HC-One Limited

Pytchley Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected the service on 6 & 7 July 2017 and the inspection was unannounced. Pytchley Court is a care home with nursing and provides care and support for up to 37 older people including people living with dementia. At the time of the inspection there were 36 people using the service.

There was a registered manager in post. It is a requirement that the service has a registered manager. 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.

At our previous inspection on 3 November 2016 we found that improvements were required in the management of people's medicines. At this inspection we found that while some improvements had been made, we found other area of concern.

People did not always receive the medicines they were prescribed and protocols were not in place for the management of medicines which were prescribed on an 'as required' basis.

Staff had received training and understood their responsibilities to report suspected abuse. Risk was assessed but risk management plans did not sufficiently protect people from harm.

Safety and maintenance checks were carried out to help ensure that the premises and equipment were safe. There was a fire risk assessment in place and staff knew how to respond to a fire alarm or emergency.

Safe staff recruitment procedures were followed and checks were carried out before people were offered employment.

Staff had not received all the training they required to meet people's needs. People did not always receive care and support that was based on best practice guidance.

Staff were not following the principles of the Mental Capacity Act and people may have had their liberty deprived without authorisation.

People said they liked the food and meals provided. Some people may not have had enough to drink.

People said they liked the staff and they were kind and caring. We saw some instances where staff did not respond appropriately to people's distress or discomfort.

Privacy and dignity was mostly respected and people felt able to be as independent as possible.

Complaints were not always investigated in a thorough way and appropriate action to resolve the complaint was not taken.

There were limited opportunities for people to follow their chosen hobbies and interests.

People and staff felt supported by the management team. Quality monitoring systems were not effective in identifying shortfalls or levering improvement.

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 safe.

People did not always receive their prescribed medicines.

Risk was assessed but management plans were not always sufficient to protect people from harm or were not reflective of people's current needs.

Staff understood their responsibilities to protect people from abuse.

Staffing numbers were not always sufficient to meet people's needs.

Routine maintenance and safety checks were carried out to ensure the premises and equipment were safe to use.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not received all the training they required to meet people's needs. People did not always receive care and support that was based on best practice guidance.

Staff were not following the principles of the Mental Capacity act and associated Deprivation of Liberty Safeguards.

People enjoyed the meals provided but some people did not have enough to drink.

People told us they had access to healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always respond to people's needs or to their distress.

Some people did not feel they were involved in making decisions

about their care and support.

People mostly had their privacy and dignity respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

People knew how to make a complaint. Complaints were not always thoroughly investigated nor was appropriate action taken to resolve the complaint.

People's care and support did not always reflect their individual preferences.

Opportunities for people to follow their hobbies and interests were limited.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality monitoring systems were not effective or used to drive improvement.

The registered manager was supportive and approachable.

Pytchley Court Nursing 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. The inspection visit took place on 6 and 7 July 2017 and was unannounced. The inspection team consisted of one inspector and an expert by experience

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed information that we held about the service to plan and inform our inspection. This included information that we had received from people who used the service and from other interested parties such as the local authority. We also reviewed statutory notifications. A statutory notification contains information relating to significant events that the provider must send to us. We spoke with six people who used the service and four relatives. We spoke with the registered manager, deputy manager, a nursing assistant a member of the care staff, a qualified nurse, the cook and the area director. We looked at the care records of five people who used the service. We also looked at records in relation to people's medicines and health and safety and documentation about the management of the service. These included policies and procedures and training records and quality checks that the registered manager had undertaken. We looked at two staff files to see how the provider had recruited and supported staff members.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 3 November 2016 we found inconsistencies in the arrangements for the management of medicines. Staff did not always have access to an up to date photograph of each person or details about their medical conditions or allergies and the provider's policy for keeping this information with people's medicine administration records (MAR) charts had not been followed. The amount of tablets left in stock did not always tally with records of the tablets that had been administered.

At this inspection we found that action had been taken to address these issues. People had a photograph in place to assist staff in identifying them and details about people's medical conditions and allergies had been recorded. The stocks of medicines we checked was accurate and tallied with the amounts recorded. However, we found other areas of concern within the management of people's medicines.

One person had been prescribed medicine for pain four days before our inspection. The medicine was prescribed to be given 'as required'. None of this medicine had been given to the person despite this person telling staff they were in pain. There was no protocol for staff to follow regarding this medicine and or in what circumstances it should be given.

