Cheshire West and Chester Council

Leftwich Community Support Centre

Inspection report

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Date of inspection visit: 05-06 November 2014
Date of publication: 18/03/2015

Ratings

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

Overall summary

This inspection took place over two days on the 5 and 6 of November 2014.

Leftwich Community Support Centre provides accommodation for up to 31 people who require a respite or short stay. Accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor. The home has 31 single bedrooms. There were 16 people staying at the home at the time of our inspection. The downstairs unit is used for people who require some further time and rehabilitation following a period in hospital. They are able to access the rehabilitation services provided by the intermediate care team. The upstairs unit is used for people who require a short stay for a number of reasons, such as to give their carers a break.

At the time of our visit, there was refurbishment underway to provide a seven bedded unit for people with dementia. We were told that the expected date of opening was January 2015.

Summary of findings

There was a registered manager in post. A registered manager is a person who is 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we last inspected Leftwich Community Support Centre we found the service was meeting all the Regulations that we assessed.

At this inspection, we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The actions we have told the Provider to take are at the end of this report.

Staff knew how to keep people safe from abuse and were aware of how to report concerns. People told us they felt safe and cared for. However, we found that the care being provided was not always safe.

Staff were not following the Mental Capacity Act 2005 (MCA) for people who lacked capacity to make decisions for themselves, or the Deprivation or Liberty Safeguards (DoLS) where restrictions needed to be put in place for their own health and safety or that of others. This meant that people's rights were not always protected or taken into account.

Medicines were not always managed safely for people and people were not getting the correct medicines all of the time. There were discrepancies in numbers of medicines available and medicine records. Medicines were not always stored correctly.

We observed positive interaction with care staff but care was "task orientated" and there was very little to keep people occupied and socially stimulated.

The registered manager did not carry out her own assessment prior to a person coming to stay, which meant that staff could not always meet a person's needs. The care documentation was not detailed or sufficient enough to explain fully to staff what care was required for each person. It was not reviewed or updated when a person's physical or mental health changed. There was a risk that people would not receive the right care or medical intervention.

The provider did not have any quality assurance systems to monitor the quality of the service or identify and manage risks. This meant people were not protected against the risks of receiving unsafe or inappropriate care.

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.

People's medicines were not always managed safely and records had not been completed correctly. People did not always get the medicines they needed.

People's care plans did not always reflect their care needs and risk assessments were not always in place, which put people at risk of receiving inappropriate care.

People we spoke with told us they felt safe and care staff were aware of their responsibilities to report concerns and knew how to recognise and respond to abuse correctly.

Inadequate

Is the service effective?
The service was not effective.

Health concerns were not always identified which resulted in people's health care needs not being met and a delay in medical assessment.

The manager had not sought advice where they thought people's freedom was being restricted. Staff said they had not received recent training in the Mental Capacity Act 2005 and were unable to describe the requirements of the Act. Correct steps were not followed to assist people with limited capacity to make decisions.

People had a choice about what and where to eat. People told us they enjoyed the meals they were served and there was plenty of choice. Special diets were catered for. However, people's diet and fluids were not adequately monitored.

Requires Improvement

Is the service caring?
The service was caring.

Staff had a good rapport with people and people were positive about the care they received from the staff.

We saw that people were supported with kindness and patience. We also saw staff treating people with dignity and respect.

Good

Is the service responsive?
The service was not responsive.

We found people's care needs were not assessed prior to admission to ensure that staff were able to give the care needed. People had not always been involved in planning their care and their histories, preferences, likes and dislikes were not recorded.

Inadequate

Summary of findings

The service did not respond to people's changing needs by ensuring amended care plans were put in place. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

People told us and we observed that there was not much to do in the home. We saw staff had very little time to engage in social activities with people.

Is the service well-led?
The service was not well led.

People could be put at risk because there were no systems in place for monitoring the quality of the service or seeking the views of people who used the service.

However, staff said they felt supported by the manager and that their views were taken into account. Staff had regular supervision and meetings to discuss their concerns and performance.

Inadequate

Leftwich Community Support Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days on the 5 and 6 of November 2014. Our first visit was unannounced and the inspection team consisted of a two inspectors. On the first day of our visit we spoke with people who lived in the home and their visitors, spoke with staff and observed how people were cared for. We also looked at some records. One inspector returned to the home the next day and looked in more detail at some areas, examined staff records and records related to the running of the service and spoke with the manager.

