

Four Seasons (No 7) Limited







Charlton Park Care Home

Inspection report

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Ratings

| | | |
|---------------------------------|----------------------|---|
| Overall rating for this service | Inadequate |  |
| Is the service safe? | Inadequate |  |
| Is the service effective? | Inadequate |  |
| Is the service caring? | Requires Improvement |  |
| Is the service responsive? | Requires Improvement |  |
| Is the service well-led? | Requires Improvement |  |

Overall summary

We carried out an unannounced comprehensive inspection of this service on 29 and 31 December 2014 at which breaches of legal requirements were found. We found that systems for the management of medicines were not safe and did not protect people using the service. People were not receiving sufficient food and fluids or the correct diet as advised by health care professionals. People's capacity to give consent had not been assessed in line with the Mental Capacity Act and the provider had not applied for Deprivation of Liberty Safeguards assessments in relation to restrictions placed on them. People were at risk of receiving unsafe or

inappropriate care and treatment as accurate records were not always maintained. The provider had failed to implement an effective system to regularly assess and monitor the quality of service that people received and identify and manage risks relating to health, welfare and safety of people using the service and others.

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

We took enforcement action and served warning notices on the provider in respect of more serious breaches

Summary of findings

requiring them to become compliant with Regulations 13 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations by 02 February 2015. Regulation 13 relates to the management of medicines and Regulation 14 relates to meeting people's nutritional needs.

We undertook this focused inspection on the 4 March 2015 to check that they had complied with these regulations.

This report only covers our findings in relation to the follow up on the breaches of regulations for medicines and people's dietary requirements. We have asked the provider to send us an action plan telling us how and when they will become compliant with the other breaches. These breaches will be followed up at our next comprehensive inspection of the service.

Charlton Park Care Home provides nursing care and support for up to 66 people in Greenwich South London. Following a number of safeguarding concerns raised in June 2014 the local authority placed an embargo on admissions to the home. At the time of this inspection this embargo was still in place. The manager had worked at the home since 23 June 2014. They were registered with the Care Quality Commission on 11 March 2015 as the manager for the home. 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 and associated Regulations about how the service is run.

At our focused inspection on the 4 March 2015, we found that action had been taken by the provider to improve the way medicines were managed. Systems for the management of medicines were safe. Protocols for the use of pain relieving medicines were in place, and pain assessments were completed for people prescribed these medicines. We found that the provider had met the legal requirements for medicines.

We also found the provider had taken action to improve the effectiveness of the service. People using the service were protected against the risks of inadequate nutrition and dehydration. There were appropriate arrangements in place to ensure that people were receiving the food and fluids as recorded in their care plans and as advised by health care professionals. We found that the provider had met the legal requirements for nutrition and hydration.

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?

We found that action had been taken to improve the safety of the service.

Medicines were managed safely. Protocols for the use of pain relieving medicines were in place, and pain assessments were completed for people prescribed these medicines.

We found that the provider had met the legal requirements for the management of medicines.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice and other breaches of legal requirements identified in December 2014 would need to be met.

We will review our rating for safe at the next comprehensive inspection.

Inadequate



Is the service effective?

We found that action had been taken to improve the effectiveness of the service.

People using the service were protected against the risks of inadequate nutrition and dehydration. There were appropriate arrangements in place to ensure that people were receiving the food and fluids as recorded in their care plans and as advised by health care professionals. Staff were up to date with current guidance regarding supporting people with swallowing difficulties to eat and drink.

We found that the provider had addressed the breach of Regulation 14(1) (a) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice and other breaches of legal requirements identified in December 2014 would need to be met.

We will review our rating for effective at the next comprehensive inspection.

Inadequate



Charlton Park 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a focused inspection of Charlton Park Care Home on 4 March 2015. This inspection was completed to check if improvements had been made to meet the legal requirements for two of the breaches to regulations we found after our comprehensive inspection 29 and 31 December 2014. We inspected the service against two of the five questions we ask about services: is the service safe and is the service effective. This is because the service was not meeting legal requirements in relation to these questions.

The inspection was undertaken by two inspectors, one of whom was a pharmacy inspector. The inspection was unannounced. Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements. We also spoke with the local authority commissioning team.

We looked at the medicine records of all of the people living at the home. We also looked at eight people's care files, information about them contained on a white board in the kitchen and a prompt sheet recording their dietary needs and meal time menus. We spoke with three people who lived at the home, two visitors, the registered manager, the deputy manager, the chef, two nurses, three care staff and a visiting speech and language therapist. We also used the Short Observational Framework for Inspection (SOFI) to observe the care and support provided to people in the dining room at lunch time. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

At our inspection on 29 and 31 December 2014, we found that people were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage people's medicines, in particular pain-relieving medicines.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

We took enforcement action and served a warning notice on the provider requiring them to become compliant with this regulation by 02 February 2015.

