

Cheriton Care Centre Limited

# Cheriton Care Centre - Badbury Wing

## Inspection report

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### Ratings

#### Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



### Overall summary

This was the first inspection of Bradbury Care Home since it became registered on 12 January 2015.

When we visited there no registered manager in post but the provider was in the later stages of applying to register a manager at the home. The previous manager resigned their position in August 2015. 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.

Bradbury Care Home provides care and support for up to 33 older people. At the time of the inspection there were 18 people living at the home.

# Summary of findings

The recording and storage of medicines was not safe and put people at risk of harm. We found that medicines were not always stored in safe and clean environment. We also found that when staff hand wrote people's names on medication mistakes had been made. We also noted that peoples care records did not consistently illustrate the medicines they had been prescribed. This put people at risk of receiving medicines inappropriately.

The risks people faced around mealtime were not consistently known to staff. Whilst care records illustrated foods that were harmful to people when we asked care and catering staff about this issue they were unaware of the professional guidance that had been obtained. This put people at risk of harm through choking.

Staffing levels at the home were not consistently sufficient to meet people's needs and aspirations. Staff told us they would like to do more to give people a more fulfilled life but at times this was not possible. The staff were not organised in such a way as to meet peoples social needs and were mainly organised around the support tasks they had to carry out.

People told us that the staff were "Very kind and caring, they try" and "the staff are very patient and kind". However one person told us they felt as they were more able, they received less attention than those with memory problems. They also said that "staff made them feel at home and treated them ok".

The provider had not ensured there were activities to meet most people's social and emotional needs on individual basis. For those that could entertain themselves equipment such as a computer or jigsaws were available, but for those who require more motivation and staff encouragement activities and stimulation had not been provided in a planned manner.

The provider had systems in place to ensure the quality of the service was regularly reviewed and improvements were made but this had not been kept up to date. This meant that some areas of the care and support people received were not regularly audited and areas for improvement not recognised. Whilst the staff knew people's needs well, the records relating to people's care and support were not always up to date.

The provider was meeting the requirements of the Mental Capacity Act 2005 and assessments of people's capacity had consistently been made. The staff at the home understood some of the concepts of the Act, such as allowing people to make decisions for themselves.

People and their relatives were given information about the running of the home and how they could comment on areas for improvement.

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

# 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?

The service was not safe. The recording and storage of medicines was not safe and put people at risk of harm.

The risks people faced through eating food that would cause them harm were acknowledged in their care records, but the care instructions were not carried out putting people at risk of harm.

There were insufficient staff on duty to meet people's social and emotional needs in a person centered way. The provider had a plan to address this.

Requires improvement



### Is the service effective?

The service was effective but some improvements were identified. The system for offering choice at mealtimes was not effective.

The service understood and implemented the requirements of the mental capacity act and deprivation of liberty safeguards but some of peoples care records had not been updated to reflect these assessments.

Staff received training in order to meet peoples support needs.

Requires improvement



### Is the service caring?

The service was caring but improvements were required. Whilst staff demonstrated empathy and knew some of the people well they showed little insight into people social and emotional needs.

Staff understood the need to treat people with respect and dignity.

Requires improvement



### Is the service responsive?

The service was not consistently response at meeting people's needs. The care records were not always up to date and reviews of people's needs had not always been completed.

Whilst people's initial assessment of need illustrated the support they required this was not always provided.

The provider had a system in place for people and those important to them to be able to comment on the service they receive.

Requires improvement



### Is the service well-led?

The service was not consistently well led. The staff were not organised to meet peoples individual needs.

Whilst there was a system for ensuring the service was acknowledging areas for improvement this was not fully effective and improving the quality of care available to people. The management acknowledged this and had a plan to address this.

Requires improvement



# Summary of findings

People and their relatives were given information about the running of the home and how they could comment on areas for improvement.

There were systems in place to ensure staff were supported to carry out their work effectively.

