Cherry Garden Properties Limited

Castle House

Inspection report

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Date of inspection visit: 17 September 2015
Date of publication: 27/10/2015

Ratings

Is the service safe?	Requires improvement
Is the service effective?	Good

Overall summary

We carried out an unannounced comprehensive inspection of this service on 15 and 18 December 2014. Breaches of legal requirements were found. We also undertook a focussed inspection on 30 April 2015 to check whether requirements had been met. Some areas of improvement were found but there was continued non-compliance in areas of safety and ensuring there were enough staff with the right skills and competencies. CQC took enforcement action because improvements were needed to ensure the well-being and safety of people living at the home.

After the focussed inspection in April 2015, the provider wrote to us to say what they would do to meet legal requirements in relation to improving their service. The provider had until 31 July 2015 to make improvements and become compliant.

We undertook this unannounced focused inspection on 17 September 2015, to check that they had followed their plan and to confirm that they now met legal requirements in relation to the warning notices. This report only covers our findings in relation to the warning notices. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk. The inspection team consisted of one inspector.

The purpose of this current inspection was to specifically look at how consent was being gained and recorded for care and treatment. For people who lacked capacity, we needed to assure ourselves, their best interests had been fully considered in the use of equipment which may restrict their movements. This included the use of bedrails and pressure mats which alerted staff when people got up and moved from their bed or chair. Previously staff had a limited understanding of how to ensure their practice was in line with the Mental Capacity Act 2005 (MCA) which protect people's rights. We had also found in the previous inspections staff lacked the right skills to provide care and support safely and effectively. In this inspection we were checking staff had received training and their competencies were being monitored.

We found that although issues highlighted in the warning notices had been addressed, an issue was identified in respect of use of some equipment which could place

Summary of findings

people at risk. This related to the use of pressure relieving equipment to prevent people developing pressure sores. We found pressure relieving mattresses were not set at the right setting for people's weight. We found there was no documentation to show staff what setting this equipment should be set at to ensure its effectiveness for the person. We also found some of this equipment had not been serviced for several years. We have issued a requirement in relation to this breach in people's safety. We were assured by the manager and operations manager they would take immediate actions to address this.

Since the last inspection this service had removed two regulated activities which meant they were no longer providing placements for people with on-going nursing needs. People living at this service were now under a residential service contract and any nursing needs were being met by the community nurse team. This meant the service no longer employed nursing staff. Care staff had received training to take over some roles previously completed by nurses. This included medicines administration and review and development of care plans for people. Care staff had received a wide range of training to enable them to take on additional duties. This training included understanding the MCA and Deprivation of Liberty Safeguards (DoLS).

Staff confirmed this training had been useful and they had been provided with prompt cards to remind them to consider consent and capacity into their everyday practice. Our observations showed this was working to good effect. We saw staff checking with people before delivering care and support, ensuring consent had been gained. Where people lacked capacity the service had evidenced that best interest meetings had been held to consider a particular decision was in the best interest of the person.

During this inspection we heard how staff had received refresher training in safe moving and handling. This included a practical demonstration of using moving and handling equipment. Our observations showed staff on duty were comfortable and confident in using equipment to safely transfer people from their armchair to a wheelchair to have lunch. Staff reported they felt they were working better as a team, had a manager they could share their views with and took responsibility for ensuring safe practices were used at all times.

Since the last inspection the registered manager has resigned and de-registered with CQC. A new manager had been employed who was in the process of applying to register with CQC. 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
Some aspects of the service were not safe.

Equipment to help prevent pressure damage was not always being used appropriately which could place people at risk.

There were enough staff with the right skills and competencies to meet peoples' needs.

Requires improvement

Is the service effective?
The service was effective.

People were supported by staff who were trained and supported to meet their emotional and health care needs.

People were supported to make decisions about their care and support and staff obtained their consent before support was delivered. The manager knew their responsibility under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to protect people.

Good

Castle 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.

This inspection took place on 17 September 2015 and was unannounced. It was completed by one inspector who spent six hours at the service.

We spent time talking with four people who lived at the service and two visiting relatives. We also spoke with five care staff, the manager, the provider operational manager and the administrator. We looked in detail at four people's care records and risk assessments and spent a short time observing how care and support was being delivered. We reviewed records in relation to staff training and the number of staff available on each shift.

Requires improvement

Is the service safe?

Our findings

When we inspected this service on 30 April 2015 we found there were not always enough staff on duty with the right skills and training to meet people's needs safely and effectively. We issued a warning notice in relation to this breach in regulation.

