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Tremethick House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced focused inspection took place on 20 July 2017. The last inspection took place on 11 April 2017 at which time we identified two breaches of the regulations. The breaches related to medicines management, care plan and risk assessment reviews, monitoring records not always completed, and failure to display their last inspection report for the public. Two warning notices were issued against the provider with regards to these breaches. The service was rated as Requires Improvement. We carried out this focused inspection to check on the action taken by the provider to meet the requirements of the warning notices.

This report only covers our findings in relation to "Is the service Safe, Responsive and Well-led?". You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tremethick House on our website at www.cqc.org.uk

Tremethick House is a care home which offers care and support for up to 42 predominantly older people. At the time of the inspection there were 35 people living at the service. Some of these people were living with dementia.

At the last inspection we were concerned about the medicines administration processes at the service. Since the last inspection the service had reported two further medicine errors. The service use an electronic medicines management system and staff had been trained in its use. At this inspection we found there had been improvements in the processes and practices of medicines administration. Regular audits of the medicines management were helping to identify any errors and reduce the risk of future issues. However, we continued to find prescribed liquids, Gaviscon and Lactulose, in the medicines trolley and prescribed creams in people's rooms that had not been dated when opened. This meant staff were not aware when the item should be disposed of.

At the last inspection we were concerned that care plans were not always effectively reviewed to take account of any changes in a person's needs. Risk assessments were not always completed where a risk had been identified. Some people who required monitoring of their position, their weight or their food and drink intake did not always have this recorded by staff. Pressure relieving mattresses used to help reduce the risk of skin damage were not regularly checked to ensure they were set appropriately for each person. The service was not displaying its most recent inspection report as they are legally required to do.

At this inspection we found the service had taken action to help ensure each review of a persons' care plan led to a review of their risk assessments. Risk assessments were in place when concerns had been identified. Staff had improved the recording of when they provided care and support for people, such as re-positioning, food and drink recording and monitoring of peoples' weights. Pressure relieving mattresses were now audited each month following a check of peoples weights to help ensure they were set correctly. The services most recent inspection report was clearly displayed in the entrance hall of the service.

The service had two vacancies for care staff at the time of this inspection. The service had identified the

minimum numbers of staff required to meet people's needs and these were being met. Staff and people told us they felt there were sufficient numbers of staff. The service audited their call bell response times. The report for the week prior to this inspection showed people waited between two and nine minutes for staff to respond, this had improved from the previous two weeks reports showing waits of up to 12 minutes.

People had access to some activities. Activity co-ordinators were in post who arranged regular events for people. These included music and quizzes and some trips out to the local community. However, some people told us that they felt there was not enough to occupy them during the day and at weekends. The management team confirmed they were reviewing activity provision to ensure it was what people enjoyed.

The two acting managers were supported by the operations manager and the provider. The staff told us that morale had improved and that they were working well together. Healthcare professionals told us they had noticed recent improvements in the service provided at Tremethick House and that they felt it was a safer service since the provider had taken action to address concerns.

We found the provider had taken effective action to address the concerns in the two warning notices. However, we still had concerns about the management and administration of medicines.

We have not changed the rating of this service as a period of sustained improvement is required before we can judge the service is entirely safe.

We found a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 entirely safe. Systems for the administration of medicines were not robust.

Staff knew how to recognise and report the signs of abuse. They knew the correct procedures to follow if they thought someone was being abused.

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service.

Care plans recorded risks that had been identified in relation to people's care and these were appropriately managed.

Is the service responsive?

Good

The service was responsive. People received personalised care and support which was responsive to their changing needs.

People were able to make choices and have control over the care and support they received.

People knew how to make a complaint and were confident if they raised any concerns these would be listened to.

People were consulted and involved in the running of the service, their views were sought and acted upon

Is the service well-led?

Requires Improvement

The service was well-led. There were clear lines of responsibility and accountability at the service.

Quality assurance systems were effective in highlighting areas were the service could improve. Action had been taken to address the concerns of the previous inspection.

Staff were supported by the management team. Staff morale had improved since the last inspection.

Tremethick 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.

