Care UK Community Partnerships Ltd

Cedrus House

Inspection report

Creeting Road East, Stowmarket Suffolk IP14 5GD
Tel: 03333211987
Website: www.careuk.com

Date of inspection visit: 13 and 22 October 2015
Date of publication: 29/12/2015

Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21 August 2015. After that inspection we received concerns in relation to how the service supported people living with diabetes. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Cedrus House on our website at www.cqc.org.uk

This focused inspection took place on 13 October 2015 and was also unannounced.

The service is registered to accommodate up to 70 people. On the day of this inspection there were 35 people living in the service.

There was a registered manager in place. 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.

The pre-admission assessment we viewed had not been fully completed. It did not provide the service with a full picture of the person's care and support needs so that the service could decide whether they could meet their needs.

Care plans did not consistently reflect people's needs, not always being fully completed and containing contradictory assessments of a person's ability. Quality monitoring system did not identify that the assessment was incomplete and therefore a risk

Staff had received training in diabetes but were unable to recall the training.

Clinical governance systems were not effective and did not ensure that staff received up to date guidance and

Summary of findings

information and that people received safe care. Some guidelines had not been updated in line with current guidance and where policies had been reviewed these had not been disseminated to relevant staff.

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

The service was not consistently safe.

Assessments were not always thorough which meant that risk was not always assessed effectively.

Care plans did not always accurately reflect a person's needs.

Medicines were managed safely.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Clinical governance systems were not effective and did not ensure that staff received up to date guidance and information.

Quality monitoring systems did not identify incomplete documentation.

The quality of the training and staff understanding of the training had not been monitored by the management to ensure that staff understood their responsibilities and were providing good quality care.

Cedrus House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Cedrus House on 13 and 22 October 2015.

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.'

The inspection team consisted of an inspector, a pharmacy specialist and a specialist advisor. The specialist advisor had been requested to advise on diabetes care in the service.

We spoke with two people using the service, two registered nurses, one care team leader, one member of care staff, the registered manager and the area manager for the service. We also spoke with two visiting care professionals. We looked at two care plans and a number of service policies including the diabetes management policy.

Requires improvement

Is the service safe?

Our findings

The providers Admission and Discharge policy states that 'The Pre Admission Assessment Form will be completed in full, signed and dated by the member of staff conducting the assessment.' The pre-admission assessment we looked at was not carried out as per the provider's policy. It was not signed or dated and was not fully completed. It is not clear from the form whether the issue of diabetes has been raised or, if it had been raised, if the response was negative. Failure to establish the answer to questions such as this meant that the provider did not have a full picture of a person's needs and was therefore unable to complete an accurate care plan detailing how they were going to meet the person's needs.

We also noted that a pre-assessment had shown that a person required a standaid hoist. The sling type or size had not been recorded. The section relating to 'transfers' is blank and there is no evidence as to how the decision to use a standaid had been made.

A care plan, for this person, in the section 'medical condition' records the person as being non-weight bearing and requiring the support of two carers for all moving / transfers. However another part of the care plan entitled 'mobility' records said that they can weight bear with the assistance of a standaid. This contradiction in the care plans may meant that the person may not be supported appropriately and safely with their moving and handling needs. Standaids should not be used for people who cannot consistently and reliably bear weight through their legs and have sufficient upper body muscle strength.

During the inspection we noted that the person had bed rails fitted. Documentation for the use of bed rails had not been fully completed and the bed rails were fitted in an unsafe manner. The person was at risk of harm because the bed rails had been fitted in an unsafe manner

The service approach to quality was not integral and staff were not aware of potential risks that may compromise quality and safety.

The above demonstrated a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1) and (2)(a), (b) and (e).

As part of the focus on diabetes we looked at how the service managed people's diabetes medicines. One person who was unable to independently administer but wished to be as independent as possible. The service was working with the district nursing service to allow them to do as much as they were able. We found that staff had a good understanding of safe practice relating to the administration of diabetes medicines and this was put into practice.

Requires improvement

Is the service well-led?

Our findings

Clinical governance systems were not effective and did not ensure that staff received up to date guidance and information. For instance when speaking with a registered nurse they referred to a flowchart available to them from the service regarding hypoglycaemic episodes. This flow chart referenced NICE Clinical Guideline, No 15, dated July 2004. This guidance has been updated and replaced by NICE guidelines 18 and 19 dated August 2015. Therefore the clinical guidance being used was out of date and not in line with best practice.

When carrying out our inspection on 13 October 2015 we were given the service diabetes best practice guidelines. These showed the issue date a July 2015 with a review date of July 2018. However, when carrying out our inspection on 22 October 2015 we found that the service diabetes practice guidelines available in the first floor treatment room was an older version due for review in August 2015. Changes in policy were not being disseminated to staff meaning that up to date policies and procedures were not being followed.

There were opportunities for the service to identify potential risk through ensuring accurate information had been sought prior to admission and confirmation that it was correct after admission. The manager was unable to provide any information which showed how assessments were monitored. We were concerned that information gathered prior to admission was not reviewed to ensure that it was correct and met the person's needs.

The manager could not provide any information to demonstrate how they assessed the competency of staff in relation to diabetes care. Staff we spoke with recalled that they had received training but not the content the training. Staff understanding of the training they had received had not been monitored by the management to ensure that staff understood their responsibilities and were providing good quality care.

Bed rails were not being used in a safe manner and in accordance with the provider's policy. There use was not being monitored to ensure they were safe and used in the most effective manner.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Adequate assessments of a person's needs were not being carried out.