Cedars Care (Winscombe Hall) Limited

Winscombe Hall

Inspection report

Winscombe Hall Care Centre
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 24 October 2016.

Winscombe Hall is a care home which provides accommodation for up to 39 people, some of whom are living with dementia. At the time of the inspection there were 32 people living at the home. The home comprises of two areas; Stable Cottage provides care to people living with dementia and The Halls which provides nursing care. The home is situated on the outskirts of the village of Winscombe

There was not 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. The provider was in the process of applying to be Registered Manager and there was also a compliance manager and business manager who had been put in place since the last inspection.

We carried out an unannounced comprehensive inspection of this service on 21 and 22 January 2016. Breaches of legal requirements was found as where restrictions were in place the provider had not ensured effective processes were in place to make best interest decisions in accordance with the Mental Capacity Act 2005. Medicines were not always administered safely and the service was failing to monitor and mitigate the risks relating to the health, safety and welfare of people. Sufficient numbers of staff had not been deployed to respond to people's needs and accurate, complete and contemporaneous records were not kept in respect of each service user.

After the comprehensive inspection, we used our enforcement powers and served Warning Notices on the provider on 4 March 2016. These were formal notices which confirmed the provider had to meet the legal requirements by 14 July 2016.

We undertook this focused inspection to check they now met these legal requirements. This report only covers our findings in relation to these requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Winscombe Hall on our website at www.cqc.org.uk

We found action had been taken to improve the areas of the service looked at but some areas required further improvement.

Improvements had been made to staffing levels to ensure there were enough staff available to respond to people's needs. The provider has employed more people and views about the increase in staffing were positive.

Risks to people had been identified and measures were put in place to reduce risks. Where risk assessments

were in place they contained accurate information to support people safely. Some further information relating to risks around the use of bed rails was needed in some people's rooms.

Medicines were administered safely and were looked after in line with national guidelines. There was a system in place to check the expiry date of creams and ointments.

Whilst some improvements had been made to ensure the principles of the Mental Capacity Act 2005 were being followed we found that further improvements were necessary to ensure people's rights were fully protected where they lacked capacity to make decisions for themselves.

Improvements had been made which ensured records were up to date and accurate. We found some weights to be missing from records but the weights had been recorded in a book rather than the person's care plan so all the information wasn't kept together.

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

We found action had been taken to improve the safety of the service

People were looked after by enough staff to meet their needs.

People's medicines were administered and stored safely.

Risks to people were identified and assessments contained enough information to keep people safe.

Is the service effective?

Requires Improvement

We found some action had been taken to improve how effective the service was.

People had mental capacity assessments in place but some contained conflicting information.

Best interests decision had not been documented for people where they lacked the capacity to make decisions for themselves.

Is the service well-led?

Requires Improvement

We found action had been taken to improve the governance of the service.

People's records were accurate and up to date and full care plans were in place for people.

Winscombe Hall

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.

We undertook this unannounced focused inspection of Winscombe Hall on 24 October 2016. This inspection was done to check that improvements planned by the provider after our comprehensive inspection on 21 and 22 January 2016 had been made. The team inspected the service against three of the five questions we ask about services: is the service Safe, Effective and Well Led. This is because the service was not meeting some legal requirements.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received from the service including their action plan following the last inspection which detailed the improvements they intended to make.

The inspection was undertaken by one adult social care inspection manager and one specialist advisor who had a nursing background. During our inspection we spoke with the provider, Compliance Manager, Business Manager, a nurse and four staff. We looked at the care records of nine people living in the home. We also looked at records relevant to the running of the service such as staffing rota's.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of this service on 21 and 22 April 2016 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). Some aspects of the service were not always safe as the provider was failing to always monitor and mitigate the risks for people. Bed rails were not always fitted safely and staff were unclear on what slings to use when supporting people to change position. Also medicines were not always being managed safely. During this inspection we found that improvements had been made to ensure the provider was compliant with this regulation.