During the visit, we spoke with seven people staying there, two relatives, one friend, two senior care staff, four care assistants, the registered manager and the locality manager. We observed care and support in communal areas, spoke with people in private and looked at the care records for four people. We also looked at records that related to how the home was managed.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). 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. We reviewed notifications of incidents that the provider had sent us since the last inspection. We also contacted local commissioners of the service, the local authority safeguarding team, an infection prevention and control nurse specialist and the district nursing team who supported some people who lived at Leftwich Green to obtain their views about it.

Inadequate

Is the service safe?

Our findings

We found that medicines were not managed safely and as a result some people did not receive their medication as prescribed: for example we found discrepancies between the amount of tablets signed as given by staff and the tablets in stock for individuals. Staff recorded the number of tablets available at the beginning of each week for each person. They did not record at what time of the day this count had been carried out. It was, therefore, not possible to accurately count the number of tablets that someone should have at any given point during that week to ensure they had received the tablets prescribed.

We looked at four people's medicine charts and found that there were no gaps in the administration records. This would indicate that all their prescribed medicines had been given. We counted the medicines in stock and found that there were more in stock than there would have been if all had been given as recorded. This was the case for 17 medicines.

Some people had been prescribed medicines for pain relief 'when required'. Care records did not clearly explain when these medicines should be used and for what purpose. This meant the person might not get maximum benefit from taking the medicine. We looked at the Medicines Administration Records (MARs). We saw that staff had not recorded what dosage had been given when it could be variable (i.e.one or two tablets), which meant there was no clear audit trail of these medicines. It also meant that there was a risk that people could possibly be given more than the prescribed maximum dose per day.

Records showed that there were occasions when medication was refused but staff had not recorded why it had been refused, if the implications of refusing were understood and what action staff took as a result.

There was no enablement plan or risk assessment in place where a person was taking homely remedies (these are medicines which can be purchased "over the counter"). We were informed that staff did not administer these and that the person themselves took responsibility for taking them. There was no evidence that staff had checked that these remedies did not interact with other prescribed medicines or that they had assessed a person's capacity to understand and self-administer the medicines.

Controlled drugs (CDs) were not stored as legally required. The CD cupboard did not meet current legal requirements. There were a number of CDs for people that were no longer resident at the home and these should have been returned or disposed of. One drug, Temazepam, was stored in an individual's medicine cupboard in their room, but current legislation requires that it be stored in a CD cupboard. Neither the staff nor the manager were aware of this requirement for this drug. Some CDs had not been recorded in the CD register, which is a requirement.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risk assessments used were standard documents and covered such things as moving and handling, use of denture cleaning products, night checks, use of fire evacuation mats, medication, being left alone at night and sunburn. They were not personalised to the individual. They did not always contain accurate information. Therefore there was a risk that care being provided would not be what the person required.

The manager could not show us any emergency plans in place to cover such situations as the home being short of staff when the manager was not available, lift breakdown or fire. The staff and manager were able to describe what would happen and we observed a fire drill but there was no written protocol or procedures for any new staff to follow. The registered person should have procedures in place for dealing with emergencies that could arise from time to time.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that staff were employed in a safe way. We looked at recruitment records and saw that all the checks and information required by law had been obtained before new staff were offered employment in the home. All recruitment was checked and approved by the manager, personnel and human resources. For agency staff, the provider was reliant on a recruitment agency having made these checks.

People told us that they felt safe and that they did not have any concerns. One relative said, "She feels very safe", and people who used the service said "I feel safe here" and "It is

Inadequate

Is the service safe?

better for me here than hospital". The provider had a safeguarding policy that care staff were aware of. They were able to give examples of what constitutes abuse and felt confident in reporting any suspected abuse. They told us that they had attended safeguarding training and had been given a copy of the whistleblowing procedure. We saw evidence of where a member of staff had reported a concern to the manager. Staff were also able to tell us the correct procedure to report an accident or incident.

We found there were sufficient staff during our visits to provide care and support to people. We did not observe any person having to wait for care. A person told us, "When I ring my bell for assistance staff respond within a reasonable amount of time". A visitor said "Call bells are answered quickly". However, staff we spoke with expressed concern that there were not always enough staff when the people staying required more care. For example, at night, if a person on one unit required the assistance of two staff, they said that this left the other units without a staff member while the assistance was being provided, as there were only two staff on duty.

