Cherry Garden Properties Limited

Castle House

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service effective?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8 and 15 December 2014. 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 relating to staffing and to equipment.

We undertook this focused inspection to check that they had followed their action plan and to confirm that they now met legal requirements. Since our last inspection we had also received some information of concern and used this inspection to follow up on these concerns. 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 Castle House on our website at www.cqc.org.uk

During this focussed inspection we found there were continued breaches in relation to the supply of the right equipment to ensure people were kept safe and that their privacy and dignity was upheld. For example although the registered provider had provided more moving and handling equipment, they had not ensured there were sufficient jugs within the home for people to have access to drinks at all times. They had not supplied any means of screening for two people who shared a room. This meant staff could not ensure people's privacy and dignity at all times.

We found that one person's fire door had been hanging off its hinges for a month. There was also outstanding electrical work needed to ensure the building was safe.

Although care staff levels had increased, we found staff did not always have the right skills to ensure people's needs were being met safely. For example we found that staff had not received training in understanding the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and how they applied this in practice. Staff were unsure what actions they would take if they felt people were being unlawfully deprived of their freedom to keep them safe. There were further examples of where nursing staff had taken decisions about people who were

Summary of findings

placed within the home as a residential placement and therefore their nursing needs should have been met by the community nurse team. We saw examples of poor decisions being taken without the right risk assessments or follow up taking place. This included one person whom staff were using bedside rails without a risk assessment or best interest decisions being completed. The bedside rails had been put up without protectors which could have caused injury to the person.

The registered manager had given her notice as she said she was not being supported by the provider, who had suggested she cover four nursing shifts in one week, instead of using agency staff. 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.

We found three breaches of Regulations in the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found 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 always safe.

Staffing numbers had increased, but some staff did not have the necessary skills to people's needs.

Equipment had not been supplied to ensure people's safety, privacy and dignity.

Some parts of the building were not properly maintained.

Requires improvement

Is the service effective?
The service was not always effective.

Staff did not understand how to apply the principles of the Mental Capacity Act 2005 to ensure people's rights were upheld.

Where restrictive practices were used this had not been fully risk assessed or considered as part of people's best interests.

Requires improvement

Castle House

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 was unannounced and took place on the 30 April 2015. It was completed by one inspector who was following up on some information of concern received and to check on breaches in requirements from the last inspection in December 2014.

During this inspection we spoke with five people who use the service, three relatives, and six staff as well as the registered manager and registered provider.

At the time of the inspection there were 19 people living at the service. We looked at three care records, reviewed staffing rotas and toured most parts of the building. We also looked at some records relating to the maintenance of the service.

Requires improvement

Is the service safe?

Our findings

During the inspection completed in December 2014 we found a number of areas where the provider had failed to act swiftly to address environmental or equipment issues. This included ensuring all electrical equipment and bathroom facilities were fit for purpose. We issued a compliance action under regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This stated the registered person had not made suitable arrangements to ensure people were protected from the risks of unsafe equipment as they had not made suitable arrangements to ensure they were properly maintained. The registered provider sent us an action plan which stated they would be compliant with the regulation by the end of March 2015. This included reviewing the moving and handling equipment and ensuring all electrical equipment had been fully tested. The plan also said they would review the bathroom on the first floor to ensure it was more user friendly.

Staff said they now had access to a new hoist and standing aid, which had enabled them to ensure people, had their moving and handling needs met in a more timely way.

The registered manager said the portable electrical equipment had been tested, but they were still awaiting agreement from the provider to have further electrical work agreed to ensure the electrical wiring system at the home was safe. The registered manager said she had documented parts of the electrical testing report which required urgent work, but to date had not been able to get the electrician back as he had not yet been paid for work already completed.

The first floor bathroom had not been altered in any way. The bath was still positioned so staff were unable to get a hoist under it so were unable to safely use this bath for people with mobility issues. One person said they had not had a bath for up to two years. They described how staff assisted them with bed baths and washes, but their wish was to have a ‘‘Soak in a bath.’’ There was no accessible shower or other bathing facilities upstairs for this person to safely use.

We had received some information of concern which stated that the service did not have enough water jugs to ensure all people had access to drinks in their rooms. We checked bedrooms and found where people were in their rooms, they did have access to water jugs, but they were not present in all bedrooms. The registered manager said she had already raised this as a request to the provider and had also asked for some special beakers to trial for people who found swallowing a difficulty. The registered manager said they were told to purchase the beakers from petty cash and the jugs were still on order. When we fed this back to the provider, they said, the jugs had been ordered but their normal supplier did not have the size requested and the beakers were not available from the supplier they used so they were still looking for a supplier to provide these and had suggested in the interim that the service use their petty cash to purchase the beakers. The registered manager said it was not possible to order the beakers via petty cash as they needed to order them via a supplier and would therefore need an account. Since the inspection the provider has stated they were not made aware the registered manager could not order the beakers without an account.

We found one person’s bedroom door was hanging off its hinges. This was also a fire door on the bedroom of someone who was unable to move in the event of a fire. The registered manager said she had made the provider aware of the issue of the door needing urgent repair since the beginning of April 2015. When we fed this back to the provider, they said the registered manager had not actioned getting quotes for the work to be done promptly. The provider has said he registered manager was given authorisation immediately to get quotes. This was followed up with an email from the providers office to ensure the authorisation was in writing, however this had not been actioned. They also said there were other rooms the person could have moved to in the interim of waiting for a tradesperson to fix the door. The provider accepted that they had some responsibility to also ensure that repairs needed to be actioned in order of priority. Not having a fire door in place left the person at risk.

