

Caring Homes Healthcare Group Limited

Rendlesham Care Centre

Inspection report

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12 July 2016

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Ratings

Overall rating for this service	Inspected but not rated
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Is the service safe?	Inspected but not rated
Is the service well-led?	Inspected but not rated

Summary of findings

Overall summary

We carried out this unannounced focused inspection on 12 July 2016 to look at new concerns raised following the death of three people as a result of choking.

This report only covers our findings in relation to this topic.

Rendlesham Care Centre is a residential home that provides care to up to 60 people who are elderly and frail with complex needs, including dementia and nursing related needs.

The service had 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.

During our comprehensive inspection of 25 November 2015 we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which were: Regulation 12, Safe care and treatment, Regulation 18(1) Staffing and Regulation 17 Good governance.

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

During this focused inspection we found continuing breaches of Regulation 12, 17 and 18. You can see what action we told the provider to take at the back of the full version of the report.

Arrangements were insufficient for managing risks and improving the safety of individuals who have swallowing/eating/drinking difficulties (dysphagia).

Risk assessments were not personalised and relevant to the individual. They did not consider associated signs and symptoms specific to the person that could indicate potential or actual risk of choking. Plans in place for managing risk were not detailed, informative or specific to the individual. Therefore staff did not have sufficient information to guide them on how to monitor and review those people, recognise when symptoms were worsening and identify emerging increase to their risk of choking.

The service did not have a pro-active approach to staff learning and development in line with the home's stated purpose and the needs of people using the service. Staff had not received training in the wider risks related to dementia, including dysphagia. They therefore did not understand how difficulties associated with dysphagia are caused, exacerbated or how to recognise any change or deterioration in swallowing difficulties.

People's safety and welfare were compromised because the provider did not have a robust and effective system in place for identifying and remedying deficits in care to improve the safety of individuals who have

or are susceptible to swallowing difficulties, and prevent recurrence of serious untoward events.

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 registered provider had not taken all reasonable action to improve the safety of individuals who have swallowing/eating/drinking difficulties (dysphagia).

Risk assessments were not personalised and relevant to the individual's specific needs.

Risk assessments were not completed and reviewed by staff with the appropriate knowledge, skills and competence to do so and did not include detailed, informative, plans specific to the individual for managing the risks to that person from choking.

Staff employed, including kitchen staff had not received appropriate training on dysphagia (swallowing/eating/drinking difficulties)

Inspected but not rated

Is the service well-led?

The service is not well led.

The provider did not have effective governance, including systems to assess, mitigate risk, monitor and drive improvement in the safety of the service provided including the safety of individuals using the service.

Inspected but not rated

Rendlesham 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.

This focused inspection took place on 12 July 2016 and was unannounced. The inspection was carried out by two inspectors.

We had received information which raised concerns about how people at risk of choking were being cared for. Before the inspection we reviewed information we held about the service. We had also received information from other stakeholders including the local authority safeguarding team and the Coroner.

During the inspection we spoke with the registered manager, the regional manager, five staff members and the cook. We looked at the care records for three people using the service. We also looked at other records and information relating to the management of the service such as staff training, policies and procedures and quality monitoring information.

Is the service safe?

Our findings

Whilst it is not possible to prevent all episodes of choking, we found that the registered provider had not taken all reasonable action to improve the safety of individuals who have swallowing/eating/drinking difficulties (dysphagia).

People with dementia are more susceptible to dysphagia and also to behaviours such as eating too fast or pica (eating or attempting to eat non-food items) which in turn result in an increased risk of choking. Staff told us that they had received some basic training in relation to dementia awareness but this did not cover the wider risks related to dementia, such as dysphagia.

During lunchtime we observed an incident involving a person assessed as high risk of choking. They were seated in an armchair that was leaning back. They had not been supported to sit at a dining table in an upright position to aid eating and swallowing. A staff member placed their pureed meal on a small table in front of them; they were not provided with any further support or supervision. The individual could not reach the table and so they put the meal on their lap. Fifteen minutes later the person began to cough continually, they started to go very red in the face and it was evident that they were choking. A member of staff went over to assist. They held the persons arms up in the air for a better position and patted them on the back, the choking subsided and after a drink they began to recover.

