stay in their room or use the communal areas if they wanted to. People told us they chose their clothes and got to dress in their preferred style. We saw staff knocked on people's bedroom or bathrooms doors and waited for a reply before they entered. Most staff spoke respectfully about people when they were having discussions with other staff members about any care needs.

Requires Improvement

Is the service responsive?

Our findings

Most people we spoke with felt their care needs were not always met in a timely way. One person we spoke with said, "It varies how long staff take to come". They said, "They have two people on duty at night and it is not enough. People are calling out all the time for the toilet. They need more staff. There is a lot of sitting waiting for them to come to you." While a further person told us that when they called for staff it could, "Take five minutes to, occasionally, half an hour to respond". While a further person told us the home was, "Terribly short staffed" and that they "try not to bother them". With another person stating, "I have to wait my turn", and that they thought staff had "forgotten them". They continued to tell us they, "Have to wait longer at night" and that, "A couple of times I've rung more than once to get someone".

We spoke with staff about if they felt they were able to meet people's needs in a timely way. Staff told us they had raised at previous team meeting for extra staffing, particularly during the morning as at least nine people preferred to get up early. One staff member said, "They try to recruit, but nobody stays. We work together to get things done". We spoke with the registered manager after our visit about staffing levels and whether they felt staff were able to meet people's needs in a timely manner. They told us that in their experience increasing staffing levels in the morning did not work, and said this was because, "Night staff then don't work, as they know there are more day staff". However, from what people told us, the provider could not be assured they were meeting people's care needs in a timely way and had not explored staffing levels appropriately.

We spoke with people to understand if staff met their individual needs. We spoke with one person who told us they had been living in the home for one month, and during this time had only one shower. They told us they had enjoyed the shower as it had helped them relax, and they had slept better that night. We asked if they had asked staff for more frequent showers, they told us, "No, but they haven't offered either". The person told us that sometimes their family members would help them, "Have a quick wash". A further person told us they had to go to bed by 10pm but would rather it was 11pm. They told us this was because the day staff left at 10pm and as there were only two staff who worked at night, staff did not have the time to support them to bed at 11pm.

We spoke with one person who was registered blind. They told us, "I don't know if I'm sitting on my own or if there is someone to talk to". They explained they needed to be prompted so they knew who was there. They told us, "I like to sing but no one responds". In the morning we saw that this person had fallen asleep at the dining table after breakfast. A staff member walked past them and brushed them along the top of the shoulder as they walked past and said, "I'll take you to the lounge now". The person woke and said, "Am I not in the lounge already?" however the staff member had already walked away and did not respond to the person. We spoke with the person's relative who said staff were, "On a learning curve" and now "Put drinks in [the person's] hand".

We asked people if they had the opportunity to discuss their hobbies and interest with the staff so they had a better understanding of their likes and dislikes. People told us that some activities did take place, but said that not many people attended them, as they were not always activities they enjoyed, for example, a bean

bag throwing competition. One person said, "Nobody has asked me what I would like to do". While a further person told us the activities list stated there was one to one support, which they would like, but this had not happened for them. Another person told us they would enjoy a gentle exercise and movement class, but thought this had not happened for safety reasons. On the day of our visit there was a film on, we saw two people had attended, but both were sleeping. In the afternoon we also saw an art session taking place, which four people attended and told us they had enjoyed this activity.

All of the above information demonstrates there was a breach in regulation which was Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Person Centred Care.

The provider shared information with people about how to raise a complaint about the service provision. This information gave people who used the service details about expectations around how and when the complaint would be responded to, along with details for external agencies were they not satisfied with the outcome. We looked at the provider's complaints over the last nine months and saw two complaints had been received. One was a concern that had been raised to CQC which we asked the provider to respond to, and the second complaint was around missing laundry. We found that these had been responded to with satisfactory outcomes for the people who had raised the complaint. The provider had demonstrated how they had learnt from the complaint and put actions into place to reduce the likelihood of the concern from happening again.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. However, on the day of our inspection visit the registered manager was away and a registered manager from the provider's sister home supported our inspection. 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.

People told us that the registered manager was not always regularly visible within the home. Four people we spoke with told us they only saw the registered manager in the morning during breakfast. One person said, "I don't see much of either the [registered] manager or [home service manager]. I wish they would walk round, so we aren't a forgotten person". The person felt that if the registered manager was more visible then they would identify areas for improvement.
We asked people if residents meetings were held. One person told us they had a residents' meeting which was held by the activities co-ordinator, but stated, "People are nervous of complaining". From speaking with people who lived in the home, the overall feeling people had, was that staff were kind towards them and supported them with their care needs when they were able. However, people expressed their frustration with the time they had to wait to receive support from staff. People felt they did not have the opportunity to raise this with management and make a change to the way the service was run.

We spoke with staff who told us the registered manager held meetings where they were able to discuss what was happening in the home and we found that staff were up to date with what was happening within the service. Staff told us the registered manager would offer support if they requested this, for example, with assessing a person's mobility.

We discussed with the registered manager about how they supported their staff, and checks they made to ensure staff were preforming as expected. We had identified consistent errors within one person's care record around management of risks to their safety. Where the registered manager had completed a check of the person's care records, this was not effective. This was because the check had not identified the errors within the assessment. The registered manager told us that this staff member had an identified learning need which required them to have further measures in place for completing paper work tasks. However, the registered manager could not demonstrate how they had supported the staff member to complete the assessments in-line with their individual learning needs, to ensure this did not hinder people from receiving safe and proper care. We also found that where the registered manager had identified missing signatures in May 2017, the staff member had continued to miss signing the documents and this had not been identified by the registered manager at further reviews.

Where we had identified concerns around the management of risk to one person it was identified that the records held were not clear, complete, or kept in good order. Where the person had an accident these were not always clearly recorded and analysed to see how risks to the person should be managed. When we asked to see further information, for example, a health professionals letter about an important change in the

person's care, this could not be found as some of the person's records were mixed with another person's records. This information had to be specifically requested from external healthcare professionals. Incomplete records puts people at risk of receiving inappropriate care and treatment, as staff cannot demonstrate they are supporting people in-line with healthcare professional's guidance and advice.

The provider completed checks around areas such as staff training, incidents and accidents, medicines and care records. The experience of people was looked at within these areas. For example, the provider had spoken with people to understand how they were feeling about the support being offered to them. These checks found that people were happy with the service provision. However, at the visit in June 2017 the provider sampled two people's care records which identified a shortfall in the lack of management to reduce the risk to one person's who had experienced falls. This had been raised with the registered manager as a need for action. However, following our findings regarding another person's managed risks of falls, we could not be assured the registered manager had taken learning from the provider's checks to improve their practice and provide consistently safe care for all people living in the home.

All of the above information demonstrates there was a breach in regulation which was Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Good governance.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 1) The care and treatment of service users must— (a) be appropriate, (b) meet their needs, and (c) reflect their preferences. (2) But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11. (3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user; (b) designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met; (c) enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment; (d) enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible; (e) providing opportunities for relevant persons to manage the service user's care or treatment;

(f) involving relevant persons in decisions relating to the way in which the regulated activity
is carried on in so far as it relates to the service user's care or treatment;
(h) making reasonable adjustments to enable the service user to receive their care or treatment;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service
users and others who may be at risk which arise from the carrying on of the regulated activity;
(c) maintain securely an accurate, complete and contemporaneous record in respect of each
service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;