

MDJ Homes Limited

Shaws Wood Residential Care Home

Inspection report

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Kent
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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 05 September 2017 and was unannounced.

Shaws Wood Residential Care Home offers accommodation and long term care and support to up to 39 older people. Some people were living with dementia, some had mobility difficulties, sensory impairments and some received their care in bed. Accommodation is arranged over two floors. There is a passenger lift for access between floors. At the time of the inspection there were 38 people living at the service.

There was a registered manager employed at the service. 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.

At the last comprehensive inspection, the service was rated Good overall and Requires Improvement in the 'Safe' domain.

We carried out an announced comprehensive inspection of this service on 19 and 21 October 2016. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches of Regulation 12 and Regulation 19 of the Health and Social Care Act Regulated Activities Regulations 2014, Safe care and treatment and Fit and proper persons employed. The provider sent us an action plan on 16 December 2016, this told us they had already taken action and were now meeting the regulation. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Shaws Wood Residential Care Home on our website at www.cqc.org.uk.

At this inspection we found that the service still required improvement in the 'Safe' domain. We received positive feedback about the home from people and a relative.

Topical medicines were not appropriately administered and recorded. Protocols were not in place for all as and when required medicines.

Risks to people's safety in the event of a fire had not been appropriately assessed, mitigated and managed.

Risk assessments had been reviewed and updated when people's care and health needs changed. Actions had been taken as a result of any accidents and incidents.

There were suitable numbers of staff deployed on shift to keep people safe. Effective recruitment procedures were in place to ensure that potential staff were of good character and had the skills and

experience needed to carry out their roles before they were employed.

The home was clean and smelt fresh by the end of the day. Personal protective equipment was in place to protect people and staff from the dangers of cross infection.

Staff knew and understood how to protect people from abuse and harm and keep them safe. The home had a safeguarding policy in place which listed staff's roles and responsibilities.

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 this 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?

The service was not consistently safe.

Medicines had not been appropriately managed and recorded. Topical records did not always show that people had received their medicines as prescribed. Protocols relating to people who were prescribed as and when required medicines were not always in place.

Risk assessments were clear and up to date so staff had clear guidance in order to meet people's care needs. However, people's fire safety had not always been appropriately assessed and mitigated.

Staff had a good knowledge and understanding on how to keep people safe from abuse.

There were sufficient staff to meet people's physical, social and emotional needs. Recruitment processes were safe and ensured only suitable staff were employed.

The service was clean and tidy and practices were in place to minimise the spread of any infection.

Requires Improvement 

Shaws Wood Residential 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.

We undertook an unannounced focused inspection of Shaws Wood Residential Care Home on 05 September 2017.

This inspection was carried out to check that the provider had made improvements to meet legal requirements since the last inspection to the service on 19 and 21 October 2016. We inspected the service against one of the five questions we ask about services: is the service Safe? This is because the service was previously not meeting legal requirements. This inspection was carried out by one inspector and an assistant inspector.

Prior to the inspection we reviewed other information we held about the service, we looked at the previous inspection report, the provider's action plan following the last inspection and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We also reviewed information we had received from whistle blowers.

During the inspection we reviewed nine people's records and a variety of documents. These included people's risk assessments, daily records and three staff recruitment records. We also requested information by email from Healthwatch and from local authority commissioners.

Some people were not able to verbally express their experiences of living in the home. We observed staff interactions with people and observed care and support in communal areas. We spoke with six people who lived in the service. We also spoke with one relative who visited the service and six staff including, care staff,

senior care staff, the handyperson, the registered manager and the head of operations.

Is the service safe?

Our findings

At our last comprehensive inspection on 19 and 21 October 2016 we found that the provider had failed to ensure care was delivered in a safe way which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had also failed to operate recruitment procedures effectively which was breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to meet the regulations. We also made two recommendations. We recommended that the provider engaged a suitable and qualified person to ensure the call bell system worked effectively. We also recommended that the provider followed good practice guidance in relation to topical medicines records. The provider sent us an action plan which showed they had met the regulations by 16 December 2016.

At this inspection we found that medicines were not managed effectively. Recruitment practice had improved. We found that fire safety in the home required improving to ensure that people were protected from the risks of fire.

