Caldwell Care Limited

The Firs

Inspection report

83 Church Road,
Locks Heath,
Southampton.
SO31 6LS
Tel: 01489 574624
Website: www.caldwellcare.co.uk

Date of inspection visit: 12 May 2015
Date of publication: 26/06/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 3 and 6 October 2014. A breach of the legal requirements was found and we issued a compliance action for a breach in relation to the safe management of medicines. The provider sent us an action plan saying they would have made the required improvements by 2 April 2015.

As a result we undertook an unannounced focused inspection on 12 May 2015 to follow up on whether action had been taken to meet the legal requirements. You can read a summary of our findings from both of these inspections below.

Comprehensive inspection 3 and 6 October 2014

This inspection took place on 3 and 6 October 2014 and was unannounced.

The Firs Care home provides accommodation for up to 22 older people who are physically frail or may be living with dementia. At the time of our inspection there were 20 people living at the home. The home provides long term care, respite care and day care. It does not provide nursing care. Most people needed assistance with managing daily routines such as personal care. A small number of people routinely needed support with eating or support with moving and positioning. The home is located in a residential area of Locks Heath. There is a small car park located at the front and there are accessible gardens. The accommodation is arranged over two floors and there is a lift available for accessing the first floor. There are 16 single rooms and three shared rooms. All of the rooms have en-suite facilities.

The Firs has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Summary of findings

There were systems and processes in place for managing people's medicines, for example staff had received appropriate training. However the systems were not effective in ensuring that medicines were administered, stored and disposed of correctly.

Risks to people's safety were identified and managed effectively. However some risk assessments contained conflicting or out of date information. Some risk assessments needed to be more detailed about the actions staff needed to take to ensure that people were protected from harm.

There were some quality assurance systems in place to monitor and review the quality of the home. However these needed to be more robust to ensure that they were an effective tool in identifying any shortfalls or areas for improvement.

There were sufficient numbers of suitably qualified staff. Some staff told us that at times they felt that care could be enhanced further by having some additional staff on duty. Three people told us that at times, there could be a slight delay in staff being able to assist them as they were busy supporting other people. New staff had been recruited to ensure that staffing levels remained responsive to the needs of people using the service.

Safe recruitment practices were followed which made sure that only suitable staff were employed to care for people in the home.

People told us that they felt safe and we saw that there were systems and processes in place to protect them from harm. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team. Staff were aware of the importance of disclosing concerns about poor practice or abuse and were informed about the organisations whistleblowing policy

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Staff understood how the Mental Capacity Act (MCA) 2005 was applied. Mental capacity assessments had been undertaken which were decision specific. Where people were deemed to lack capacity, appropriate consultation had been undertaken with relevant people such as GP's and relatives to ensure that decisions were being made in the person's best interests.

People told us that their staff members provided them with the support they needed. Staff told us that the registered manager supported them to develop their skills and knowledge by providing a programme of training which helped them to carry out their roles and responsibilities effectively. Staff received regular supervision which considered their development and training needs.

Staff worked effectively with healthcare professionals, for example, links had been developed with the continence service to help ensure that staff were following best practice guidance. People were supported to see healthcare professionals such as GP's, chiropodists, community nurses and opticians.

People were positive about their care and the support they received from staff. Interactions between staff and people which were kind and respectful. Staff were aware of how they should respect people's dignity and privacy when providing care.

Staff were aware of what people needed help with and what they were able to do for themselves. They supported and encouraged people to remain as independent as possible.

People's preferences, likes and dislikes had been recorded and we saw that support was provided in accordance with people's wishes. People were involved, where able, in decisions about their care which helped them to retain choice and control over how their care and support was delivered.

People knew how to make a complaint and information about the complaints procedure was included in the service user guide, including how to raise concerns with the Care Quality Commission. People were confident that any complaints would be taken seriously and action taken by the registered manager.

There was a programme of activities in place which people seemed to enjoy, although some health and social care professionals told us that they felt the activities offered could be more diverse.