Part of the information of concern we received stated that two people were sharing a room and there was no screen in place to ensure privacy and dignity when either were receiving personal care. We checked this and talked with staff who confirmed there was no screen in place and confirmed they had been providing personal care without ensuring individual’s privacy and dignity because they did not have access to a screen to use.

Requires improvement

Is the service safe?

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found there was not always sufficient staff to meet people's needs in a timely way. We issued a compliance action which stated the service was in breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. The registered person had not taken steps to ensure the health and safety of service users as there were not always sufficient numbers of suitably, skilled and experienced persons employed for the purpose of carrying out the regulated activity.

During this inspection staff said that apart from staff sickness , they had enough staff to meet people's needs in a timely way. This usually meant five care staff plus one nurse each morning shift and four care staff plus one nurse for the afternoon shift, with two care staff and one nurse for the waking night. The staff team also included a part time activities person working three days per week, a cook, a kitchen assistant a cleaner and a laundry person. The registered manager explained they have had ongoing difficulties recruiting nurses for the service and one of their two full time nurses had just resigned. The registered manager explained that she had been away on leave the previous week prior to the inspection and came back to find the provider was proposing she cover four of the nursing shifts. Also, for one of the other nurses who usually covered days would cover the night shifts to accommodate planned leave. The registered manager said the provider knew well in advance the night shifts needed to be covered for the week beginning the 27 April 2015, but had suggested the registered manager do these shifts so they would not need to use agency nurses to cover the shortfall.This would mean that they would not have adequate time to carry out their management duties. We fed this back to the provider who said it had been a suggestion, which did not actually happen and they had tried to cover the shifts with agency staff. The registered manager had stated this was because she refused to do the shifts and as a consequence had resigned as she did not believe she was getting the right support to enable her to move the service forward. The provider stated the registered manager had a full time administrator, daily email and phone support from head office and the operations and compliance manager visiting at least twice weekly was they were in post. Minutes of a quality review meeting held with the commissioners document that the registered manager had been covering one or two late shifts each week, which the commissioners said was not sustainable over the longer term. The provider was in full agreement with this statement and was a major factor in the decision to move from nursing to residential placements.

We observed one unsafe incident where two staff assisted someone to get up to a standing position giving them an under arm lift. This is not a safe moving and handling technique as it can cause injury to the person or staff. Staff later said, in hindsight they should have used a standing aid, but the person they assisted usually can move from sitting to standing with only minimal support

There had been two recent incidents reported via the safeguarding processes which show the staff may not have the right skills to meet people's complex nursing needs. One issue identified was where a person was admitted to the home requiring personal care meaning any nursing care needs should be met by the community nurse team. They had not been referred to the community nursing team for one health concern in a timely way because a nurse working at the home had provided the care and treatment themselves. The person had experienced some unnecessary pain and discomfort due to these actions. The community nursing team have an after-hours number and contact details were available to the nurse for her to call them out.

There was another incident where a nurse was unable to find one person's medicines to administer so handed over to the night nurse that the person had not received them. The nurse who received this information spoke with the registered manager and together they found the medicines for this person, which were stored with the rest of the medicines. The registered manager said she was not consulted or communicated to at the time, and she was available and working on the premises. The lack of communication about being unable to locate one person's medicines could have placed the person at risk and highlighted a lack of skills to appropriately meet people's needs.

.There was evidence that staff did not always have the right skills to meet the needs of people This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

In the previous inspection completed in December 2014, we identified staff lacked understanding in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and how they applied this in practice. Staff were unsure what actions they would take if they felt people were being unlawfully deprived of their freedom to keep them safe. The provider sent us an action plan which said staff would receive training in MCA and DoLS by 31 March 2015.

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

During this inspection staff said they had not received training in either the MCA or DoLS and there were examples where this had impacted on their practice. One person who lacked capacity due to the frailty and illness had recently had a fall from their bed and a nurse had decided to use bedrails to prevent further injury from falls. Neither the nurse nor the care staff who followed the written instruction to use bedrails had considered that the use of this equipment may have constituted a type of deprivation. They had also failed to record how the decision to use bedrails had been reached as part of a best interest decision, in keeping with the principles of the MCA. There was no risk assessment in place to show that risks associated with bedrails had been assessed or considered, and there were no padded bumper sides in use to protect the person from injury if they moved their limbs in bed and caught them on the metal bedrails. The provider has told us they were not made aware of this situation.

One person was described as having 'variable capacity' and due to their increased confusion a decision had been made to use a pressure mat to alert staff if they moved off their bed. There was no specific capacity assessment to show whether this person was able to understand and consent to the use of this equipment being used to alert staff as a measure to keep them safe. There was no evidence of a best interest decision being made with relevant parties and in line with the MCA to ensure the person's rights were upheld.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where services users lacked capacity the service failed to act within the Mental Capacity Act 2005 to ensure their best interests were considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Failure to ensure there were suitably qualified, competent, skilled and experienced persons deployed in order to meet service users needs