Forest Pines Care Limited

Chelmer Valley Care Home

Inspection report

Broomfield Grange, Broomfield Hospital Site
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26 September 2017
27 September 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 26 and 27 September 2017 and was unannounced.

Chelmer Valley Care Home is nursing home registered to accommodate up to 140 residents some of whom may have dementia. At the time of our inspection 50 people were living at the service.

The service has had a new manager in post since March 2017 and they are currently going through the process to be registered with the 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.

The service was last inspected in November 2016 and was rated overall good with requires improvement in safe due to the deployment of staff. We undertook this inspection in response to concerns raised about people's safety. This was a focussed inspection to review safe and well-led.

The service was not consistently safe. People's medication management and administration was not always managed safely to ensure people were receiving their medication appropriately. We found some people did not have clear documentation in place to support the administration of as required medication. We also found when medication needs changed these had not been reviewed promptly.

Risk assessments did not always reflect the needs of people and the best way to support them. We observed poor moving and handling techniques being used by staff. People did not always receive effective pressure area care. Equipment used to relief pressure areas was not always used efficiently and had not been serviced.

The service was not using effective quality monitoring processes to monitor its performance or to look for ways of improving the service for people. The manager needed to improve their oversight of the service and use audits and quality monitoring to drive improvements.

Staff showed a good knowledge of safeguarding procedures and were clear about the actions they would take to protect people. Recruitment checks had been carried out before staff started work to ensure that they were suitable to work in a care setting.

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 consistently safe.

Improvements were required to ensure that appropriate risk assessments were in place to support people. People were at risk due to equipment not always being used correctly.

There were not robust systems in place to manage the administration of people's medication safely.

The manager had appropriate systems in place to ensure that people living at the service were safeguarded from potential abuse and the risk of harm.

The deployment of staff was suitable to meet people's care and support needs.

Is the service well-led?

Requires Improvement

The service was not consistently well led

The manager did not have effective quality monitoring processes in place to allow for a clear overview of the service.

The manager needed to review the systems being used to ensure they were effective and that they drove improvements at the service.

Chelmer Valley 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 checked 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 and 27 September 2017 and was unannounced. The inspection team consisted of three inspectors.

Before our inspection we reviewed information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law. We also spoke with other stakeholders such as the Local Authority (LA) and Clinical Commissioning Group (CCG) who shared their concerns with us.

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 spoke with eight people who used the service, eight people's relatives, nine members of staff, the manager and the deputy manager for the service.

We reviewed 16 people's care records and seven people's medication administration records. We looked at the staff personnel records for four members of staff. We also looked at the service's arrangements for the management of medicines, safeguarding, incident and accident information and quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

Before the inspection we had been made aware of a number of concerns at the service in the previous few months. These concerns had been raised by stakeholders we work in partnership with; these included the Local Authority and Clinical Commissioning Groups. We found the manager had been working closely with the stakeholders to address issues, however not all improvements had been embedded completely to ensure people were looked after safely.

A safeguarding concern had been raised that a person had not received their pain relieving medication promptly due to the service running out of the required medication. This resulted in the person being in pain when it had been their wish to remain pain free. We saw the manager had taken steps to learn from this and had put processes in place to ensure this did not happen again. Staff had undergone further supervision and training around medication practices and an auditing system had been put in place to ensure all required medication was in stock. We reviewed the provider's medication practices and although the above mentioned system was working we found other issues with medication management at the service. For example we found that some people who were prescribed 'as required' medication did not have protocols in place to guide staff how to administer this medication. One person was on a variable dose of pain medication; nursing staff were not recording how much of the medication they were giving. Also on the person's pain scale monitoring sheet they were recording that the person was not in any pain yet they were administering varying levels of pain relief medication. We therefore could not be sure the person's pain relief was being managed effectively or safely by staff.

Another person had been prescribed oxygen for a lung condition on an 'as required' prescription; however staff informed us that this was being given continuously. We discussed this with staff and they agreed that they should have made the GP aware that the person now required continuous oxygen. We checked the person's care plan which stated if the need for oxygen increased they should be referred to the GP. The deputy manager referred the person to the GP for review whilst we were there.

We found other issues with the recording of medication, patches and topical creams. On recording charts there were gaps were staff should have signed when the person had received their topical creams. Body maps used to record patches had not always been completed correctly to show the correct placing of the patch or when the patch had been removed. There were some incidences of medication administration cards not being signed when people were given medication. We therefore the could not be assured that people always received their medication as prescribed due to failures in record keeping. The deputy manager did complete medication audits however these had not highlighted the issues we found. In addition they had not implemented an effective system to ensure issues were addressed by staff.