We undertook an unannounced focused inspection of Tremethick House on 20 July 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our April 2017 inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, responsive and well-led? This is because the service was not meeting some legal requirements in these areas

Before the inspection we reviewed information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with six people living at the service. Not everyone we met who was living at Tremethick House was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and observed care practices. We spoke with three staff, two acting managers, the operational manager for Anson Care and the provider. We also spoke with two visiting healthcare professionals.

We looked at care documentation for five people living at Tremethick House, medicines records and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we were concerned about the medicines administration processes at the service. There had been medicine errors reported by the service. In one instance a person had been given the wrong medicine and in another the service had run out of one person's prescribed medicine and the person had subsequently experienced a seizure. Staff did not change the dose of one person's medicine having been directed to do so by the GP practice. The provider reported they had 'lost a concerning amount' of two specific medicines. This was referred to external agencies for investigation. Errors had been identified by the service in the processes and practices used by staff and within the local pharmacy which led to difficulties and resultant errors in the home's management of medicines, in the management of medicines and they had begun to take action at the last inspection to address these concerns.

The service used an electronic medicines management system and staff had been trained in its use. Since the last inspection the service had reported two further medicine errors. In one event a person had been given another person's medicine and in another event a person was given a medicine that they had been reactive to in hospital in the past. The hospital had not advised the person's GP of this concern. This person was admitted to hospital, and subsequently treated for sepsis. They had recovered and returned to the service.

At this inspection we found staff had taken guidance from a pharmacist and there had been improvements in the management of medicines administration. There were additional checks in place to help ensure medicines did not run out. Regular audits of the medicines management processes were helping to identify any errors and reduce the risk of future issues. This had led to a reduction in errors. The service had identified the root cause of one of the recent events as having been when staff, who were carrying out medicine rounds, were distracted from their task leading to errors being made. Staff who were in the process of doing the medicine round now wore red tabards clearly showing they were not to be disturbed. Staff we spoke with confirmed this had been discussed with them all and they were clear about not disturbing staff during medicine rounds. The second event had highlighted the importance of effective communication and recording of any allergies people may have on to the medicine records when they arrived at the service. The service had taken steps to help reduce the risk of such events re-occurring.

We found prescribed liquids, Gaviscon and Lactulose, in the medicines trolley and prescribed creams in people's rooms that had not been dated when opened. Prescribed creams in people's rooms were not always clearly dated when they had been opened and when they should be disposed of. One tub of prescribed cream in use in a person's room was dated June 2016. This was removed by staff at the time of the inspection. This demonstrated staff were not monitoring the disposal of creams when they were no longer safe to use. We judged that the provider had taken steps to improve the safety of medicines administration at the service, however, errors were still occurring. We will review medicines management again at our next comprehensive inspection.

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

The service were holding medicines that required stricter controls. We checked the records for these medicines against the stock held and they tallied. There were weekly audits of these medicines recorded.

The service were storing medicines that required cold storage, there was a medicine refrigerator at the service. There were records that showed the medicine refrigerator temperatures were monitored. Medicines that required cold storage were stored safely.

At our last inspection we were concerned that some people who were frequently falling did not have risk assessments in place and advice sought, was not recorded. This meant it was not clear what action the service had taken to help reduce future falls. One person had experienced 12 falls in January 2017. Other people's falls were not always recorded on the audit so action was not taken to help address the risk.

At this inspection we found accidents and incidents that took place in the service were recorded by staff in people's records. All events were audited by the managers on the electronic care management system. This meant that any patterns or trends could be recognised, addressed and the risk of re-occurrence was reduced. We reviewed the person who fell 12 times in January 2017 and found the number of falls had dramatically reduced. an occupational therapist had provided the person with a chair with a raised foot rest, and also a pressure mat was in place in their room. Staff were now alerted as soon as the person moved out of their chair. This meant staff could support the person in a timely manner. Another person who had fallen recently had the event recorded in their care file and the risk assessment had been reviewed. The person had been referred to the falls clinic for advice and support. We judged that the provider had taken appropriate action to address the concern regarding accident and incident management in the warning notice.

