Derbyshire County Council

Castle Court Care Home

Inspection report

Linton Road
Castle Gresley
Swadlincote
Derbyshire
DE11 9HP

Tel: 01629532256
Website: www.derbyshire.gov.uk

Date of inspection visit:
18 August 2017

Date of publication:
12 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 14 August 2017. At our last comprehensive inspection on 30 June 2016 we found that medicines were not always managed in a way to ensure people were protected from the risks associated with them and that staff did not have clear guidance on how to support people in their best interests when they were unable to make decisions independently. We completed a focused inspection on 20 January 2017 and found that the provider had addressed the areas that required improvement. At this inspection we found that these improvements had not been sustained. We also found that there were other areas which required improvement.

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

Castle Court provides accommodation and personal care support for up to 41 older people. There were 32 people living at the home at the time of our visit. There were not always enough staff available to meet these people's needs. This meant that people were left at risk of harm at times. It included when people behaved in a way which could be harmful to themselves or others. There were not always plans in place to support staff to manage this behaviour. Other risks had not been updated after incidents to ensure that the plans in place to reduce the harm had been considered. Staff did not always recognise some incidents as potentially harmful situations. These had not been shared with the responsible external agencies to ensure that people were safeguarded against harm.

People's capacity to make their own decisions was not always considered to ensure that they were able to do so. Applications to restrict people's liberty to protect them were made without considering what capacity they had through an assessment. People did not always have a choice of food and drink. When they required specialist meals this was not always given to them. Some healthcare appointments were not maintained to assist people to manage conditions.

There were not always plans in place to give staff guidance to support people well. Other plans were not up to date. People did not always have their needs met as requested. They were not always provided with the opportunity to pursue meaningful activities.

Some of the risks associated with medicines were not managed to protect people from harm. The management systems which were in place to monitor the safety of the home were not always effective. Some information about accidents and incidents had not been included in the reporting to give an accurate overview so that the provider could put actions in place to improve it.

We were not notified of all of the changes in the home that we require as part of the registration so that we can monitor how it is managed. People and staff did not always feel that their feedback was listened to and used to improve the service. Staff received regular training but did not always have the opportunity to implement the learning from it to ensure that people were supported more effectively.

People did have caring relationships with people who ensure that their privacy and dignity was respected. Their families were welcomed to visit regularly and they could meet them privately.

Safe recruitment procedures were followed to ensure that staff were safe to work with people. The provider's previous rating was displayed in the home and on their website as required.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

There were not always enough staff to meet people's needs or protect them from the risk of harm. Staff did not always recognise situations which could be harmful to people and report them to the correct agencies. Medicines were not always managed to ensure that people had them as prescribed. Safe recruitment procedures were followed to ensure staff were safe to work with people.

Is the service effective?

Requires Improvement

People did not always consent to their care and some decisions were made on their behalf without considering their capacity to make them for themselves. People did not always have their healthcare and dietary needs met. There was not always a choice of food and drink available. Staff received training but did not always have the opportunity to use this to ensure that they delivered effective care and support.

Is the service caring?

Good

Caring, kind relationships were developed with staff. People had their dignity and privacy respected and their important relationships were encouraged.

Is the service responsive?

Requires Improvement

People did not always receive care that was responsive to their needs. They were not provided with many opportunities to pursue hobbies and interests. Plans to guide staff in supporting people were not always up to date. Complaints were managed within the provider's procedure.

Is the service well-led?

Requires Improvement

We did not receive all of the notifications that we require to ensure that the service is well managed. Some of the quality improvement systems were not fully completed to ensure that they were effective in monitoring the service. People and staff did not always feel that their feedback was responded to ensure that issues were addressed. The provider ensured that their previous rating was displayed.

Castle Court 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 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 unannounced inspection took place on 14 August 2017. It was completed by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We had not asked the provider to complete a provider information return (PIR) on this occasion. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we gave them the opportunity to share their plans with us during the inspection.

We used a range of different methods to help us understand people's experiences. People who lived at the home had varying levels of communication. We spoke with ten people and also observed the interaction between people and the staff who supported them throughout the inspection visit. We also spoke with three people's relatives about their experience of the care that the people who lived at the home received.

We spoke with the deputy manager, two senior care staff and four care staff. The registered manager was on leave on the day of the inspection and so we contacted them after the inspection to obtain and review further information. We looked at care plans for seven people to check that they were accurate and up to date. We also reviewed the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

There were not always enough staff to keep people safe from harm. People told us that they had to wait for staff to support them. One person we spoke with said, "They are very short of staff here, that is very obvious. If I press my buzzer it can be about 20 minutes before anyone comes". Another person said, "Sometimes no one goes past my door for ages so no one is checking we are okay". We observed that five people were in one communal area for over one hour without any staff contact. Only one person was able to use a bell to call staff and we saw that person was asleep for the majority of that time. People in this lounge all required support from the staff to move safely. One of the people had previously acquired a serious injury when they fell while waiting for staff attention. We saw the person's risk assessment had not been updated to clearly demonstrate how often they should now be supported.