Risk assessments had been undertaken where people had bed rails in place. We checked eight people's bedrails to ensure they were positioned correctly. Seven of these were integral bedrails which significantly reduced the risk of entrapment and all eight of the bed rails had covers fitted to them which reduced the risks associated with using them further. The one bed rail which was not integral was well secured. Each room with bedrails in had a laminated picture showing staff the potential risks of entrapment but we fed back to the provider that additional factors, such as pressure ulcer mattresses and the height of someone, can also pose risks. The nurse on duty was directed to information meaning they could ensure these additional factors were part of the documentation already in place for risks around bed rails.

Both types of mobile hoists observed to be in use had been assessed as safe to use within the last year. Instructions for staff to follow when assisting someone to move with the aid of the hoists, were clearly documented in care plans. This information included how many staff needed to assist the person, the size of slings and any other equipment needed. Not every person who required a sling had their own one for use. The nurse on duty assured us the extra slings required were already on order.

Improvements to medicine management had been made and the home had changed the pharmacy they used so they could use a system they felt to be safer. All Medicine Administration Records (MAR) were checked within the home. Only two of these were now handwritten and both the people these related to had come into the home between monthly dispensing and therefore would have handwritten charts until the pharmacy next dispenses their medication. We raised with the compliance manager that the providers medication policy did not give guidance to staff on handwritten MAR's for new residents or those discharged from hospital with medication. They stated this had already been identified as something which required action and they would ensure this happened.

On one of the handwritten MAR's charts the clarity of hand writing was poor for one of the drugs meaning a mistake could have been when issuing this medication to the person. The drug involved would mean the mistake could have serious harmful effects to the person. The stated dose read as 1.25 mg – 25mg but the dose should have read as 1.25mg to 2.5mg. The risks relating to this were reduced as the nurses issuing the medication worked within the home frequently and would have good knowledge on the use of this drug. The issue was immediately put right by the nurse.

The use of topical creams was well recorded with a body map indicating the site for administration and the number of applications required each day. Creams were dated when opened to ensure that they were not

applied after the manufacturer's 'use by date'. Fridges used to store medicine were within the correct temperature ranges and there were records of twice daily temperature checks which would ensure medication remained at the required temperature to keep if safe and effective for people.

At the last inspection of this service on 21 and 22 April 2016 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). The provider was not ensuring that sufficient numbers of staff were deployed to meet the needs of those living in the home. Staff were not always responding to people who were requesting support and during lunch people were waiting long periods of time for their food as staff were assisting other people. During this inspection we found that improvements had been made to ensure the provider was compliant with this regulation.

Most staff felt confident in staffing levels and stated that when agency staff are required to cover any sickness they are "usually people who have worked in the home before". A staff member commented "staffing numbers have got better over the 6 months I've been here". The provider had increased the staffing levels since the previous inspection including another carer and an activity co-ordinator. The compliance manager had recently reviewed the staffing levels against the dependencies of people in the home and was looking to recruit a further person for The Halls. They were also planning on employing a further kitchen assistant to help, particularly over the lunch period. Some staff reported to us that clearing tables and loading and unloading the dishwashers during mealtimes could take them away from spending time with people. The management staff were responsive to changing staffing needs during the inspection and arranged an extra member of staff during the lunch period as there were two extra people visiting for lunch.

When people asked for help staff were quick to respond and people received their lunch in a timely manner. We observed lunch on The Stables and The Halls and all those who required support with their meals received assistance from staff. Staff did not appear rushed over the lunch period and everyone was able to eat together at the same time. The senior carer was able to be observant of other staff and offer support if needed. Some people, who were unable to move themselves, remained in the dining area around 30 minutes after they had finished eating. One person was observed to have tried to stand up several times during this period indicating they wanted to leave the room. This was fed back to the provider who assured us they would review the deployment of staff following mealtimes to ensure people weren't left in the dining room following the lunch period.

Requires Improvement

Is the service effective?

Our findings

At the last inspection of this service on 21 and 22 January 2016 we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). The provider was not acting in accordance with the Mental Capacity Act 2005 (MCA) as they had not followed the MCA Code of practice whilst supporting people to make decisions. Capacity assessments were not in place where people required them such as for the use of bed rails or movement sensors. Where capacity assessments were in place they were not specific to each decision that needed to be made and best interest's decisions had not always been considered where people lacked capacity. Also families were asked to make decisions on behalf of people when they had the capacity to do so themselves. During this inspection we found that changes had been made to ensure they met the requirements of the regulation however further improvements were required.