The home was spacious and had appropriate equipment, such as hoists, to keep people safe. Equipment was checked and serviced at the required intervals and staff were trained in its use.

Requires Improvement

Is the service effective?

Our findings

CQC monitors the use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We were told that no one living at the home at the time of our inspection required an application to be made under the Deprivation of Liberty Safeguards (DoLS), as there was no one who was subject to a level of supervision and control that may amount to a deprivation of their liberty. All bedrooms had door alarms that could be set to monitor the movements of someone staying at the home where it was felt they could be at risk. We asked staff how and when they would use these. They did not consider undertaking a capacity assessment, best interest decision or a DoLS application. One person was being served alcohol every tea time but there was no evidence that staff had checked the contraindications of this with medication or associated risks. The registered manager informed us that staff were restricting the person's alcohol intake at the request of the family. There was no evidence that staff had given consideration to the person's capacity to consent, or why there was a need to do this.

We discussed the Mental Capacity Act 2005 with the registered manager and staff. Neither the registered manager nor the staff were knowledgeable about the Deprivation of Liberty Safeguards (DoLS) and in what circumstances someone might have a restriction placed upon them. They had not sought appropriate advice or considered making a referral for an individual for whom they had placed previously on one to one supervision by a care worker. They did not demonstrate a clear knowledge and understanding of how to ensure that the rights of people, who were not able to make or communicate their own decisions, were protected. Care records did not demonstrate that the principles of the Mental Capacity Act 2005 had been used when assessing an individual's ability to make a particular decision.

Enablement plans and risk assessments made no reference to a person's capacity around decision making. There was no record, on the provider's own documentation, to indicate whether someone had made a Lasting Power of Attorney. Staff indicated that it was the responsibility of the social worker to make assessments and judgments about capacity. This meant that key decisions may not be made in keeping with the law.

Staff told us that they had either not had training in MCA and DoLS or it had been a long time since they had training in the subject. Some staff were due to have further training in 2015.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service said that the food was very good. The meals we observed looked appetising and well presented. Meals were provided at set times during the day. There was a choice of main meal and dessert each day. The chef told us that they would also prepare something else if a person wanted an alternative. Menu choices were presented to the chef each morning, including special diets.

However, there was no system in place for monitoring those people who may be at risk of unplanned weight loss or weight gain. People were weighed upon admission but not at regular intervals throughout their stay. Staff did not always record the food or fluid intake of persons where there were concerns that would indicate it was required. We saw that one person's care notes indicated that they had a reduced appetite, but there was no record of any monitoring of their weight or dietary intake. Another person had a catheter and had been passing very dark urine on the 18, 19, 24 of October and 4 November and there had been signs of blood in the person's urine. Their daily notes stated that staff were "monitoring" fluids. However, there was no fluid chart to indicate what the person was drinking or passing out. The records of another person recorded that they had not passed urine during a shift, but their enablement plan did not address the risk of dehydration. Staff informed us that they did not always keep fluid records but they "push fluids for everyone".

One person's social work assessment stated that they required a low fat soft diet. This information had not been recorded in their enablement plan or added to the information provided to the chef. Neither the care assistants nor the chef were aware of this and the person had been served roast pork dinner and crumble with custard at lunchtime.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service effective?

Care workers received an induction before starting work at the home. This included training in safeguarding adults, medication, infection control, moving and handling and dementia care. The induction programme was linked to "Skills for Care". This meant care workers were trained to nationally recognised common induction standards.

The home had a system in place to record the training that individual staff had completed and each staff file contained a record of the training they had completed. Staff told us that they had received training in key topics such as safeguarding, infection control, moving and handing, medication management, first aid and fire safety.

Staff confirmed they received regular supervision and annual appraisal to enable them to fulfil their roles effectively. There was evidence that staff, at all levels, had individual and group supervisions. These were recorded and available in the staff files. They also had observational supervisions. Staff told us that they were asked their opinion and that they felt the manager listened to them.

Good

Is the service caring?

Our findings

People who used the service said that staff responded to call bells promptly and said staff "treat me with respect" and "maintain my dignity". They said staff were "patient" and "encourage you to do things for yourself". We spoke with families and they were positive about the care received. Comments included; "Everything is excellent, the staff are nice and cooperative, they look after mum", "My mum feels very safe here, nothing is too much trouble, staff know what they are doing and know what mum likes". People confirmed that there were no restrictions on visiting.