Another person was prescribed medicine to be given when they became anxious or distressed and another medicine to be given when they were in pain. During our inspection this person was upset for the majority of the time. They were unable to communicate verbally and so could not explain why they were upset or tell staff they were in pain. Neither the prescribed medicine for anxiety or the prescribed medicine for pain had been administered for the last three weeks. This was despite the person being visibly upset and crying out.

Another person was prescribed cream to be applied to their legs. This person told us they had not had their cream applied on the day of out inspection. Records showed it had not been applied for the previous two days. This persons legs looked red and sore.

These matters were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Two people told us they received their medicines at the right time and that staff supported them to take their medicines. One person said "Medication is usually on time maybe a little late at night but you only have to ring the buzzer to remind them and they bring them straight away". Staff had received training in the safe administration, storage and disposal of medicines. We observed staff administering medicines to people and saw that they did this in a safe way. The medicine trolley was locked when unattended by the staff member. Medicines received into the service or returned to the pharmacy were recorded in line with current guidance for the safe management of medicines.

People told us they felt safe. One person said "I feel safe because I like the peace and quiet of my room, but there is always someone about popping their head round the corner to see if I am alright". Another person told us "I feel safe here it's like being at home I can come and go as I please everyone is friendly."

Staff knew how to recognise the signs of abuse and understood their safeguarding responsibility. A member of staff told us they would report any concerns to the nurse in charge. They felt sure that appropriate action would be taken.

Staff knew what action to take in the event of an accident. One person had a fall in their room on the first day of our inspection. Staff called an ambulance and the person was attended by paramedics. However, later in the day we saw this person was alone in their room and did not have a call bell within reach. This person had no way of requesting staff assistance as they were unable to walk until we gave them their call bell and informed the staff.

Risk was assessed and management plans were in place for each person. However some people's management plans did not sufficiently protect them from harm and did not reflect the person's current needs. For example one person who had lost a significant amount of weight had not had this risk evaluated since April 2017. Another person had a pressure sore that was getting worse. Staff had incorrectly graded the severity of the sore.

Safety checks were carried out on the premises and equipment such as hoists and lifts to ensure these were safe for people to use. Fire safety and prevention equipment was also frequently checked .There was an up to date fire risk assessment. Staff knew about evacuation procedures and what to do in the event of a fire or fire alarm.

Most people said there were enough staff to meet their needs. One person told us they were not able to get up at the time they wanted to because there were not enough staff. A relative told us they had heard staff asking a person to wait for assistance going to the toilet because staff were busy serving lunch. We spoke with the registered manager about staffing numbers and how they were calculated. They told us there was a ratio of staff to people who use the service. Shortly after our inspection the provider wrote to us and told us that staffing numbers were in fact calculated based on people's dependency needs and were reviewed frequently. During our inspection we saw that there were enough staff to meet people's. Staff told us that there were sufficient numbers of staff and they were able to meet people's needs.

Safe recruitment procedures were followed and checks were carried out on all new staff. This meant that so far as possible only staff with the right character and skills were employed and this reduced risk for people who used the service.

Requires Improvement

Is the service effective?

Our findings

The majority of people we spoke with felt that staff had received the training they required to meet their needs. One person said they did not feel that staff always met their needs because they were often uncomfortable and in pain. One person had a pressure sore and staff were not providing care which was based on best practice. We discussed this with the area director and immediate action was taken.

Staff we spoke with said they received the training and support they required. One member of staff said they would like more training about providing sufficient amounts of food and fluid. The majority of training provided was computer based. Records showed that some areas of training had a low attendance rate and were not up to date. For example, only 50 % of staff had up to date training in nutrition and hydration and in dementia care. It was not clear how the qualified nurses employed ensured they were providing care that was based on best practice guidance. There were no records of recent training qualified nurses had attended. We were told that one qualified nurse had attended training with the clinical commissioning group but there was no evidence of how this training had been implemented at the service. This meant that we could not be sure that people were receiving effective care based on best practice from staff who had the knowledge and skills they needed to carry out their roles .

The provider was not using 'the Care Certificate' to provide induction training to new staff. The Care Certificate is nationally recognised good practice induction training for adult social care workers. The registered manager agreed to introduce the care certificate to induct new staff.

People told us that staff asked for their consent before carrying out care and support. However we saw that staff did not always properly explain what they were doing when using the hoist to move people from chair to chair and therefore it was not clear whether the person's consent had been obtained.