We found that although issues highlighted in the warning notices had been addressed, an issue was identified in respect of use of some equipment which could place people at risk. This related to the use of pressure reliving equipment to prevent people developing pressure sores. Pressure relieving mattresses were not set at the right setting for people's weight. There was no documentation to show staff what setting this equipment should be set at to ensure its effectiveness for the person and some of this equipment had not been serviced for several years. We were assured by the manager and operations manager they would take immediate actions to address this. They planned to ensure that for each person who had been assessed as high risk of developing pressure damage, they would include further details within the risk assessment. This would include what equipment was being used and what setting the mattress should be set on. They said they would also make this information available to care staff within people's rooms so staff could have easy access to this and check the mattress setting each day.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection staff were available in the right numbers and with the rights skills to meet people's needs in a timely way. Staff had received training and support to enable them to deliver care safely. For example previously we had found staff had not always used the right equipment to safely move people from their armchairs to wheelchairs. On this inspection, staff confirmed they had received updated training on safe moving and handling for people. We observed staff using equipment safely and competently to ensure people were supported to move and transfer with the right equipment. Staff were confident in their approach to moving people with equipment and gave people time and explanations as to what they were doing. One senior member of staff said they were ''not afraid to challenge any poor practice.'' Staff confirmed more time and resources had been invested into ensuring they had the right training. This included newer staff who had an induction process which followed national good practice and guidance.

Since the last inspection the provider had made the decision not to provide nursing care placements. They now only provide people with care and support in residential placements. People's nursing needs were now being met by the community nurse team. This meant the nursing staff had left and care staff had been trained to take up some of the roles the nurses had previously completed. This included administration of medicines and updating of care plans and risk assessments. Staff confirmed they had received training and support to take on these additional responsibilities. Only senior staff were completing the tasks relating to medicine management. This was being closely monitored by the manager with weekly audits. Staff and the manager said the medicines management was working well and there had been no errors. We did not check this as part of this inspection.

The staffing rota showed there were four care staff available throughout most of the day, with support from the manager, cook, kitchen assistant, cleaner and part time activities coordinator. At the time of this inspection, there were 12 people living at the service, although one was in hospital. People, who were able to give their views, said there was enough staff available to meet their needs. One person confirmed their call bell was answered in a timely way.

Staff said there were enough staff available to meet people's needs. One staff member commented that they had developed a better sense of team working and they were looking forward to being able to support new people to the service as they believed they were ''Offering really good care.''

The manager and operations manager said they had kept staffing levels up at four care staff per shift despite being low in the numbers of people they currently provided a service for as they wanted to develop staff skills and knowledge and did not want to lose staff where they had invested resources in training them. They had been looking at a dependency tool to use which would help them adjust staffing levels as the number of people they supported increased and/or their needs changed. The manager also

Requires improvement

Is the service safe?

said they spent most of their time working alongside care staff to monitor their skills and competencies. We were able to conclude the service had met the warning notice in relation to regulation 18.

Good

Is the service effective?

Our findings

At the previous inspection in April 2015, we found staff lacked an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This meant they had not always fully considered consent or best interest meetings for people who lacked capacity and where there was a potential to restrict their liberty. For example with the use of bedrails. We issued a warning notice in relation to this serious breach in regulation. The provider sent us an action plan, which showed how they planned to be compliant in this regulation. This included ensuring all staff had additional training to help them understand the MCA and how this works to ensure people's rights are upheld.

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

During this inspection we saw staff had received addition training. This training included understanding the MCA and Deprivation of Liberty Safeguards (DoLS). Staff confirmed this training had been useful and they had been provided with prompt cards to remind them to consider consent and capacity into their everyday practice. Our observations showed this was working to good effect. Staff checked with people before delivering care and support, ensuring consent had been gained. Where people lacked capacity the service had evidenced that best interest meetings had been held to consider whether a particular decision was in the best interest of the person. For example, where someone lacked capacity to make the decision to use bedrails to keep them safe from falling out of bed, their family and GP had been consulted about this. This demonstrated the service was involving others in best interest decisions.

Where people were being restricted or were under continuous supervision, the manager had applied to the local authority for a DoLS authorisation . These were in the process of being assessed. This meant the service were trying to ensure they were acting in the best interest of people and working in a way which was the least restrictive. The DoLS assessors would assist the home to ensure this was fully monitored. We were able to conclude that the service had met the warning notice in respect of regulation 11.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable equipment because there was no record of what staff should check to ensure the equipment was being used properly and it had not been regularly maintained. Regulation 15 (1) (d).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.