Lunan House Limited

Croxteth Park Care Home

Inspection report

Altcross Road
Mossway, Croxteth
Liverpool
Merseyside
L11 0BS

Tel: 01512866280
Website: www.fshc.co.uk

Date of inspection visit:
24 April 2017

Date of publication:
15 May 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced focussed inspection was conducted on 24 April 2017.

Situated in North Liverpool and located close to public transport links, leisure and shopping facilities, Croxteth Park Care Home is registered to provide accommodation for up to 42 people with personal care needs. The location is a single storey property which is split into two separate units. One for people living with dementia and one for people with physical care needs. Each bedroom has its own en-suite facilities.

A registered manager was in post. 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.

Prior to the inspection we had received information of concern from the Office of the Coroner relating to the management of falls' risk and the assessment of people's capacity to consent to care. This focussed inspection looked in detail at systems and practice in relation to people at risk of falls. This report is restricted to the safe, effective and well-led domains. The caring and responsive domains will be assessed as part of the next comprehensive inspection.

The initial assessment of risk in relation to falls was completed to a high standard and we saw that risk was reviewed monthly or following a significant incident. In each case, the records were clear and sufficiently detailed to alert staff to the potential risk and what action was required to reduce the frequency and impact of falls.

Risk was further reduced because the building was of a modern, single-storey design with open plan areas. This meant that staff could monitor people more easily. Each bedroom had a call-bell system so that people could call for assistance if they fell or needed support with other activities and daily tasks. Staff were vigilant in monitoring people's movements and completed regular checks during the night to ensure people' welfare and safety.

Where falls had occurred body maps were used to record any injuries and referrals were made in a timely manner to healthcare professionals and specialists for their advice and support around the management of people at risks of falls.

The Coroner's report highlighted a potential issue regarding people's capacity to consent to care and their right to refuse treatment. As part of the inspection we looked at how people's capacity was assessed and recorded in relation to care, treatment and restrictions on their liberty. We looked in detail at the circumstances relating to one person's alleged refusal to attend hospital for an x-ray.

The records that we saw showed that the home was operating in accordance with the principles of the

Mental Capacity Act 2005 (MCA). Capacity assessments were focused on the needs of each individual.

The records relating to the person named in the Coroner's report were complete and clearly demonstrated that the person did not have capacity to understand the implications of any refusal to attend hospital. The registered manager and deputy manager were clear about their responsibility to act in the best-interest of people living at Croxteth Park Care Home and to seek medical attention as required.

The higher than expected volume of falls required us to look at monitoring and audit systems to ensure that they were sufficiently robust to identify patterns and trends and promote people's safety.

We looked at paper and electronic records relating to falls and spoke with the registered manager and deputy manager. The systems that we saw were both extensive and robust. Each incident and accident was recorded in a timely manner and entered on an electronic reporting system. The system generated an immediate alert to the registered manager and populated a spreadsheet which was accessed and monitored remotely by a dedicated safety and quality team.

The registered manager was clear regarding their responsibility to monitor and report falls both internally and to the Care Quality Commission (CQC). The records that we saw indicated that all notifications to the CQC had been submitted correctly and in a timely manner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risk in relation to falls was recorded in appropriate detail and subject to regular review.

Staff were vigilant in monitoring risk and made referrals to healthcare professionals in a timely and effective manner.

Is the service effective?

Good

The service was effective.

The service operated in accordance with the principles of the Mental Capacity Act 2005.

Staff understood the need to gain consent and to make decisions in people's best-interests.

Is the service well-led?

Good

The service was well-led.

A registered manager was in post.

The service had an extensive and robust system in place to record and monitor falls.

The registered manager understood their responsibility to report falls and had made notifications to CQC as required.

Croxteth 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 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 24 April 2017 and was unannounced.

The inspection team consisted of an adult social care inspector and a specialist advisor with experience in falls management.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also reviewed the information provided by the Office of the Coroner in the form of a Regulation 28 Report.

We observed care and support and spoke with people living at the home and the staff. We also spent time looking at records, including five care records for people assessed as being at risk from falls, accident and incident records and other records relating to the management of the service.

On the day of the inspection we spoke with the registered manager and the deputy manager.

Good

Is the service safe?

Our findings

Prior to the inspection we had received information of concern regarding the assessment and review of risk in relation to falls. We requested access to five care records for people who were assessed as being at high risk from falls, including the records for the person who was the subject of the Coroner's report.