The layout of the home meant that if staff were supporting people in one part of the home they were unable to see people in other areas of the home. We observed further instances when people were not observed by staff in communal areas for over twenty minutes. This included people who needed support to manage their behaviour and people who needed assistance moving. At night staff told us and records confirmed that there were two care staff on duty to care for people. Staff we spoke with told us that there were at least six people who required two staff to assist them during the night. There were other people who were restless at night and did not sleep until the early hours of the morning. One member of staff said, "I think at least one other person at night would be better. One night we had an extra member of staff because they were doing shadow shifts. This meant that when someone fell, one member of staff could take medical advice on the phone, one could stay with the person and the other could help others. I don't know how we would have coped without the extra staff member". Another member of staff told us, "If two of you are supporting someone at night then you can't go to other people and they just have to wait". People we spoke with confirmed that staffing levels at night did not always meet their needs. One person told us, "At night is the worst, there are no staff to be seen. Sometimes some of the other people who get a bit confused walk up and down the corridors opening and closing our doors and there are no staff to help them. It can be very disturbing and worrying for us in bed".

All of the staff we spoke with told us that they did not think there were enough staff to be able to meet people's needs. One member of staff said, "People's needs are getting higher and we just don't have enough staff to be able to support them well. We have no time to speak with them and it is affecting staff morale". We asked to see how the staffing levels were planned to meet each person's needs; for example using a tool which assesses people's dependency. We were told that although people's dependency was assessed, this information was not used to determine how many staff were needed to ensure people were safe. This meant that we could not review how the staffing levels had been planned to meet individual need.

The staffing levels had an impact on the way that risk was managed for people living at the home. We saw that one person could become distressed and we were told that when they did, their behaviour could be frightening to other people. When we spoke with staff they told us that the person responded to being spoken with and liked company. We observed that the person sat alone for long periods of time at a table with no interaction from staff. One other person we spoke with said, "That person sits there all day long and

never really does anything, they must get very bored. I talk to them and we have a chat sometimes; it's such a shame because they do get upset and cry but no-one seems to know how to manage them properly". Staff told us that when the person became distressed in the evening or at night, it was particularly difficult to spend time with them because it was a busy time of day. When we reviewed the person's care records we saw that there was not a plan in place to give staff guidance to help the person to manage their behaviours.

This evidence represents a breach in Regulation 18 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

We looked at the records of people's falls to see what action the provider had taken to reduce the risk. One person told us about a fall that they had and their relative confirmed that they saw them bruised. We could not find a record of this fall and there was also no record of the person's injuries. When we spoke to a member of staff about this they found that it had been put onto the online system but not reported as an accident. When we looked at people's risk assessments after falls we saw that they were not always reviewed. This meant that we could not be sure that the person had received the care they needed or that actions were taken to reduce further risk.

Incidents of behaviours which could cause harm to others were not analysed on a regular basis. None of the incidents had been considered to be safeguarding concerns. When we reviewed a notification of serious injury after the inspection visit we found that it should have been reported to safeguarding and had not. When we looked at records we saw that there had been no safeguarding referrals made for the past three years. This meant that we could not be sure that the manager and staff understood potential harm or reported it in a timely manner.

People told us that they received their medicines when they needed them. We saw that time was taken to give them to each individual and that staff ensured the people had taken them when necessary. However, when we reviewed the amount of medicines which should be stored for each person we found that it did not correlate with the records. This meant that people may not have received their medicine or may not have had the correct amount.

Some people needed to receive their medicines in a certain way to ensure that they were effective. For example, when some people took one medicine they needed to omit another one because they would react with each other. There was no written guidance to ensure staff knew about this. When we asked a member of staff they said, "There is nothing written down we are just told". This meant that there was a risk that new or temporary staff may not know the correct procedure.

Some people had additional medicines prescribed to be given 'when necessary' or 'as required'. There was also no guidance to support staff to know when this medicine should be given. For example, we saw that after one person had a fall, advice was given that they should not take certain tablets if they were dizzy. They were still prescribed this and there was no written guidance for staff to know when they should not take it.

Arrangements were not always in place to ensure that medicines with a short expiry were dated when they were opened. Some medicines were not always stored within the recommended temperature ranges for safe medicine storage. We saw that on eight occasions the maximum fridge temperature had exceeded the recommendation for the medicine stored in it. When we spoke with a member of staff about this they were not aware what the maximum temperature should be. This meant that there was a risk that it was no longer effective due to incorrect storage.