At this inspection we checked to see if the service was working within the principles of the MCA. The MCA provides the legal framework for making particular decisions on behalf of people who may lack the 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.

We checked nine people's files and found that some improvements had been made to the way that the service assessed people's capacity. However, there were still further improvements that needed to be made. We were told by the compliance manager that everyone in the home had their care plan reviewed by the previous registered manager and they had updated mental capacity assessments before they finished working for the service. We found that for some of these assessments the different stages of the mental capacity assessments had been followed and were clearly documented making it easy for staff to see if the person was able to make the decisions for themselves.

Several of the files we looked at were confusing and held conflicting information relating to capacity so it was unclear for staff if someone had capacity to make specific decisions themselves. For example, one form stated the person was unable to weigh up and retain information to make the decision and in a later part of the form it stated that the person was able to make the decision. On other forms next to the question 'do you have reasonable belief that this person has the capacity to make this particular decision?' the answer was "Yes – Limited capacity" meaning it was unclear if people had capacity to make the decision or not. Therefore there was a risk that staff could make decisions for people when they were able to do that for themselves or could leave decisions to people when they did not have capacity to make decisions. This meant people's rights may not always be upheld.

Some information had been crossed through and updated on the mental capacity assessment forms but the amendments had not been signed or dated meaning it was impossible for staff to tell when the assessment had last been reviewed. It is important to review these assessments regularly as people's capacity to make decisions can change particularly when people have fluctuating capacity.

Where people lacked capacity to make specific decisions for themselves best interests decisions had not always been made for people. For example, where bed rails were being used for people that lacked capacity there was no process to ensure the decision by the provider for that person was the less restrictive option for them or that they had taken into account all relevant information. There were also no documents to show the provider had tried to take into account the persons past and present wishes and feelings and no documents to show that families and other relevant parties had been involved in the decision making.

We fed our concerns back to the compliance manager who stated they would be reviewing all of the assessments relating to Mental Capacity to ensure they were following the principle of the Act. They stated they had relied on the previous manager, who had now left, to make sure they were reviewed and in line with the Act. The concerns were also fed back to the provider who stated it would be a priority to ensure they were following the principles of the Act.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection of this service on 21 and 22 April 2016 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). The provider was failing to ensure that an accurate and complete record was maintained in respect of each person. Where one person should have been weighed weekly the records showed this had only happened monthly and where someone required assisting with turning in their bed the records were not clear on how often this should happen and staff gave differing accounts of this. Also the home had not followed their policy of having a full care plan in place within 72hours of someone entering the home. During this inspection we found that improvements had been made to ensure the provider was compliant with this regulation.

The compliance manager stated the home was in a transition period of moving people from being weighed monthly to weekly when there was a clinical need to do so or where people had requested this. Most of the records checked showed that when required people were being weighed weekly and the records were updated to show this. This meant improvements had been made and it was now easier for staff to see if people's weight was reducing or increasing so they could take appropriate action. Two of the records we looked at had some dates and weights missing. We fed this back to the compliance manager who said they had identified this as a problem and that staff had note books to record the weights in. Whilst this showed the weights were being taken the information had not always been transferred to the person's record. This meant that the records were not complete and any weight loss might not be picked up as quickly if all the weights were recorded in one place for all staff to see.

Where people required assistance to be turned at night to help prevent pressure sores developing the records reviewed were clear that this was happening as guided by the care plan. We checked four people's records who required turning every one to three hours and the records showed this was being done as required. The compliance manager had also reviewed everyone who was previously receiving assistance with turns in their bed at night and this requirement had been removed for several people in the home as it was identified it was not required for them. This showed that care needs were being responded to when they changed.

We were told that the nurses were responsible for compiling people's care plans when they entered the home. We asked the nurse on duty who is responsible for compiling a care plan if someone is admitted into the home during an out of hours situation which would be at night or over the weekend. They stated there is a nurse on duty 24 hours of day every day meaning that there should not be a delay between someone moving into the home and a full plan for them being written so staff would know how to assist people as soon as possible. As no one had moved into the home in the week before the inspection we were unable to check if full care plans were being written within the appropriate length of time but we were told this had been happening.