At our last inspection we found care plans contained risk assessments for a range of issues such as moving and handling, falls and people's nutritional needs. The electronic care plan system clearly showed an alert indicating some people had lost weight. No action had been recorded as having been taken to address this concern. Risk assessments had not been reviewed to take account of weight loss even after a care plan review had taken place.

At this inspection in April 2017 we found there were no alerts showing any weight loss on the electronic system. The service was regularly reviewing people's weight, this was being carried out by care staff and the recorded weights passed to a manager. The manager then reviewed the person's weight and recorded it on the electronic system. Staff were effectively monitoring people's food and drink intake when directed in people's care plans. We judged that the provider had taken appropriate action to address the concern regarding risk assessment and management in the warning notice.

Staff were confident of the action to take within the service, if they had any concerns or suspected abuse was taking place. They were aware of the whistleblowing and safeguarding policies and procedures.

The service held the personal money for people who lived at the service. People were able to easily access this money to use for hairdressing, toiletries and items they may wish to purchase. The money was overseen by the managers. We checked the money held for three people against the records kept at the service and they tallied.

We looked around the building and found the environment was clean and there were no unpleasant odours. Hand gel dispensers were available throughout the building. Personal protective equipment (PPE) such as aprons and gloves were available for staff and used appropriately to reduce cross infection risks.

The service had two vacancies for care staff at the time of this inspection. The service had identified the minimum numbers of staff required by carrying out dependency scores on each person. People's needs were being met. Staff and people told us they felt there were sufficient numbers of staff. We saw from the staff rota there were six care staff in the morning and five in the afternoon supported by a manager on each shift. There were two staff who worked at night. The provider had changed the shift pattern of the afternoon shift, with one member of staff remaining to support the two night staff until 10.30 pm. This meant there were two care staff available during the evening medicine round to support people. This showed the service had responded to concerns regarding medicines administration errors recently and increased staff levels to help ensure no future errors occurred.

People told us they felt there were sufficient numbers of staff on shift. The service audited their call bell response times. This audit showed a recent improvement in the week preceding this inspection where people waited between three and nine minutes compared to the previous two weeks where people were waiting up to 12 minutes for staff to respond to call bells.

Good

Is the service responsive?

Our findings

At the last inspection we were concerned that pressure relieving mattresses used to help reduce the risk of skin damage were not regularly checked to ensure they were set appropriately for each person. Although staff were auditing pressure relieving mattresses this was not effective in ensuring each person's mattress was set correctly. There were several people who required nursing support who were living at the service at the time of that inspection. The tissue viability nurse visited the service during this inspection and reported that one person's pressure sore had shown, "Some deterioration" and they required increased re-positioning. They suggested staff move this person every two hours. However, there were gaps of up to eight hours in this person's re-positioning records since that advice was given. This meant staff were not following the guidance in the care plan and the person had experienced some deterioration in their skin condition.

At this inspection the service managers were closely monitoring information passed to them by care staff who had weighed people regularly. The weights for each person were transferred to the pressure relieving mattress audit to ensure mattresses were set correctly each month. We checked mattresses for four people at this inspection and all were set correctly for the person using them. There were no people living at Tremethick House who were being seen by the tissue viability nurse at the time of this inspection. Some people were being monitored by the district nurses with no one having pressure sore dressings as a result of any deterioration in their skin condition. We judged that the risk of people developing skin damage due to pressure, had improved and staff were monitoring this risk more effectively.

At the last inspection we were concerned that care plan reviews did not always take account of the changes that had taken place in some people's needs. This meant staff were not always provided with current information and guidance on how to support people well.

At this inspection all care plans had been regularly reviewed and where a change had taken place in a person's needs this was reflected in the latest review. We judged that the provider had taken appropriate action to address the concerns regarding care provision in the warning notice.

Daily notes were consistently completed on the electronic care management system and enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being. There was a shift handover meeting held where information was shared on each person living at the service. This helped ensure there was a consistent approach between different staff and this meant that people's needs were met in an agreed way each time.

People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at the service. Staff were able to tell us detailed information about people's backgrounds and life history from information gathered from families and friends.

People had access to a range of activities both within the service and outside. Activities co-ordinators were employed and organised a programme of events including trips out and visits from entertainers. On the day

of the inspection people told us they felt bored, especially at weekends, and that some of the activities were not what they enjoyed. The management team assured us they were reviewing the activities provided and were listening to people's views to ensure they enjoyed them.