We undertook this unannounced focused inspection on 04 March 2015 to check that the improvements required following our enforcement action had been implemented.

We found that systems for the management of medicines were now safe. When we looked at the records for medication administration and medicines supplies for people at the service, we saw that all prescribed medicines were available, were stored securely, and that records were clear, accurate and up to date. This showed that people were receiving their medicines as prescribed. We found that where anyone had an allergy status recorded, it corresponded with allergies recorded in their care records. We checked the process for the use and recording of topical medicines, and we saw that staff had been provided with body maps, giving details of where and how often to apply these medicines. Records were made when these topical medicines were used, providing evidence that these

were used as prescribed. Controlled drugs were stored securely according to legal requirements, and regular stock checks were carried out to ensure safe and correct use. Regular stock checks were also carried out on medicines supplies, to check whether medicines were being administered correctly.

We looked at the records for those people who were prescribed pain-relieving medicines, and saw that there were up-to-date protocols in place. These were kept with people's medicines records and provided staff with sufficient instructions on when to administer these medicines. There were safe processes in place for the use of prescribed pain relieving patches. For people prescribed pain-relieving medicines, specific care plans had been put in place and there was a record that pain assessments were being carried out regularly to assess the level of pain. Medicines were therefore administered to people when needed, and people were not at risk of being left in pain.

We spoke with people who had been prescribed pain relieving medicines, and they told us that staff asked them regularly whether they were in pain, and that they received their medicines on time to manage their pain. We looked at the medicines records and care plans for someone who did not have capacity, and was unable to communicate verbally when they were in pain. We saw that the GP had changed their pain relieving medicines from when required use to regular use so that this person's pain was managed.

We found that the provider had addressed the breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Is the service effective?

Our findings

At our inspection on 29 and 31 December 2014, we found that people were not always protected against the risks of inadequate nutrition and dehydration; the provider did not have appropriate arrangements in place to ensure that people were receiving the food and fluids as recorded in their care plans and as advised by health care professionals. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

We took enforcement action and served a warning notice on the provider requiring them to become compliant with this regulation by 02 February 2015.

We undertook an unannounced focused inspection on 04 March 2015 to check that the improvements required following our enforcement action had been made.

People using the service were protected against the risks of inadequate nutrition and dehydration. We looked at the care files of eight people using the service. In each file we saw that nutritional needs assessments and swallowing risk assessments had been completed. These assessments had been reviewed each month. Where nutritional needs assessments indicated that people were at high risk of malnutrition or swallowing risk assessments indicated they were at risk of choking we saw that referrals were made to the speech and language therapy team (SALT). People at risk of losing weight were weighed weekly and a record of their food intake was recorded. Their care plans highlighted their dietary needs, for example, if they required a soft, puree, normal or a diabetic diet.

There were appropriate arrangements in place to ensure that people were received the correct diet as identified in their care plans and as advised by health care professionals. There were guidelines in place advising staff on people's nutritional needs and how they should be supported with food and fluids. Where required we saw that people were having fortified drinks and encouraged to eat snacks between meals. Where people were diabetic or

where on a low sugar diet we saw this was highlighted in their care files and there were guidelines in place for staff to support them if they became unwell. In one person's care file we saw food and fluid guidance was available for staff advising them to observe the person swallowing and to encourage meals and ensure fortified meals and drinks were available at all times.

We saw a white board in the kitchen and an "at a glance" prompt sheet and meal time menus. These showed the dietary requirements of all of the people using the service. We checked these with all of the care files we looked and found they accurately reflected people's dietary support needs. We spoke with the chef. They told us that people with diabetes and those who were diet controlled diabetics were provided with less sugar in their meals. They showed us that these people's meals were labelled with their names. The chef told us that the speech and language therapist contacted them directly after reviewing people's nutritional needs and advised them of any changes. This information was then recorded on the white board, the at a glance sheet and meal time menus. These changes were also discussed at hand over meetings. The chef and three members of staff told us they had attended a two day training course on nutrition and food texture modification in January 2015. This meant that staff were up to date with current guidance regarding supporting people with swallowing difficulties to eat and drink.

We spoke with a visiting speech and language therapist. They told us that the referrals made to them and their team were always appropriate. The nurses always gave them accurate information in a timely manner and any recommendations the SALT made were followed by staff. They said "The good thing about here is that it's not only the nurses that know what to do. The kitchen staff and care staff all know what to do to support people. It all runs quite smoothly."

We found that the provider had addressed the breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.