The initial assessment of risk in relation to falls was completed to a safe standard and we saw that risk was reviewed monthly or following a significant incident. However, the registered manager acknowledged that the pre-admission assessment documentation could not be located for the subject of the Coroner's report. The other care records that we saw contained detailed pre-admission assessments. At each review of falls' risk, a score was entered on to the person's record so staff could track any increase or decrease in risk. In each case, the records were clear and sufficiently detailed to alert staff to the potential risk and what action was required to reduce the frequency and impact of falls. For example, we saw evidence that additional equipment had been ordered for people living at the service following falls. This was done so that their freedom of movement was not unduly compromised. The equipment was used to alert staff when people were mobile and to reduce the risk of serious injury should a fall occur.

Risk was further reduced because the building was of a modern, single-storey design with open plan areas. This meant that staff could monitor people more easily. Each bedroom had a call-bell system so that people could call for assistance if they fell or needed support with other activities and daily tasks. Staff were vigilant in monitoring people's movements and completed regular checks during the night to ensure people' welfare and safety.

Where falls had occurred body maps were used to record any injuries and referrals were made in a timely manner to healthcare professionals and specialists. However, we did identify that information about falls was recorded in different parts of the care record. For example, the daily notes and the mobility care plan. This made it more difficult to establish if staff had accessed the most recent information. We also saw that some records were incomplete. For example, the daily notes for the subject of the Coroner's report indicated that the person remained in hospital, but they did not detail the circumstances which led to the admission. The reason for the admission was recorded elsewhere in the care record. We spoke with the registered manager about this. They acknowledged that staff may have to read more than one section of the notes and agreed to instruct staff to copy all important information to the daily notes section of the care record to further reduce risk.

We noted from information held on our system that the volume of falls was higher than would be expected in a service of this size. We looked at the referral and assessment records and spoke with the registered manager about this. It was clear that a large proportion of people referred to the service presented with a high risk of falls on their arrival. The registered manager assured us, and we saw evidence, that when the service could no longer safely meet people's needs because of their mobility issues, they were referred for additional support or more suitable models of care.

Good

Is the service effective?

Our findings

The Coroner's report highlighted a potential issue regarding people's capacity to consent to care and their right to refuse treatment. As part of the inspection we looked at how people's capacity was assessed and recorded in relation to care, treatment and restrictions on their liberty. We looked in detail at the circumstances relating to one person's alleged refusal to attend hospital for an x-ray.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The records that we saw showed that the home was operating in accordance with the principles of the MCA. Capacity assessments were not generic and were focused on the needs of each individual. Applications to deprive people of their liberty had been submitted appropriately. We looked at notifications for DoLS and saw that they had been correctly completed.

The records relating to the person named in the Coroner's report were complete and clearly demonstrated that the person did not have capacity to understand the implications of any refusal to attend hospital. We looked at the records relating to the recent incident where the person was alleged to have refused to attend hospital for assessment and x-rays following a fall. The person was taken to hospital approximately two weeks later on the advice of a GP where a fracture was diagnosed.

The registered manager and deputy manager who, between them, were present with a community matron at various points during the incident and during the follow-up were adamant that there was no physical indication that the person had suffered any injury in the fall. They confirmed that the person was checked on more than one occasion by visiting professionals and staff for signs of rotation or shortening of the limb and bruising. There was evidence of these visits and checks in the care records. They also confirmed that the person continued to mobilise as they did prior to the fall over the course of the two weeks.

The registered manager and deputy manager did not recall the person directly refusing to attend the hospital and were clear that they would have over-ruled the person in their best-interests if they had any concerns. We saw evidence of best-interests decisions of this type being made and recorded in other care records.

It was clear from the records that we saw that the person was assessed by an experienced community matron and received other treatment from external healthcare professionals prior to being assessed by a

GP.- There was some confusion caused because the person was complaining of pain in their groin during the two week delay. We were told and saw in records that this type of behaviour was not unusual, but pain relief was prescribed and administered as a precaution.

Good

Is the service well-led?

Our findings

A registered manager was in post.

The higher than expected volume of falls required that we looked at monitoring and audit systems to ensure that they were sufficiently robust to identify patterns and trends and promote people's safety.

We looked at paper and electronic records relating to falls and spoke with the registered manager and deputy manager. The systems that we saw were both extensive and robust. Each incident and accident was recorded in a timely manner and entered on an electronic reporting system. The system generated an immediate alert to the registered manager and populated a spreadsheet which was accessed and monitored remotely by a dedicated safety and quality team.

The system required staff to report under a number of headings including; level of injury, location, cause, investigating officer and outcome. We saw records which evidenced that falls had been reported and investigated appropriately by senior staff and that changes had been made as a result.

The registered manager and the deputy manager were clear regarding their responsibility to monitor and report falls both internally and to the Care Quality Commission (CQC). The records that we saw indicated that all notifications to the CQC had been submitted correctly and in a timely manner.