Summary of findings

The registered manager who actively sought feedback from people and staff in order that improvements could be made to the home. The registered manager told us that the provider visited the home frequently and was supportive of the management team which included provided the resources needed to effectively meet people's needs.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Focused inspection 12 May 2015

At our inspection in October 2014, we identified that the service was failing to ensure that medicines were stored appropriately, that an accurate record of the medicines administered was maintained and that medicines were disposed of safely. We issued a compliance action in relation to Regulation 13 relating to the management of medicines. We were sent an action plan which described the improvements the provider planned to make in order to comply with the above Regulation. This plan stated that the provider would have made the required improvements by 2 April 2015.

On the 12 May 2015 we conducted a focused inspection. This inspection found that the required improvements had not been made. The provider had failed to remedy the breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. In addition we found a number of new concerns in relation to how medicines were managed within the service.

We reviewed a number of medication administration records (MAR's) and found that many of these contained gaps in recording with no reason noted as to why. Information about allergies was incomplete or potentially incorrect. For example, one person was prescribed an Epipen. There were no protocols in place to guide staff on the circumstances in which they might need to use 'as required' or 'PRN' medicines.

Medicine audits were not being effectively used to drive improvements and to ensure that medicines were being managed safely. None of the concerns we found during the inspection had been identified by the provider. Therefore we could not be assured that the medicines administration systems were monitored effectively to ensure that people received their medicines as prescribed.

This was a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

The service had made improvements to way in which medicines were stored. The service now had a dedicated medicines fridge and the temperature of this was being monitored on a daily basis. All medicines viewed were within their use by date which meant that they were safe to use.

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?

Requires improvement 

Comprehensive Inspection 3 and 6 October 2014

The service was not always safe.

Whilst people told us that they felt safe living at The Firs, we found that the service did not have appropriate arrangements in place to protect people against the risks associated with the unsafe use and management of medicines.

There were staff available in sufficient numbers to meet people's needs and provide person centred care, although, some people told us that at times, there could be a slight delay in their needs being met.

Staff had a good understanding of the signs of abuse and neglect and were aware of what to do if they suspected abuse was taking place.

Recruitment practices were safe and that relevant checks had been completed before staff worked with vulnerable people .

Focused Inspection 12 May 2015

The service did not have appropriate arrangements in place to protect people against the risks associated with the unsafe use and management of medicines. Accurate records were not being maintained of the medicines administered.

The Firs

Detailed findings

Background to this inspection

Comprehensive inspection 3 and 6 October 2014

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 completed over two days on 3 and 6 October 2014 and was unannounced. The inspection was carried out by an inspector.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. Before the inspection, the provider completed a 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 used this information to help us decide what areas to focus on during our inspection.

On the day of the inspection we spoke with six people and four relatives. We also spoke with the registered manager, the deputy manager, six care staff and the chef. We reviewed records relating to the management of the home and reviewed four staff records. We also reviewed records relating to five people's care such as their care plans, risk assessments and medicines administration records.

Where people were unable to tell us about their experiences due to complex needs, we used other methods to help us understand their experiences, including observation of their support. For example, we used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

Following the inspection we spoke with four community health or social care professionals to obtain their views on the home and the quality of care people received.

The last inspection of this service was in August 2013. This found that recommendations from a electrical safety inspection had not all been completed within the relevant timescales. The registered manager arranged for the recommendations to be completed and provided us with evidence that this had been done shortly after the inspection.

Focused inspection 12 May 2015.

This inspection was carried out by an inspector. During the inspection we spoke with the registered provider and the deputy manager of another of the provider's services, who told us they were assisting with the management of The Firs whilst the recruitment of a new manager was taking place. We also spoke with a senior care worker who was undertaking the medicines round on the morning of the inspection. We looked at fourteen medication administration records (MAR's) and other documentation relating to the management of medicines. We spoke with one person living at the service.

Requires improvement

Is the service safe?