# Cheriton Care Centre - Badbury Wing

## 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 1 September 2015 and was unannounced. The inspection was completed by one inspector.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. At the time of the inspection a Provider Information Record (PIR) had not been requested. 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. In order to gain further information about the service we spoke with the six people living at the home and two visiting relatives. We also spoke with seven members of staff.

We looked around the home and observed care practices throughout the inspection. We reviewed five people's care records and the care they received. We looked at people's medication administration records, (MAR). We reviewed records relating to the running of the service such as environmental risk assessments and quality monitoring audits.

We contacted two health care professionals involved in the care of people living at the home to obtain their views on the service.

Observations, where they took place, were from general observations. We also 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.

# Is the service safe?

## Our findings

The medicines procedures at the home were not safe. We looked at the room where medicines were stored and noted that the room was dirty with large accumulations of dust and dirt on the floor, the windows were dirty and dead flies were apparent around the frame. We found that one blood pressure medicine had the wrong name on it because staff had handwritten the wrong person's name on it, apparent as the pharmacy label identified a different person.. This meant that there was a possibility that the wrong person could receive the wrong medicine putting them at risk of harm.

The medicines were not stored securely. We looked at the storage arrangements for medicines and found that whilst the provider had the appropriate storage arrangements these were not consistently used.

Peoples care records did not consistently illustrate the medicines they were taking. We looked at one person's medicine requirements in their care records. These records were not up to date as the person had been prescribed medicines that were not recorded in the medicines administration records kept in the medicines trolley. In this instance the medicines were to be given "as required". However the guidance to staff for the administration of these medicines stated for anxiety. There was no guidance to staff as to what constituted anxiety or any other interventions that they should consider before administering this medicine. This meant that staff may give medicines inappropriately. The above illustrates a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The system to ensure people were not put at risk by eating food that was harmful to them was not effective. In one person's care records there was a speech and language therapy assessment (SALT) giving staff guidance on what food the person could eat and the consistency of food as they were at risk of choking. We asked staff if any person had a special diet or SALT assessment. Two of the staff did not tell us about anyone having a SALT assessment or any special requirements. We spoke with the chef and asked

them if anyone has a special diet. They identified a person who was diabetic but did not identify the person with the SALT assessment. We did not see any records that would suggest that this person received their diet in line with their SALT assessment. This meant that staff may put people at risk of harm as they did not know peoples individual dietary requirements. This is in breach of regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient staff to meet the social and emotional needs of the people living at the home. We spoke with people living at the home; some told us there were enough staff others thought not. We spoke with staff who told us they did not have time to sit and talk with people until later in the day. We observed that staff were very busy in the morning supporting people with their physical needs, serving breakfast and reassuring people who were showing signs of distress. We looked at the staffing rotas that showed the plan was to have four care staff members between 8 am until 2pm and a four between 2pm until 8 pm, between 8pm to 8am two staff were on duty. We observed that the staff member responsible for medicines administration was occupied with this task up until approximately 10.30am meaning there was three staff to support people over two floors of the building. Some of these people required the support of two people to get up meaning that at times there was only one staff available to support people on both floors. We looked at the staffing rotas for the previous three weeks. Out of the 21 days it was recorded that on seven of those days there was only three staff on duty on either of the two day shifts. We spoke with management who acknowledged that at times they had been short staffed and told us about measures they are taking to employ more staff.

Staff had the knowledge to understand what abuse is and how to contact outside agencies should they have concerns about the people living at the home. Staff told us about their understanding of safeguarding people living at the home from abuse. They told us they had received training and were able to describe who they could go to if they considered people were at risk of abuse. What we were told reflected the provider's policy on abuse.