People had their capacity to make decisions assessed and this was recorded in their plan of care. 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).

Four people had a deprivation of liberty authorisation in place. The registered manager told us they were in the process of applying for further authorisations and carrying out best interest decisions. Care records did not set out how staff should apply the deprivation in the least restrictive way. Although mental capacity was assessed this was not decision specific and best interest decisions had not always been made. We saw that one person did not want to be moved in the hoist and became quite distressed. This constituted a deprivation of this person's liberty but there was no deprivation of liberty authorisation for this or a best interest decision. This meant we could not be sure that in moving the person against their will staff were

acting within the law.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

People told us they were happy with the food they received and with the choice and portion sizes. People made choices on the day from the menu which was read to them by staff. People said if they didn't like what was on the menu they could request something else and staff were happy to oblige. One person said "The food is lovely if I don't like what is on the menu I can ask for something else, I often do, I like a salad as an option sometimes, nothing is too much trouble for them, I have asked on one occasion for something else to eat once supper was over and they very kindly made me a sandwich, one of the staff always brings me in a packet of crisps because I like them."

Some people were unable communicate verbally and could not tell staff what they wanted to eat and drink. Peoples food likes and dislikes were recorded when they first move into the service and kitchen staff had a record of this to assist with menu planning. Staff we spoke with were able to tell us the things people liked to eat and drink. They knew that one person preferred puddings and desserts rather than savoury meals. Catering staff knew about people's specialist dietary needs such as a pureed diet or a fortified diet. They told us how they added cream and butter to food for people who required extra calories.

At lunchtime music was played in the dining room and some people were chatting and appeared relaxed. Staff assisted people with their meals in an appropriate way and at the person's pace. In the afternoon people were offered ice creams in the garden. Tea coffee and biscuits were available and jugs of water and juice were on hand in people's rooms and communal areas. We saw that one person had a drink in front of them but required staff to assist them and had to wait two hours before staff assisted them with their drink. A visitor told us they did not think their relative always had enough to drink. Records showed that two people did not have enough to drink for several days. A target amount of fluid was recorded which the person should drink each day. There was no evidence that any action was taken when target fluids were not reached or that these fluid records were being checked by staff each day.

People had access to the healthcare services they required. One person said "I'm taken to the foot clinic regularly they have given me a cream for my legs and the nurses put it on every day for me." Another person told us "The GP comes here twice a week if we need anything then we can ask to see him."

Nurses we spoke with could not demonstrate a good understanding of sepsis. Sepsis is a medical emergency which requires early identification for successful treatment. The deputy manager told us there was no guidance about sepsis available for staff at the service. People had their vital observations such as blood pressure and pulse measured when they first moved into Pytchley Court. We could not find any evidence that people's observations were monitored or even checked when people became unwell. The deputy manager told us there was a folder containing these recordings but they could not find it.

Care staff were able to describe how they recognised people's deteriorating health and what action they would take. They told us they would report any loss of weight or skin changes to the nurse in charge.

Requires Improvement

Is the service caring?

Our findings

The majority of people we spoke with said that staff were caring and kind. One person said "All the staff genuinely care for us". A visitor said about the staff "They are lovely people, they know I live on my own and invited me to come and have Christmas lunch with my relative". We saw staff approaching people in a gentle way and treating people with respect. However, we also saw that one person was asking to go to bed because they were tired. This person was sitting in a wheelchair and asked staff on several occasions throughout the morning if they could go to bed. Staff did not respond to this request or give the person any explanation.

We saw a member of staff move a person forward in their wheelchair without any explanation or warning. This caused the person to cry out as they were not expecting to be moved. We saw staff moving a person in a hoist without giving enough explanation or reassurance. This person was calling out and upset, staff chatted to each other through the procedure, they did not get down to the persons level to make eye contact or ensure the person could hear them. They did not respond appropriately to the person's distress.

Staff we spoke with knew about people's needs and the things that were important to them. A staff member told us they made people feel important by sitting and chatting to them about the things they liked. A staff member told us how they responded to a person's distress. They told us this person liked to be in their room or in the garden and enjoyed music.