Our findings

Comprehensive Inspection 3 and 6 October 2014

Each person we spoke with told us they felt safe living at The Firs. One person said, "Yes I feel quite safe". Throughout our visit, we saw that staff and the management took time to talk with people, reassuring them which seemed to support them to feel safe and secure.

Whilst people told us that they felt safe living at The Firs, we found that the home did not have appropriate arrangements in place to protect people against the risks associated with the unsafe use and management of medicines.

Medicines which included insulin were kept in a fridge which was also used for food storage. Guidance by the Royal Pharmaceutical Society 'The safe handling of Medicines in Social Care', states that medicines should be kept in a separate secure fridge, or in small homes, in a separate fridge, when there is a constant need to refrigerate medicines such as insulin. We found that the medicines were stored in an uncovered and un-lockable container. Some medicines must be stored in a fridge because at room temperature they start to break down or become less effective. The temperature of fridges used for the storage of medication should between 2°c and 8°c. The temperature of the medicines fridge was being checked daily and appeared to be within range which helped to ensure that the medicines remained safe to use. However the records of the fridge temperatures needed to be more robust as the service had two fridges and it was not clear which of the two fridges the temperature readings related to.

There were gaps in four people's medication administration record (MAR) where staff had not signed to confirm whether a medicine had been administered. Therefore adequate records were not always being kept to demonstrate that people were receiving their medicines safely. Some people were prescribed medicines to be taken 'when required'. We looked at a care plan for one of these people. This did not contain detailed guidance for staff members about when to give the medicine. However when we spoke to staff they were able to consistently tell us about the signs and symptoms which might indicate the medicine was required.

Medicines should be used in the order in which they were dispensed and surplus or unwanted medicines should not be kept for longer than is necessary. Arrangements were in place to dispose of medicines correctly, but this had not always been completed in a timely manner. For example a person had stopped taking a particular medicine in May 2014, but the surplus had not been returned to the pharmacy by the time of our inspection in October 2014. One person's eye drops which should have been discarded 28 days after opening were still being administered 32 days after opening.

The home had arranged for a pharmacy audit to be undertaken and had recently started to undertake internal audits to check that the medicines were being handled safely in the home. These audits did not fully record the outcome of any investigations or actions undertaken as a result of the audit that had been completed. The audits had not identified the issues that we found. Therefore we could not be assured that the medicines administration systems were monitored effectively to ensure that people received their medicines as prescribed.

People's medicines were not managed safely. The registered manager had not ensured that people's medicines were administered, stored and disposed of correctly. This is a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

We observed a senior staff member administering medicines to people using the service. The senior staff member either handed the medicines to the service user or administered the medicines as preferred by the service user. One person was receiving disguised or covert medication. We saw that this was only done after appropriate mental capacity assessments had been completed and it had been agreed by relevant persons that this was in their best interests.

Appropriate arrangements were in place in relation to obtaining medicine which helped to ensure that medicines were available when people needed them. Medicines were stored safely in locked cupboards and trolleys which only the senior carer had access to on each shift. Controlled drugs which are medicines that require a higher level of security were stored in appropriate cupboards. We looked at the records for these medicines and saw that they were accurate.

A range of tools were being used to assess and review people's risk of poor nutrition or skin damage. Measures

Is the service safe?

had been put in place to address identified risks for one person where aspects of their behaviour placed them at risk of harm. We saw a detailed moving and handling risk assessment and risk assessments in relation to the use of bed rails. Other risk assessments were recorded on a resident risk assessment document. This considered the level of assistance people needed with a range of tasks such as using the toilet, eating and drinking or moving around the environment. We found that these risk assessments were not always specific enough and did not contain sufficient details about how identified risks should be managed. We also saw two examples where the information in the risk assessment was out of date and did not reflect the person's current needs. This was despite the fact that the assessment had been reviewed monthly. This meant that the arrangements for reviewing the assessments was not always effective at ensuring that these remained up to date and accurate.