One person was receiving covert medication, this meant that, in their best interest, it had been agreed the person needed to take medication even though they were not aware they were taking it. In the person's notes it had been recorded that the GP and pharmacist had agreed to this, however the documentation from the pharmacist did not indicate clearly which medication could be given covertly and if not, how medication should be administered. This goes against the service's policy which states 'There must always

be a plan for covert treatment and administration of medication. A pharmacist must have approved the method and preparation of the medicine.' This meant there was a risk that the person was receiving the medication in way that could change their individual effectiveness. The deputy manager and manager were informed to address this.

The CCG, during their reviews, raised that when people required pressure relieving equipment to prevent the breakdown of pressure areas leading to sores, these were not always being used effectively. To address this issue the deputy manager and manager had put a system in place of marking the correct setting on the equipment and implementing checks on the equipment by care staff or nurses each day. However, when we checked the equipment we found a number of mattresses on the wrong settings. One person who had been admitted 48 hours previously had their mattress set to firm and static. We asked the nursing staff why this was the case and they informed us it was because they did not know the person's weight to set the correct setting. Any airflow mattress set to static is not alternating pressure and therefore is not working to prevent pressure areas, mattresses should only be on this setting for short periods such as during personal care. They immediately addressed this. We found another mattress that was not working, we raised this with the staff and they arranged for the maintenance person to change the air flow pump. Once this was done the mattress was seen to be functioning correctly. Although the above mentioned concerns had been addressed during our inspection; this was only due to inspectors identifying the concerns and bringing it to the attention of the provider at the time.

We checked when the pressure relieving equipment should have been serviced and we saw this had been due in April 2017 but servicing had not been carried out. The manager showed us evidence that they had followed this up in July 2017 with the supplier however this had still not been completed.

In addition to pressure relieving equipment not always being on the correct setting we found in people's care plans and notes there were at times conflicting information for staff to follow, for example in one section of a person's notes it said that a person needed to be assisted to turn every two hours whilst in another section it stated every four hours. Recording charts were not always completed to show the frequency of turns. The manager could not explain this discrepancy. Despite the shortfalls we were informed that no one currently living at the service had acquired a pressure sore whilst being supported at the service.

Our observations showed that staff did not follow one person's moving and handling care plan on two occasions. Instead of assisting the person with a standing hoist as specified in their moving and handling assessment staff physically assisted them by placing their hands on the person's back. Staff also placed their hands under the person's arm and held them around the top of their arm. This is not a recognised safe technique for supporting people with moving and places them at risk of bruises and shoulder injuries. We reported this to the manager and deputy manager, they told us that they were disappointed that this had happened and that they would address this with the moving and handling trainers to review staff practices.

Staff did not always have the information they needed to support people safely. For example we found risk assessments were not always up to date or reflective of the needs of the person. We found staff did not always follow people's risk assessments, specifically in relation to being at risk of choking.. We saw one person eating unsupervised when it was recorded that they needed to be supervised due to a risk of choking. When we bought this to the manager and deputy manager's attention, they told us that this person had improved so the risk assessment was no longer valid. They had not however considered referring the person back to the speech and language therapist for a re-assessment of their support needs so that the risk assessment could be updated.

These failings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. Safe care and treatment.

The Local Authority had been working with the service to investigate safeguarding concerns. We saw the manager had acted on concerns. From minutes of meetings we saw that all staff had been reissued with the service's 'whistle blowing' policy to support them in being confident in raising concerns. Staff we spoke with all knew how to raise a safeguarding concern and we saw documents supporting this on display at the service. We noted that staff had come forward when they had identified an issue with a member of staff to report this so as to ensure that people were safeguarded.

The service had a high level of falls both witnessed and unwitnessed. We noted that some falls had resulted in serious injury and we looked at general falls management as part of this inspection. Specific incidents may be investigated separately in line with our powers to investigate avoidable harm. The manager told us that they were gathering data and that staff adopted risk reduction approaches such as using pressure mats. The manager told us that where people fell persistently they were referred to the falls team for assessment and advice.

In addition the manager told us that as a consequence of the high level of falls they had signed up to work with the local authority PROSPER project. The PROSPER project is sponsored training and support from the council to support services in improving. The manager told us that they would be specifically looking at fall reduction.

People told us that there were enough staff to attend to their needs, one person said, "I have a red button to press if I want staff you don't have to wait too long, they are all my friends." Another person said, "If I push my button they come quickly or pop in and say they will be as quick as they can." A relative told us, "The staffing is very good, they use very few agency."