The management team held residents meetings and sought people's views on all aspects of the service provided at Tremethick House. Some people asked for changes to the meals provided and this had been acted upon by the hospitality manager. Other people asked for specific cleaning tasks to be carried out and this had been done.

People and families were provided with information on how to raise any concerns they may have. Details of the complaints procedure were contained in the pack provided when people arrived to live at the service. The acting managers held details of any concerns raised and how they had been responded to.

Requires Improvement

Is the service well-led?

Our findings

The service is required to have a registered manager. 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 service did not have a registered manager in post at the time of this inspection. However, two managers had applied to the Care Quality Commission to become joint registered managers. This application was in the process of being reviewed by the Care Quality Commission.

At the last three comprehensive inspections, April 2015, March 2016 and April 2017 we found breaches of the regulations relating to the quality and monitoring of records held at the service. For example, re-positioning records, weight loss monitoring and care plans not always accurately reflecting people's current care needs. At our last inspection the records relating to a person's Deprivation of Liberty Safeguard authorisation were inaccurate. The service were not displaying their latest inspection report to the public as they were legally required to do.

The service had commissioned an independent quality audit in January 2017. This report highlighted what was working well and what area needed some improvement. This report had highlighted concerns with medicines management, care plan detail, recording of care and action taken following accident and incidents. The audit stated that care plans did not always accurately reflect the support needed or delivered to people. It also stated that direction in care plans was not always followed by staff. At the last inspection we found such concerns continued to occur.

At this inspection the provider and management team had worked hard to improve the quality and the monitoring of all records held at Tremethick House as detailed in the Safe and Responsive domains of this report. The records relating to people's Deprivation of Liberty Safeguard status were accurate and being regularly monitored to ensure any conditions attached were being supported.

The most recent CQC inspection report was clearly displayed in the entrance hall of the service for the public information.

The service was monitoring its continuous improvement against the independent external audit undertaken in January 2017 and matters identified in the latest CQC inspection report. We were provided with the plan which showed some aspects of improvement had been completed where others were still on-going pieces of work.

Breaches of the regulations relating to management of information and records at the service had been met by the management team. The management team had sought guidance from the electronic records support service to help ensure they were operating the system effectively. Staff had been regularly prompted about the importance of accurate recording of all care and support provided. The management team had an effective system of recording changes in people's care and support needs to ensure staff were provided with

current accurate information.

The concerns relating to medicines management at the service remained. The service had reported two further medicine errors since our last inspection. Although the provider and management team had taken steps to make the medicines administration processes more effective we cannot judge the service to be safe in this area at this time. The service remains in breach of the regulations relating to safe medicines management.

The two acting managers had clear lines of accountability and responsibility both within the service and at provider level. The two acting managers and the newly promoted Head of Care worked in the service every day allowing them to provide care and supporting staff across all seven days of the week; this meant they were aware of the culture of the service at all times. This had led to improved motivation throughout the staff team. Staff told us they felt they were all now pulling together and would 'pick each other up' if one staff member noticed anything that may have been overlooked by another staff member.

Staff told us they felt well supported through supervision and regular staff meetings. All staff we spoke with were aware of all the work that had been done to meet the requirements of the warning notices. They were committed to continually improve the service provided at Tremethick House.

The two acting managers worked in the service every day providing care and supporting staff this meant they were aware of the culture of the service at all times.

There were systems in place to monitor the quality of the service provided. Audits were carried out over a range of areas, for example, medicines management, pressure relieving mattresses and hospitality provision.

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly. Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service was notifying CQC of any incidents as required, for example expected and unexpected deaths.

The environment was clean and well maintained. People's rooms and bathrooms were kept clean. The provider carried out regular repairs and maintenance work to the premises. The boiler, electrics, gas appliances and water supply had been tested to ensure they were safe to use. There were records that showed manual handling equipment had been serviced. Fire alarms and evacuation procedures were checked by staff, the fire authority and external contractors, to ensure they worked

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for the service users. The service ensure the proper and safe management of medicines.