Staff had not recognised that coughing during or after a meal or drink was a symptom of dysphagia and a potential risk for choking. A staff member said that this person always coughed at meal times. They were not aware people with dysphagia can choke on saliva or phlegm. Regular coughing or repeated chest infections can indicate worsening dysphagia and increased risk of aspiration and choking. This person had had two previous episodes and this had triggered a referral to the GP for reassessment but this had not occurred at the time of our visit and there were no care records confirming a referral had been made.

Tools used for assessing risk for people in relation to eating and drinking did not consider all associated signs and symptoms that could indicate swallowing difficulties. There were no systems in place to ensure that staff were informed and guided to recognise if people were developing changes that could directly impact on eating, drinking and swallowing. For example changes may include but are not limited to: a change in voice quality, coughing during and after a meal or drink, taking a long time to swallow, evident discomfort in swallowing, particularly tablets and drooling of saliva.

Care plans in place for people identified at risk of choking were not personalised and did not identify specific symptoms experienced by the individual in relation to how dysphagia affected them. Therefore care staff did not have sufficient information to guide them on how to monitor and review those people, recognise when symptoms were worsening and identify emerging increase to their risk of choking.

People with swallowing problems and at risk of choking were not consistently provided with food and drink that were of the correct prescribed consistency, to improve their safety. Care plans did not refer to guidance and correctly detail the required consistency of food and fluid. For one person requiring thickened fluid their

care plan stated to use 'Thick and Easy' or 'requires Stage 1 thickener'. There was no information to guide staff on how thick the fluid should be or how to achieve Stage 1. Having fluids too thick is as dangerous as too thin. Too thick and it may stick in the throat and may cause coughing and choking and too thin it can go into the windpipe.

Another care plan had conflicting information. In one place it stated 'soft diet', in another 'puree diet' and in another place 'soft/puree diet'. These descriptions were open to interpretation because what is understood to be soft to one staff member may be different for another.

The NHS National Patient Safety Agency has produced Dysphagia Diet Food Texture Descriptors guidance that provides standard terminology to be used by all health professionals when communicating about an individual's requirements, to avoid unsafe care and ensure consistency of care. The guidance also includes how the textures can be achieved in a consistent way, and the foods to avoid. This guidance was not being used by the service to inform best practice.

The cook was not following this guidance and was not preparing meals in accordance with it. The cook confirmed that they had not received any training in relation to textured consistency of diets since they had been employed eighteen months ago.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment

Is the service well-led?

Our findings

In the last 12 months three people had died in incidents that related to them choking. We found there was a lack of pro-active approach from all levels of management in relation to root cause analysis. The regional manager told us that meetings at senior management level concluded that all actions that could be taken had been taken to improve the safety of people at risk of choking. Whilst some action had been taken they had not looked at the issues in enough depth to identify all the potential risks for people to improve the safety of their care and prevent recurrence.

The risk to people is especially high as a result of the conditions they typically live with. Good practice guidance and control measures had not been adopted to drive improvement and make sure the risk is as low as reasonably possible.

The service was not actively following best practice guidance to inform their processes in the service.

The Dysphagia Diet Food Texture Descriptors 2011, produced by the NHS National Patient Safety Agency, although pinned to the kitchen notice board were not being used; care staff were not aware of this guidance. The cook told us that the kitchen was informed of individual specialist or textured diet requirements via individualised food fact information record sheets completed by care staff. The cook showed us that current requests had been made for 'soft diet' requirements. It was unclear as to which descriptor 'soft diet' fell into and the cook and care staff could not tell us. Oversight and routine governance including auditing had not identified this shortfall and therefore opportunities to improve the quality of care had been missed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance

The provider's Statement Of Purpose includes their aim and objective to establish a positive and supportive care culture in which a dedicated and skilled staff team are able to maximise service user wellbeing. Our findings do not corroborate this statement. Effective training had not been sourced or provided for staff to raise their awareness to the causes and risk of individuals choking and provide them with the skills to support those individuals with eating/drinking/swallowing difficulties and maximise their wellbeing. In addition care staff told us they did not feel competent to manage emergency health situations, such as choking and had to call the registered nurse on duty. This could lead to a delay in treatment.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Governance and oversight of the service had not fully considered all the areas where quality of care could be improved.