# Is the service effective?

## Our findings

The system in place for people to have a choice at mealtime was not effective. We asked people how they chose what they had for dinner. One person told us “the staff ask us the day before, I can’t always remember what I have chosen but it’s usually alright”. The staff confirmed this was the system for offering choice at meal times. One staff said “if they don’t like what they have chosen we will offer an alternative”. We spoke with the manager about this who acknowledged people with memory problems would have difficulty with this system and agreed to look at this further.

People were given enough to eat and drink. Most people told us there was enough to eat and drink but one person commented that the portions were too small. Through discussion with them they told us that they had spoken to the chef and things had improved, they also told us that if they wanted more the staff would always get more. However they said “I don’t like to ask all the time as it makes me look greedy”. We spoke to staff about portion sizes; they told us people are served based on their preference. We told them about our concerns about one person. They told us they were working with them to ensure they have the size of meal they want. The provider had systems in place to monitor people’s weight and took action by involving other professionals when people were at risk of malnutrition or dehydration.

Where people lacked the mental capacity to make decisions staff were guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person’s best interest. We saw that people’s mental capacity had been assessed and documented in their records and staff had followed the required assessment process. An example of this was when a person had left the building unaccompanied. As this had put the person at risk

of harm the manager had made and been granted a Deprivation of Liberty safeguards (DOLs to restrict them from going out unaccompanied. This demonstrated the manager understood when an application should be made and how to submit one. Staff were meeting the requirements of DOLS and ensured that any restrictions to people’s freedom had been authorised by the local authority as required. Health and social care professionals confirmed that applications for DOLS assessments had been requested. However we did note that not all of people’s care records had been updated with the most recent information which may in turn mean staff have conflicting guidance to follow. We spoke with the manager about this who agreed to ensure people’s records reflected their most current assessment.

Staff told us about the training available to them. They said they had received some training recently. They also told us about the face to face training received recently in areas such as ‘fire safety’. They also told us about a range of other training formats including distance learning. We looked at the records relating to the training that staff had received in the past 12 months. These showed that refresher training had taken place in areas such as ‘equality and diversity, moving and handling, safeguarding’. People told us that they felt staff had the necessary skills to meet their needs, one person stated “The staff know how to help me, they must have had training”.

People’s care records evidenced there were regular health care interventions based on need. People had access to healthcare professionals according to their specific needs. People told us if they felt unwell a doctor or other health care professional would be called. One relative told us staff ensured that people saw a specialist health care advisor when needed. People’s care records confirmed that other health care professionals were involved as required.

# Is the service caring?

## Our findings

One person's relative told us they felt confident staff at the home provided good quality care. One relative said, "Staff are kind and genuine, but there does not seem to be enough of them". Staff told us about people's individual needs and some of their interests. However the staff mainly spoke about people's physical support needs such as assistance to wash and dress and go to the toilet. When asked about people's social and emotional needs they were less clear and could only identify two people whose personal interests were well documented. They did not tell us about people's emotional needs in particular how to reassure people who showed signs of distress associated with their dementia. This meant that whilst staff were caring, their work mainly revolved around the tasks they had to perform and showed little insight into people's individual interests and aspirations. One said "I wish I had a little more time to sit and talk with people but it's a little difficult at the moment". This illustrates that staff are not, at present, offering a person centred approach to the care that they give. (albeit with mitigating circumstances associated with staffing levels and deployment of staff).

This was in breach of regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff offered people advice and encouragement. Where people needed guidance, staff were patient and supportive and carried out their work with a degree of consideration;

however most of the interactions we observed were based on support tasks rather than things that interested the individual. For example we observed staff support a person to stand. The staff member supported them and encouraged them to 'take their time' allowing them to be as independent as possible.

People were cared for by staff who showed compassion and kindness. People told us that staff were interested in them. One person said, "Very kind and caring, they try." Someone else said, "the staff are very patient and kind". Another person told us that things could improve for them and felt as they were more able they received less attention than those with memory problems. They also said that "staff made them feel at home and treated them ok" but they wished for a little more attention.