At the last inspection we found that there were gaps and inconsistencies in the medicines administration records (MAR) for people in relation to people's topical creams. At this inspection we found this had not improved. We checked a selection of topical medicines charts to ensure people had received their medicated creams as prescribed by their GP. We found there were a number of gaps in records. For example, one person was prescribed Diprobase cream twice a day, their records showed they had only been administered this cream twice on four occasions in three weeks. Another person was prescribed E45 cream twice a day. Their records showed they had only been administered this twice seven times in three weeks. This meant that there was a potential risk of harm from skin conditions or pressure ulcers. We spoke with the head of operations. They felt this was a recording issue rather than people not receiving prescribed medicines as there were no concerns with people having pressure areas and the stock levels of prescribed barrier creams regularly decreased.

We observed a medicines round. This was carried out by a staff member who had undergone medicines administration training. The staff member wore a tabard with 'Medicines round do not disturb'. The staff member checked each person's MAR before dispensing the medicines carefully from the compliance aid. The staff member explained to each person what their medicine was for when they took it to them and they ensured the medicines were taken with a drink. People who were prescribed as and when required (PRN) medicines such as Paracetamol for pain relief were asked if they were in pain and whether they needed any pain relief. Protocols were in place in the medicines room for most people's medicines. These described why people may need the medicine, what the maximum dose would be and how the person communicated that they were in pain or required the PRN medicine. One person was prescribed Paracetamol and Promethazine tablets on a PRN basis, there were no protocols in place for these medicines. Another person was also prescribed Paracetamol on a PRN basis, there was no protocol in place. This meant that staff did not have all the information they needed to safely administer the medicines on a PRN basis. Some PRN protocols in place related to people that no longer lived in the home.

Some people were prescribed medicated pain patches by their GP. There was no system in place to ensure that these were administered on to different areas of the body as recommended by the manufacturer and people were at increased risk of skin irritation from pain patches repeatedly administered to the same site. A staff member responsible for administering medicines was clear they knew that the pain patches should be administered to different areas of the body and confirmed they did this in practice. However, the administration records did not provide clear guidance to ensure that this was followed.

Medicines storage temperature records had not always been monitored consistently. For the month of August 2017 they had not been checked and recorded on the 10, 19, 26 and 27 of August. September 2017 records showed the temperature had not been monitored and recorded on 04 September. Not monitoring medicines storage temperatures could lead to medicines not being effective.

This failure to manage medicines effectively was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

MAR charts had been completed appropriately to record when people had received their medicines. Medicines stock records tallied with the amount of medicines in stock. Medicines were stored securely. Medicines audits had been carried out by the registered manager. Action had been taken to address any errors or inconsistencies within the medicines records.

Fire evacuation drills had been carried out to ensure people and staff knew what to do in the event of a fire, these had not been carried out as frequently as the provider had planned. The fire policy detailed that these should be carried out quarterly. Records showed that these had not happened on a quarterly basis. Regular fire alarm testing had taken place. Staff were able to confirm the action they would take on hearing the alarm. One staff member told us they would evacuate everyone on the top floor out of the kitchen and down the ramp. We pointed out that this ramp led to a set of steps. They then told us some of these people would not be able to use the steps. The fire escape outside the upstairs kitchen/diner was very slippery. This may need repainting to prevent falls. The registered manager told us that there were no evacuation chairs or aids on the first floor because people living upstairs were more mobile and independent than those living downstairs and that they could manage the stairs that lead from the upstairs dining room fire exit down to the ground floor outside. The registered manager detailed that if a person became immobile for any reason, the service would get an evacuation chair at that point. However we observed that there were a number of people upstairs that had restricted or poor mobility that would not be able to safely use stairs. We checked with a staff member and they told us that there were at least three people that could not use stairs. People had personal emergency evacuation plans (PEEPs) in place to detail how staff should help them evacuate in the event of a fire. These PEEPs did not always give an accurate picture of people's needs. For example, One person's PEEP stated they used the upstairs fire exits in the case of a fire evacuation. However, it stated that the person had trouble using stairs and that they were a wheelchair user. This meant there was no safe means of escape for people with mobility impairments who lived on the top floor. We spoke with the registered manager and operations manager about this and they took action to order an evacuation chair.

The provider's fire policy stated that the fire evacuation procedure must be clearly displayed around the building. We could not find any evidence of this. The fire evacuation meeting point stickers next to the fire alarms were worn and the writing on them had faded and was not legible. There were no signs or posters displayed around the building explaining the fire evacuation procedure.