There was information for people on how to access advocacy support.

There had been many compliments from those that had used the service and their families. The registered manager showed us an article that a user of the service had sent to one of the local household publications praising the service.

We observed care staff in positive interactions with people. When they provided personal care, people were discreetly asked if they wanted to use the toilet or to have a bath or shower. Staff always knocked on bedroom doors before entering and ensured doors were shut when carrying out personal care. Staff chatted to people who used the service while they moved around the home, and when approaching people, staff would say 'hello' and inform people of their intentions. Staff we spoke with demonstrated a caring attitude towards those in their care and were aware of their needs.

Because this was a short stay service, people's wishes at the end of life were not discussed as part of the admission process unless there was an indication that someone had made an advanced decision. Wherever possible, if someone's needs deteriorated rapidly and they required end of life care, the service tried to provide this with the support of the district nurses and the GP. Staff were aware of the implications when someone had a "do not resuscitate" order in place.

However, we saw entries in one person's care notes where one staff member recording did not afford the person dignity and respect. For example, the staff member had recorded in one person's daily notes, "I have lost count of the number of times [name] has beeped, each time [name] has been wet through, sometimes only minutes apart" and "buzzing for attention". The staff member had not considered why the person might be calling or followed through on the apparent continence need. This was pointed out to the registered manager who said she would address the issue with the staff member concerned.

Inadequate

Is the service responsive?

Our findings

People and families we spoke with could not remember being involved in the writing of the enablement plans (care plans), although some had signed them. These were not personalised and so staff could not demonstrate that they were providing care that was person centred. For example, they did not tell us what name someone preferred to be known by, when they wanted to get up or go to bed, what they liked or did not like. They did not give staff much information about preferences or personal history. Staff told us that they found this out by “word of mouth” or by asking the person. One person using the service said "No one has discussed my care with me but then they know me".

The registered manager did not carry out any pre-assessment to ensure that the home could meet the needs of those persons coming to stay. She said they were reliant on the information provided by the commissioners of the placement. The manager and staff told us that sometimes this information was out of date or inaccurate and so they were not always able to meet someone’s needs effectively when they arrived. The manager stated that “The hospital don’t always realise that we are not a nursing home”. Some people had had to return to hospital or move to an alternative placement as a result of this.

There was a pre-admission check list that the senior staff went through on the phone with families or commissioners prior to admission. We looked at this document (entitled ‘Notes when taking a referral’) and found that it did not direct the staff to ask key questions.

We found that the enablement plans (care plans) completed upon admission were inadequate. They did not accurately reflect the needs of the person as detailed in their social work assessment. They were not updated to reflect any health or social issues that came to light during the person’s stay. One plan was dated the 17 October 2014 but the enablement goals were dated 6 June 2014 because the plan from a previous stay had been used. It did not reflect the changes evident in the person’s health in the intervening period, such as the fact that the person now had a catheter. A risk assessment that we looked at stated that this person was fully continent and required prompting because they had a “UTI” (water infection). The enablement plan made no reference to continence needs. From the daily records, we were able to establish that this person did in fact have a catheter that required monitoring. There was no enablement plan or risk assessment to direct staff as to the care and monitoring of the catheter or how to monitor the person’s health whilst they had an infection. Another person did not have accurate information in their care file about their level of mobility and support required. Their daily notes recorded “it was impossible to turn [B] properly and repositioned as best staff could”. This was significant as this person had a turning chart in place to ensure that they did not develop any pressure ulcers. There was no detailed moving and handling risk assessment. Their care file contained inconsistent information: “weight bearing”, “uses a rotunda” and “requiring a hoist”. Staff told us that mobility was not a problem for this person and staff were able to manage their needs safely.

There was detailed information contained in the daily notes but this was not transferred into an enablement plan and so there was a risk that this information would be lost and not acted upon. This meant that someone could have a health condition that was not being assessed or monitored.

Daily notes indicated that one person had frequent bouts of diarrhoea. This could indicate a number of health conditions, such as an infection or an interaction with diet or medication and could lead to dehydration. This was recorded by different staff, on different shifts over a period of days. No one had taken any action to monitor or assess this and the information had not been passed onto the senior staff or recorded in the communication book. This was felt as a significant event taking into account some of the previous medical history of this person. This was brought to the attention of the registered manager during the inspection and she was asked to investigate further.