The provider followed recruitment procedures to ensure that staff were safe to work with people who used the service. One member of staff told us, "They did my police checks and took references before I started". Records that we reviewed confirmed that these checks had been made.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last comprehensive inspection we found that people did not always have their capacity to make their own decisions assessed. At the focused inspection on 20 January 2017 we saw that this had improved. However, at this inspection we found that this improvement had not been sustained. People's choices about their food and health were not always listened to. One person told staff who served their food that they did not like it and that they had an adverse reaction to an ingredient in the food previously. We saw that staff did not offer an alternative meal and only removed some of the ingredient from the meal. We alerted senior staff to the situation because the ingredient was present in the rest of the food and the person may have been put at harm. Another person had capacity to make their own decisions. After they had a fall we saw that the provider had spoken to their family to say that they must no longer use a piece of equipment. The person had not been consulted about this decision although they had capacity.

Other people had DoLS applications made on their behalf. These were to cover restrictions such as the front door being locked. There was no assessment of their capacity before the application and no record of decisions that had been made in their best interest. When we spoke with staff they were not always able to tell us who had a DoLS application in place and what that meant in terms of restrictions placed on them.

This evidence represents a breach in Regulation 11 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

People did not always have their healthcare needs met. We spoke with one person who told us that they should see a healthcare professional regularly. This was to help to maintain a condition and reduce further risks to their health. We checked with staff and found that they had not seen the professional for an extended period which was longer than recommended. A member of staff had recently alerted senior care staff and we were informed that it would still be several weeks before an appointment could be made. This meant that the person was at risk of harm because action had not been taken to ensure that their health was maintained.

Other people did not always receive the specialist diets they required to assist them to manage their health. We saw that everyone was offered the same dessert at a mealtime. When we discussed this with other staff we were told that a specialist meal had been provided. However, when we spoke with staff who gave people the food; they were not aware of this and had not given the specially prepared food to the correct people. This meant that people ate food that could cause harm to their health.

We saw there was not a choice of hot food at mealtimes, although we were told that people could request another meal. One person we spoke with said, "The food is average but we don't really have any choice". A relative told us, "I assume there is another choice of food if you don't like what is served, but it would perhaps be good to find out in advance so there is no delay in sorting an alternative and it could come up on the trolley ready". Therefore, people were not always able to make a choice about their meals.

Staff we spoke with told us that they received regular training and opportunities to refresh previous training. However they were not always able to demonstrate this in the role. For example, staff had attended training in the MCA and could describe what they had learnt but they had not necessarily applied this learning to the people they supported to ensure that they enabled them to make choices about their care.

New staff told us about their induction. One member of staff said, "I had quite a long induction. I shadowed other staff at first and I also did training like moving people safely and fire safety". Another person said, "I am doing the care certificate. I have completed most of it and I am just waiting for it to be signed off". The care certificate is a national approach to ensure that all new staff are competent in set induction standards. This showed us that the provider ensured that staff were provided with training and support so that they could meet people's needs. However, they needed to ensure that the learning was embedded by checking that staff were doing the job effectively.

Good

Is the service caring?

Our findings

People had kind, caring relationships with the staff who supported them. One person told us, "The staff are very busy but are a good little lot. They are very friendly and helpful and do as much as they can for me, when they are able". Another person told us, "The staff are lovely and very helpful, they are easy to get on with and I think they are respectful and look after my dignity". A relative we spoke with said, "Whenever we come the staff make us feel welcome and they look like they are happy and doing a good job". We saw that although staff were very busy but when they were able to speak with people it was in a kind and respectful manner. For example, before assisting someone to move the member of staff gently explained what they were going to do to reassure the person.

Families were welcome to visit freely. People that we spoke with told us that they could visit anytime. We saw that when they visited they could spend time privately with people in their rooms. People's rooms were decorated with their own belongings. One person invited us to their room and showed us the family photographs on the wall and the plants they were growing on the windowsill and in the bathroom.

When people required personal support this was provided privately and the person's dignity was considered. For example, we saw people being asked quietly if they needed assistance and then taken from the room. One person we spoke with said, "I have no worries about my privacy because I have my own room. I usually choose to leave the door open but if not the staff will knock". We observed that people made other choices about their care. For example, people were asked where they wanted sit and which drink they wanted.

Requires Improvement

Is the service responsive?