We had mixed reviews from staff about staffing levels with some staff stating they felt there was enough staff and others saying they could use one more member of staff. One member of staff said, "The manager always tells us we are over staffed, but they always come around in quiet periods." Another member of staff told us that they had discussed the increasing support needs of people with the manager who had told them they would review the tool they used to calculate staffing levels.

Although staffing interaction with people was not rushed we observed on occasion areas left unsupervised such as the lounges. Although the majority of the time staff were available in the lounges, when they were left unsupervised we noticed people who were at a high risk of falling; attempted to mobilise independently, which we bought to the attention of staff to intervene and support them.

Suitable arrangements were in place to ensure that the right staff were employed at the service. Staff recruitment records for four members of staff showed that the manager had operated a thorough recruitment procedure in line with their own policy and procedure and regulatory requirements. Relevant checks were carried out before a new member of staff started working at the service. These included the attainment of references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service [DBS].

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post. A new manager had been appointed in March however they were not yet registered. The provider has undergone a number of changes and up until August a management company was in place to provide support and oversight at the service.

Quality assurance systems although in place were not robust in addressing issues at the service. For example where audits were completed by the manager or deputy manager they could not evidence how they addressed the issues they had identified. Care plan audits identified missing documentation and incomplete paperwork; however there was no action plan or agreement with staff how these issues would be rectified, so repeat audits on the same paperwork showed the same issues. We discussed this with manager and deputy manager and they agreed that they had not fully developed how to monitor the outcome of audits. Medication audits when completed had not addressed the issues of missing signatures on medication charts or missing 'as required' protocols. There was no action plan to address these issues and there was no evidence to suggest the issues had been addressed with individual staff. During our review of medication charts as identified earlier in the report we found the same issues persisted.

We reviewed accident and incidents at the service to see how these were being analysed and managed. We saw that the number of falls at the service was routinely being recorded, along with the time of the fall and if people had been seen by the GP. Although this was taking place, there was no further analysis such as checking if it was the same people falling, or if they had an underlying health condition. There was no matrix or record to show if people had been referred to the falls team or if risk assessments had been changed to try and mitigate the risk of further falls. Information on whether people had been referred to the falls team was only recorded in care plans, which made it difficult to follow up as to whether an appointment had been made or if people had been seen and risks mitigated.

We discussed with the manager how staffing numbers were calculated as staffing levels had previously been raised as an issue by stakeholders. We noted that in people's care plans they had a dependency assessment completed monthly. We also noted that staffing levels had not been calculated since the beginning of July 2017. When we asked the manager how they proposed to ensure that they had the correct level of staff working on each unit they told us that they would recalculate staffing numbers when there was an increase of 10 people at the service. So when the number went up to 50 and then 60 they would recalculate the staffing numbers. We discussed with the manager how this model of staffing calculation was flawed due to the fact people's needs could change at any time and they could become more dependent requiring a higher level of staff support. The manager agreed they would review how they planned to monitor people's dependency levels against staffing numbers.

Without robust audit and monitoring tools we could not be assured the manager had a clear oversight of the service.

These failings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Staff told us that the manager and deputy manager attended each of the units and gained feedback from staff every day. Staff also told us that staff meetings were held at the service and we were provided of some evidence of these. We saw that where important feedback from safeguarding investigations had been identified the manager met with staff individually to record this feedback in supervision sessions.

Even though all of this was in place, not all staff felt listened to by the manager and some staff expressed frustrations that their ideas for improving the service were not always listened to. Some staff also expressed that communication at times could be poor at the service with them not always receiving all the information they need, for example when there is a new admission. Another issue staff had raised was the lack of a telephone service to the units, with telephone lines only being one side of the building. Also out of hours all telephone lines were transferred from reception to the first floor, this meant the ground floor could not receive external telephone calls directly. Staff told us that this was a risk of information not being passed on to them from the staff upstairs. We discussed this with the manager and they agreed this was an issue that they had so far been unable to resolve.

The manager gathered people's views on the service and had recently sent out a survey to relatives and people and was gradually getting the feedback from these. Relatives and people told us that the manager was approachable and that they were happy to discuss any issues with them. One relative told us, "I have recently discussed setting up a joint quality meeting with the manager as not many relatives seem to attend relative meetings." During the inspection we saw the chef and kitchen staff held a meeting with people to discuss the menu and to get their feedback on food at the service.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not managed safely with clear instructions to staff to mitigate the risks..

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was not an effective governance system in place to monitor and improve the quality of the service.