Risks to people's safety in relation to fire had not always been appropriately assessed, mitigated or reviewed. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action had been taken to ensure people were protected from risks associated with their care and support. Risks had been assessed and steps were recorded of action staff should take in order to keep people safe and in good health. For example, risk assessments were in place relating to maintaining skin integrity, diabetes, maintaining safety in the home, use of bed rails, falls, moving and handling, diabetes and risks of behaviours that may cause the person or others harm. Risk assessments had been regularly reviewed and amended when required.

Individual incidents and accidents had been recorded by staff. The registered manager had looked at the records and investigated each incident to see if they could be avoided in the future. Action had been taken when issues arose, such as referrals to the falls clinic and equipment.

We observed that staff supported people to maintain their safety around the home. Staff prompted people to make sure they used their walking sticks or frames. One person told us, "I like the people, I feel safe". Other people told us they were happy and liked living in the home.

A relative told us that there were enough staff to meet people's needs. They confirmed that they had been contacted by the home when their family member had fallen and that appropriate action had been taken. The relative said, "She is definitely safe here. She's happy so I am happy".

At the last inspection we found that recruitment practices were not always safe because the provider had not carried out sufficient checks to explore the staff members' employment history to ensure they were suitable to work around people who needed safeguarding from harm. At this inspection, the provider had followed safe recruitment procedures to ensure that staff employed to work with people were suitable for their roles. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Employer references were also checked. One of the staff files had small pockets of unexplained gaps in employment history of three months at a time in three different places. These had not been picked up through the employment screening checks. We spoke to the management team about this and they agreed to review this file.

We observed there were suitable numbers of staff on shift to meet people's needs, meal times were relaxed and calm. Since the last inspection, the management team had met with staff on night shifts to discuss and review staffing levels. Staff feedback had been listened to and jobs undertaken during the night had been reorganised. Staffing levels were regularly reviewed and reassessed according to the dependency levels of the people living in the home using a tool which was nationally recognised in Ireland. Call bells were answered promptly when people used them to summon help.

People continued to be protected from abuse and mistreatment. Staff had completed safeguarding adults training. Staff understood the various types of abuse to look out for to make sure people were protected from harm. Staff knew who to report any concerns to and had access to the whistleblowing policy. Staff all told us they were confident that any concerns would be dealt with appropriately. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. The registered manager knew how to report any safeguarding concerns and had done so in a timely manner.

The premises were maintained and suitable for people's needs. Outside there was a well-kept paved garden. There were flowers and shrubs in a number of containers and seating. One person told us they did the

gardening in the communal garden, which they enjoyed.

The service smelt clean and fresh at the end of the day, however when we first arrived there was a strong smell of stale urine near the front door and in one corridor and a bathroom. The housekeeping staff were seen undertaking cleaning tasks throughout the inspection, which included steam cleaning the floors in the areas that smelt, this reduced the odour in these areas. We spoke with the head of operations about the effectiveness of cleaning in these areas. The service was tidy and well kept. Staff used personal protective equipment (PPE) to protect themselves and people from the risks of cross infection when supporting people with their personal care. Staff undertook training in infection control. Personal protective equipment was available such as gloves and aprons. The laundry area had areas for keeping clean and dirty washing separate and staff understood how to deal with any soiled laundry. All these actions helped to minimise the spread of any infection should it occur.

Checks had been completed by qualified professionals in relation to legionella testing, moving and handling equipment, electrical appliances, gas appliances, the lift and fire equipment to ensure equipment and fittings were working as they should be. Maintenance and repair tasks had been carried out when required. The management team had devised a daily checklist in relation to daily health and safety reviews, pressure mats and bedroom checks. These checks had not always been carried out daily. Health and safety reviews had not taken place during weekends. Pressure mat and bedroom checks had been carried out inconsistently. We spoke with the registered manager about these. They said that these checks were carried out by senior staff but that the checks were new to staff, so staff were still getting used to doing them. The registered manager and head of operations explained they were currently reviewing these checks with a view to working out how frequently they should take place.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Registered persons had failed to manage medicines effectively. Risks to people's safety in relation to fire had not always been appropriately assessed, mitigated, reviewed or managed. Regulation 12(1)(2) (a)(b)(d)(g)

The enforcement action we took:

We served the provider and registered manager a warning notice and asked them to meet Regulation 12 by 31 October 2017