People's needs were met by staff who demonstrated a caring manner. Staff spoke with people in an empathic and friendly manner. They were respectful and addressed them by their preferred name. Conversations during meal times were mainly around encouraging people to enjoy their meals in a calm environment.

Staff understood the need to treat people with respect and that people's information was confidential. One staff member told about not discussing people outside of our work as this is confidential". Staff told us how they respected people's privacy such as waiting for a response before entering people's rooms after knocking on their doors.

# Is the service responsive?

## Our findings

The home was not consistently responsive to people's needs. An example of this was in one person's care records. The person had recently come into the home following a hospital admission with a view to building their confidence and moving back home. This was clearly documented in the multi-disciplinary discharge meeting. The initial assessment of need carried out by the home failed to acknowledge this key point of the person's needs. There was no further reference to this in the care records or guidance for staff with regards to how to work with the person to ensure their rehabilitation. There was no evidence that other professionals had been contacted in order to build a package of care that would support the person with their aspirations. The staff we spoke with did not mention these people's aspirations when asked. This meant that the persons support needs were not being met. Another person told us about their wish to resume contact with the wider community which had been disrupted by the breakdown of the lift. They said it had been weeks since they had been able to go out or even join other people on the ground floor for lunch. We spoke with staff about this persons wishes who told us it was unfortunate but the person required the lift to access the ground floor. There was no evidence that a temporary solution to meet this persons needs had been fully considered.

This was in breach of regulation 9(3) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people's needs changed the home did not consistently update individual care records. The care records did not reflect people's needs accurately. We observed that in one care plan summary it was stated that the person had capacity to make decisions for themselves. However there was documentary evidence of a MCA assessment on the person who was judged not to have capacity and was subject to an authorised DOLs. We looked at people's review of care records and found that in four instances the records had not been reviewed since March 2015, although it was clear that their needs had changed. One person's care records stated that they can manage their own personal care; however when discussing peoples

support needs with staff we were informed they could not. We spoke with the management about our concerns who told us they were currently reviewing all records to ensure they were accurate and up to date.

This was in breach of regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were some activities on offer but these were limited to people's ability to motivate themselves. We observed that one person was working on a Jigsaw and music was playing but there was little else on the day of the inspection. We spoke with one person about the activities on offer. They told us "there is not a lot for me to do here except sit and read. I have been here two months maybe; I did play cards once with a staff member". We spoke to another person who told us how staff had organised a computer for them so that they could continue their interests in writing. In the temporary first floor lounge we observed a person sat at 90 degrees to the TV clearly not interested in it. We heard them calling for staff to turn the TV down as it was very loud. Staff attended after several minutes and turned the volume down. Following a short discussion with the staff it was unclear as to why the person had been supported to the room to sit facing a window and not the TV or if they even wanted the TV on.

We asked staff about the activities on offer. Whilst they could identify what one person enjoyed the staff told us "the activities are a bit adhoc" another said "it's not great, we try to do what we can but we don't have time". This meant that if you were able to occupy yourself and motivated to do so, some activities were available, whilst for others there was limited choice of things to meet their social needs.

This was in breach of regulation 9(1) (b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had no complaints about the service or the staff and spoke of the dedicated approach of the staff team. Almost all knew that they could raise concerns directly with staff and expressed confidence in the process. One relative said, I've no complaints, when I have something that I am unhappy with the staff sort it out immediately". The complaints log showed all concerns had been addressed and resolved. There was an up to date complaints policy and staff were aware of how to help people exercise their

## Is the service responsive?

right to complain. People and relatives were given opportunities to discuss and feedback their views through satisfaction surveys, a comments box and by meeting and talking with staff.

# Is the service well-led?

## Our findings

At the time of the inspection the register manager had resigned. The home was being managed by the registered manager of the providers other home, Maumbury, located within the grounds of Bradbury. The provider had made an application to CQC for the manager to be registered at both locations. We spoke to the manager about how the home will be managed. They told us the provider was recruiting to the post of care manager for Bradbury, Mumbury already had a care manager in post. They told us their role will be to manage both of the homes with the support of the care manager and senior staff at each location.