People using the service gave mixed feedback as to whether there were always sufficient numbers of staff on duty. Four people told us that there were sufficient staff available to support them when they needed it. Two people told us that at times there was a delay in their call bells being answered. One person told us, "sometimes there is not enough staff… in the evening I can have to wait for help to go the toilet…they are busy helping people to bed". Another person said, "Sometimes they don't come very quickly when I press my bell, they are all busy". A relative told us "There have been occasions when we have felt that staff are a bit pushed".

Feedback from staff was also mixed. The majority told us that the staffing levels were adequate. One staff member said, " yes there are enough staff, there is some sickness, you are asked to cover but not too much…things always get done, it can be hard, but we do it. Another staff member said, "Yes there is usually enough staff… a couple of people have left recently, but we always try to ensure there are three people on duty". A third staff member said, "There is not enough staff all of the time". They explained that essential care was always done, but that things like activities might not happen, they said, "We might just have to put music on instead". A fourth staff member said, "There are usually enough staff….the management team always try their best….do everything they can including providing care and support themselves where needed".

Staff employed to work at the home included a registered manager who was supported by a deputy manager. Care was provided by a team of senior staff members and staff members. A maintenance person, cooks, and housekeeping staff were also employed. The ancillary staff all appeared to have a good relationship with people and readily engaged with them whilst undertaking their duties, which helped to promote a positive atmosphere within the home.

The registered manager was confident that they had a good understanding of the number of staff required to deliver a safe service. The target staffing levels for day shifts were one senior staff member and two staff members, supported by either the deputy or registered manager. At night there were two waking staff members on duty. The registered manager explained that the home were currently recruiting staff members but that there had been no need to use agency staff members for some time. They advised that the existing staff team covered gaps in the rota and that this worked well. This helped to ensure that people received care from consistent staff who were familiar with their needs. During the day the care staff were supported by housekeeping and kitchen staff. A cook was on duty until 5.30 which allowed them to prepare supper and assist with serving this before leaving for the day. This helped to ensure that care staff could focus on supporting people.

Staff rotas showed us that on six occasions during the previous three weeks, the home had not been staffed at the target levels, as determined by the registered manager, for periods of time. These gaps were generally between the time of 6pm – 8pm. The registered manager told us that these problems had arisen due to staff not giving adequate notice of their absence. We were told that in response to these situations, the deputy manager would often stay late to assist in the provision of care, but this was not always evidenced on the rotas.

Staff responded quickly and people's needs were met in a personalised and timely manner, although we were aware, particularly over the lunch-time period that some people experienced a short delay in being supported to eat their meals whilst staff were engaged helping other people. We spoke with the registered manager about the feedback from people and staff. They told us that they felt current staffing levels were adequate but that they always had the flexibility to increase staffing levels if this was required in

Is the service safe?

response to people's needs. They explained that they had recently had a number of admissions for respite care and in light of our feedback would give further consideration to the impact of this on staffing levels.

Staff had received training in safeguarding vulnerable adults and were required to repeat this on an annual basis. Staff had a good understanding of the signs of abuse and neglect and were aware of what to do if they suspected abuse was taking place. One staff member told us, that their priority was the safety of people using the service.

The Safeguarding Adults Multi-agency Policy, Procedures and Guidance was available within the home and contained relevant information about how to raise safeguarding alerts including contact details. We saw that the provider also had an "Adult Protection Policy", which staff confirmed they had read. We did note that this policy needed updating as it contained references to out of date guidance. The registered manager told us that safeguarding people from abuse was discussed with staff in their supervisions where scenarios were used to encourage staff to reflect upon how they might act to keep people safe.

Staff were informed about the provider's whistleblowing policy. All of the staff we spoke with were clear that they could raise any concerns with the manager of the home, but were also aware of other organisations with whom they could share concerns about poor practice or abuse.