Our findings

People did not have any meaningful activities provided to them throughout the day and we saw that they spent long periods of time asleep or disengaged. One person told us, "There is nothing to do here because I am not a big fan of the TV". Another person said, "There are no activities to get involved in and there are not enough staff to be able to talk much with me. I am lucky because I do have visitors". Staff we spoke with told us that since changes to the staffing structure there were no longer staff employed specifically to do activities with people. One member of staff told us, "All staff are expected to do activities now but we don't have the time to do anything with them". Another member of staff told us, "The changes that have happened have definitely impacted on activities. We used to spend time reminiscing with people or games but now we have no time. I think it means we don't know people as well because we don't have the time to get to know them".

We saw that there was an activities programme on the wall; however, none of the activities planned happened on the day of inspection. One person told us, "Oh yes they have that programme but I have been here nearly five weeks now and have never seen anything on there happen". We saw that people sat in communal lounges with televisions on for the majority of the day. One person we spoke with told us that when they came to live at the home they organised some games with other people and this was the only activity we saw take place.

People's needs were not always responded to and care given in their preferred way. One person told us, "I feel very uncomfortable with all this on my face. My razor broke a while ago and so I cannot have a shave. I've nearly got a beard which I have never had and I don't like it". When we asked staff they told us that the razor was broken but they did not know why it hadn't been followed up. Another person told us that they had difficulty drinking and had their own specialist cup. We saw that they were provided with a drink in normal tea cup and it was left on a windowsill which made it difficult for them to drink it. We saw that they did not have a table in their room to put drinks on. When we spoke with senior staff they arranged for a table to be provided.

People's care records were not always accurate and did not reflect their current needs. We saw that plans were not amended after serious incidents; for example after hospital stays or falls. For example, one plan had hoist handwritten on other guidance and a note which said 'Needs updating'. Some people had conditions which should have had a plan to assist staff to give them the correct support. For example, several people had diabetes and this meant that they should their bloods regularly tested, their diets monitored and regular health professional appointments. There was no guidance for staff about this. When we spoke with one member of staff about the readings of blood sugars they said that they would react if it was high but they could not say what high would be for each person. They told us they felt that more information would be helpful in people's care plans.

When we spoke with senior staff about this they recognised that the care plans were not all up to date. They said that it was difficult to manage because they also had to complete full care plans for each new person and recently they had had a lot of people who had come for short stays.

This evidence represents a breach in Regulation 9 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

People and their relatives knew how to complain if they needed to. One person told us, "I do know the manager and I would ask them if I was not happy about something". We spoke to the manager about the content of the complaints they received and saw the actions that they had put in place to resolve them. They were all responded to and resolved in line with the provider's procedure.

Requires Improvement

Is the service well-led?

Our findings

The provider did not always inform us of important events. We ask them to do this so that we can check that action has been taken to ensure that the home is well managed. At the inspection we were told that the registered manager had an extended period of absence from the home. We ask to be informed when a registered manager is absent for more than twenty eight days and this did not happen. We do this to ensure that there is adequate support for the service in their absence.

This evidence represents a breach in Regulation 14 of the Care Quality Commission (Registration) Regulations 2009.

The quality improvement systems in place to monitor the service and drive improvement were not always effective. For example, when there was a gap in the medicines administration record a report should have been completed and given to the senior care staff. A member of staff told us that they had completed a report for a missed administration. However, when we spoke with senior care staff they were not aware of the error and had not taken any action to remedy it. Furthermore, the manager reported to the provider on a monthly basis on certain outcomes such as accidents and falls. We found that the monthly reporting was not accurate because some falls had not been recorded as accidents and others had not been added to the total for the month. This meant that the information used to monitor the service was not always accurate so that the provider could ensure it was safe and meeting people's needs.

People told us about concerns that had been reported but we saw that no action had been taken. For example, when one individual told us that their razor was broken we found that it was in an office and no action had been taken to get it fixed. Another person told us that they gave the provider feedback about the lack of meaningful activities on offer and had not received a response. We were also told by staff that when some issues were raised with the provider they were not always resolved. For example, when we reported that the medicines fridge was not always at the correct temperature we were told that there was a problem keeping the room cool. This had been reported to the provider but no action had been taken. When we spoke with senior care staff about the delay in responding to issues they told us that the senior team at the service had also been reduced and that they found it difficult to maintain all of the management responsibilities since.

Care staff told us that they felt that they were not always listened to. They told us that they had raised concerns about the staffing levels and had been told that the provider was unable to provide additional staff because of the funding. The provider did not have a tool that would allow them to plan staffing around individual need and amend it as people's needs increased. This would have assisted them to review funding against need particularly as they had a lot of people who received short breaks at the service. Staff told us that this put additional pressure on them as they had new people each week who they had to get to know and learn how to support.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's

website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating as required.

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 14 Registration Regulations 2009 Notifications – notices of absence Notification of absence of registered manager was not made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care which met their needs or reflected their preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to consent to care was not always considered or assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff deployed to meet people's needs safely.