Another person’s daily notes indicated that they were having “panic attacks” on a frequent basis. Staff told us that they had not observed any physical symptoms but the person stated they were “having one”. There was no management plan in place to support staff in managing this behaviour or to understand it.

Staff were completing a Waterlow assessment for each person. This is an assessment of someone’s risk of developing a pressure ulcer. The assessments were not all dated, signed or the scores totalled. The results of these

Inadequate

Is the service responsive?

assessments were not always being used to inform a detailed enablement plan. A person who was "at risk" was recorded to have a sore sacrum and groin but there was no enablement plan in place for monitoring of their skin.

We observed a person who looked very unwell and who asked to go to bed. The care assistant asked the person to try to stay in their chair. It was evident from their care notes that they had been seen by the district nurse and were waiting for the doctor to come. We discussed this with the senior care assistant and expressed our concern that the person appeared to be too unwell to be sat in a chair. Staff did then put them to bed and they were later admitted to hospital.

There was a lack of activity and stimulation for those staying at the home. On the days of the inspection, people were mainly sat in their rooms or watching television. Staff and the registered manager acknowledged this but stated that funding was not available for an activities coordinator. Some volunteer school children came after school three days a week to read to people and play games. The home had recently bought a large set of dominos. People used to be able to access the day care provision, but this was no longer provided at the home. One person we spoke with said that she felt safe and the staff looked after her but complained that there was nothing to do. We observed her sat looking at the television for most of the day, but she could not hear it due to her having hearing loss.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a satisfactory complaints procedure in place. People told us that they were aware of how to make a complaint and had been given written information. There had been no formal complaints in the last 12 months.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in post, who was responsible for the day to day running of the home. The manager supervised the senior care workers, who were responsible for the planning of care, and they in turn supervised the care assistants, who provided the care.

We asked the registered manager to show us evidence of any quality audits carried out. The manager was not able to demonstrate that systems had been developed for assessing and monitoring the quality of the service or identifying, assessing and managing risks. There were no systems in place to check that people's needs were being met and that the service was operating safely.

Accidents and Incidents were recorded and actions taken at the time. There was no analysis of the information to look for themes and trends and to identify learning or changes required.

There was a checklist in place for the care documentation. Senior care staff completed a checklist on a random selection of care folders each week. This was a factual checklist of things that should be in place. It did not address the quality and robustness of those documents in enabling staff to provide care or monitor health conditions.

There was no system in place to seek the opinions of people using the service as to its effectiveness and quality. The manager told us the "best measure of this is the compliments that are received". She told us that the local authority had tried a variety of ways to seek feedback but none of them had been successful. There was a feedback form in each care folder but they weren't completed.

There was no central record kept which clearly recorded when each member of staff had last completed a training course and when the training needed to be repeated. This meant the registered manager could not easily identify if staff had completed all the required training or needed to repeat a training course to keep up to date with safe practice. Staff told us that they needed more training in providing end of life care.

The manager told us that she had tried alternative ways of carrying out medication rounds at the request of staff. After a period of review and consultation with staff, this had been revised again. However, they were clearly still ineffective as demonstrated by our findings that the medicine arrangements were unsafe.

Not all family, persons or professionals were able to identify the manager and said that most of their contact was with the senior staff members.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Assessing and monitoring the quality of service provision.

Team meetings were taking place on a regular two monthly basis where the registered manager was able to share information with staff. Staff felt that they were listened to and their views taken into account.

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 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	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The provider was not complying with the Mental Capacity Act 2005 (MCA) for people who lacked capacity to make decisions for themselves or the Deprivation or Liberty Safeguards (DoLS) where restrictions needed to be put in place for people's own health and safety.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The provider had not taken proper steps to ensure that service users were protected from unsafe or inappropriate care by means of carrying out an assessment of people's needs and planning and delivering care to meet people's needs. Regulation 9(1).

The enforcement action we took:
We issued a warning notice that required the registered provider to be compliant by 31 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The provider did not have effective systems in place to monitor the quality of the service provided or identify, assess and manage risks to the health, safety and welfare of people who used the service. Regulation 10(1)and(2).

The enforcement action we took:
We issued a warning notice that required the registered provider to be compliant by 31 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The provider did not have appropriate arrangements in place for the recording, safekeeping and safe administration of medicines.

The enforcement action we took:
We issued a warning notice that required the registered provider to be compliant by 31 March 2015.