The service was implementing a personal emergency evacuation plan for each person using the service. This detailed the assistance and equipment that they would require for safe evacuation. The provider had an emergency and crisis plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home which meant that people using the service might have to be temporarily relocated to alternative accommodation. This did not include contingency plans for other events which might affect the continuity of the service such as loss of power or loss of significant numbers of staff or bad weather.

Recruitment and induction practices were safe and relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service checks (DBS) were now being completed before staff worked unsupervised. DBS checks help employers make safer recruitment decisions and help prevent unsuitable people working with people who use care and support services. We did note that in two of the staff records a full employment history had not been obtained. We spoke with the deputy manager about this who obtained this information during the inspection.

Focused Inspection 12 May 2015

At our inspection in October 2014, we identified that the service was failing to ensure that medicines were stored appropriately, that an accurate record of the medicines administered was maintained and that medicines were disposed of safely. On the 12 May 2015 we conducted a focused inspection. This inspection found that the required improvements had not been made. In addition we found a number of new concerns in relation to how medicines were managed within the service.

The National Institute for Health and Care Excellence (NICE), Managing Medicines in Care Home (2014) states that care home providers should ensure that the person's GP is contacted to find out about any allergies they might have and this information should be recorded on the MAR. We found three examples where the information about allergies was incomplete or potentially incorrect. For example, one person was prescribed an Epipen. An Epipen is a pre-filled automatic injection device that administers a medicine in the event of a severe allergic reaction. This person's MAR recorded that they had 'no known allergies'. The member of staff we spoke with told us they thought it was in case the person came out in a rash. There were no protocols in place to guide staff on the circumstances in which they might need to use the Epipen. Therefore there was a risk that staff might not provide the appropriate response should the person experience an allergic reaction.

We found other examples where people were prescribed 'as required' or 'PRN' medicines but there were no protocols in place to support staff to understand when the medicines should be given. NICE guidance states that the following information should be included in a PRN protocol; the reasons for giving the medicine, how much to give, what the medicine is expected to do and minimum time between doses.

The above NICE guidance states that care home staff 'must record medicines administration as soon as possible' and that the MAR should be signed by the staff member who has administered the medicine. It adds that a record

Requires improvement

Is the service safe?

should be kept of when and why medicines have not been given. We reviewed a number of medication administration records (MAR's) for the month of May 2015 and found five examples where there was a gap on the MAR with no signature or reason for medicines not being administered. We also found three examples where the MAR had been signed to record that the person's medicine had been administered but the medicine was still in the dispensing device.

The NICE guidance states that the process for 'covert' or 'disguised' administration of medicines should include an assessment of the person's capacity and a best interest meeting involving the care home staff, the healthcare professional prescribing the medicine, the pharmacist and family member or advocate. The purpose of this meeting should be to ensure that there is agreement that administering the medicines without the person knowing is in their best interests. We found that the home had recently asked a person's GP to approve the covert administration of medicines in their food and drink. There was no mental capacity assessment to underpin this request and no best interests consultation had taken place.

Medicine audits were not being effectively used to drive improvements and to ensure that medicines were being managed safely. None of the concerns we found during the inspection had been identified by the provider. Therefore we could not be assured that the medicines administration systems were monitored effectively to ensure that people received their medicines as prescribed.

The failings identified above are a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment.

During the inspection, we found records which suggested that a person had received double the maximum daily dose of a medicine for a period of a week in March 2015. This medicines related incident had not been identified by the service. Due to the potential seriousness of this error we asked the provider to make a safeguarding referral to the Local Authority to ensure that the exact cause and nature of this incident was identified to promote on-going safety and learning.

The service had made improvements to way in which medicines were stored. The service now had a dedicated medicines fridge and the temperature of this was being monitored on a daily basis. All medicines viewed were within their use by date which meant that they were safe to use.

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 People who use services and others were not protected against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording and safe administration of medicines. Regulation 12 (2) (g).

The enforcement action we took:
Warning notice served on registered provider requiring them to become compliant by 31 July 2015.