The systems in place to ensure good quality care were had not been consistently used. We looked at the last audit of all of the homes systems that was carried out 11/12 May 2015. This audit was comprehensive covering areas such as “involvement and information available to people, nutrition, personalised care and treatment, safeguarding people from abuse, infection control, suitability of staffing and management”. From this audit an action plan had been drawn up which demonstrated where improvements were required and who was responsible for implementing those improvements. However we found that significant progress had not been made with the action plan. We discussed this with the operational director and manager who told us that a number of issues had not been completed by the previous manager before they left. They reassured us that they were now in the process of establishing what was outstanding from the original action plan and caring out a further audit of services to be able to implement a new action plan.

The staff group were not organised to meet the presenting needs of the people living at the home. This was demonstrated by a recent event where the passenger lift had to be replaced. The work could not be planned for, as the lift company could not repair the existing one. As a response to this the people living on the first floor had been provided with a small lounge and separate dining area on this floor. We had been told by the provider that people had been informed of the disruption and the time scales; all but one person had chosen to stay on the first floor until the new lift was installed. The provider told us how they planned to minimise the isolation people may feel from not being able to come downstairs. They told us that at least one member of staff would be allocated to work on the first

floor during the shifts. We spoke with senior staff about how shifts were organised, they did not mention that one staff member was allocated as described. When asked directly who was allocated they told us the shift is not organised that way.

Unfortunately the work to install the new lift had over run by some weeks. We spoke with one person living on the first floor. They told us they were anxious about being in their room and wanted to go downstairs to see others and to go out to pursue their interests in the community. The management of the home informed us that people had been asked their views and consulted about the disruption. We looked in people's care records that did not consistently evidence that matters had been discussed in full. However there was sufficient evidence that the provider had made people aware of the need to replace the lift and had discussed the impact this may have. We spoke with management about why the aforementioned person had not been offered to move to their adjacent home, Maumbury, who explained that due to not having a contract with the local authority this would not have been possible.

We spoke with staff who told us that it had been a difficult time as there was a period when they were unsure of what the management arrangements were going to be but this had now been resolved. They told us that they were working well as a team and they had confidence that the new management arrangements would help them support the people living at the home.

The management had a system for supporting staff through regular meetings. The records showed that staff met as a group to discuss their work on an individual and group level. Staff told us that they had yearly appraisals as well as 1 to 1 meetings with their manager to discuss their work and any training they may need in order to effectively meet people's needs.

Records showed that staff had recorded accidents and incidents. Where people had been involved in an incident or an accident, for example a fall, the staff recorded the cause, the injuries and the immediate actions or treatment that had been delivered. These accident / incident records were checked by the manager, who assessed whether an investigation was required and who needed to be notified.

People were kept informed of developments within the service. At the entrance to the service and throughout the

## Is the service well-led?

premises notice boards displayed useful information about service developments, group leisure activities, health and safety information and new projects that staff were involved in to improve care.

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 | <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>12(f) (g) Medicines administration records were not accurate putting people at risk of harm. The storage of medicines was not safe.</p> <p>12(2) (b) The acknowledged risks people faced were not consistently managed or action taken to minimise these risks.</p> |

| Regulated activity                                             | Regulation                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Accommodation for persons who require nursing or personal care | <p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>9 (1) (b)(c) People were not provided with person centred care as activities, when available, were not based on people's social and emotional needs.</p> <p>9 (3) (b) (c) Care was not designed to provide care with a view to meeting peoples preferences and needs.</p> |

| Regulated activity                                             | Regulation                                                                                                                                                         |
|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Accommodation for persons who require nursing or personal care | <p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>17(c) Care records were not accurate putting people at risk of receiving inappropriate care</p> |

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.