We received a mixed response when we asked people if they were involved in making decisions about their care and support. Some people told us staff regularly asked them if they needed anything different. One person said "I am involved with my care and I have attended meetings, I saw my care-plan when I first came here but not since". Another person said "I'm not involved as such in care-plans I don't know what they are but the staff always ask me if everything is ok and If I would like anything different." A relative said "I have a meeting with the manager once a month. I have seen my relatives care plan at least three times and I am always informed by the manager about any healthcare changing needs". Another relative told us they were not aware of their relatives care plan. They said that unless they asked staff a direct question there was no discussion or rapport with staff and this made them feel they were not involved in decision making about their relatives care and support.

People told us they were able to be as independent as possible. One person said "I can wash myself I like to be independent". Staff gave us examples of how they encouraged people to be independent. People said they had their privacy and dignity respected. One person said "Staff are very respectful towards me always knock before coming in". Another person said "I need help washing and my basin and toilet area is very small and it's a problem going downstairs for me, but the staff are very respectful of my dignity they always cover me when washing me, always wear gloves and ask me is it ok." Records showed that the majority of staff had attended training about dignity.

Requires Improvement

Is the service responsive?

Our findings

People said they knew how to make a complaint and most people said they were listened to and appropriate action taken. One person said I know how to complain, I would go to the manager". One person told us how their relative had made a complaint on their behalf but that nothing had changed to resolve the matter.

We looked at records of complaints. We did not feel that appropriate action had been taken in response to one complaint. In another complaint the staff member had used inappropriate language to describe the complainant and there was no evidence that a thorough and impartial investigation had been carried out. This meant we could not be sure that people were listened to when they made complaints, nor if appropriate action taken by the registered persons in response.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

People had their needs assessed before they moved into the service. This was to make sure people's needs could be met. A plan of care was developed and information about people's personal history, preferences and interests were recorded. The care record for one person stated that the person 'did not mind going to bed around 6 pm and getting up between 7 and 9 am. This person was not able to verbally communicate their preferences so it was not clear why this time had been selected or if it was the preference of the person. We were told that the night staff assisted about five people to get up and dressed each morning before the day staff arrived. The care staff was not sure whether people got up this early because it was their choice or not. One person said that when they asked for assistance at 5.30 am staff said they were too busy getting people up. It was therefore unclear how some people's bedtimes and getting up times were decided so we could not be sure that people were receiving personalised care in the way they wanted

People's care plans and risk assessments were reviewed at least every month. However, we saw that staff had recorded in a plan of care for pain that 'pain appears to be well controlled'. There was no explanation or assessment as to how this conclusion was reached. The person called out and was distressed for most of the time and had not been given any pain relieving medicine.

There was an activities person employed but they were not on duty during our inspection. One person said "There are not an awful lot of people to speak to like say for instance about sport, life in general, what's on the news at the moment, I can sometimes feel a little down about that and someone (staff) will pop their head in to see if I'm ok and have a little chat". The registered manager told us they were trying to recruit two further volunteers to assist with activities. Staff played music in the dining rooms at lunchtimes and because it was a warm and pleasant day some people were assisted to sit out in the garden area. However, the inspection team had to point out to staff that one person was becoming sunburned, staff then assisted them to move inside. There was a hairdresser at the service and we saw that people had a good rapport with the hairdresser and enjoyed having their hair done.

One person played their harmonica and they as well as other people enjoyed this. We did not see any other examples of people being able to follow their interests and hobbies during our two day inspection. A visitor told us "I don't think there are an awful lot of activities going on". The registered manager told us that people were able to take part in gardening. A member of the care staff said that an activities co coordinator was needed on each floor.

There was a lack of storage at the service and this resulted in hoists and slings being stored in communal bathrooms and this meant they were not always accessible to people who used the service. The registered manager told us they were trying to secure a porta-cabin for additional storage. A bath had been removed from the upstairs bathroom this meant that people had to go downstairs for a bath or shower. One person told us they used to have a shower three times a week but now they only have one shower a week and would prefer not to have to go downstairs.

Requires Improvement

Is the service well-led?

Our findings

People and staff praised the registered manager and said they were supportive and approachable. A relative said "I can't praise the manager enough; things have really improved since they came". Staff said they could approach the manager with anything and they would listen. Meetings were held for residents/relatives and for staff so that changes could be communicated and people could give feedback to develop the service. Some people we spoke with were aware of these meetings but others were not. A relative told us "I was initially involved in my relative's care-plan but I'm here all the time and I attend the meetings so if there were any issues or change in health needs they inform me when they see me".

Records showed that at a relatives meeting people had raised concerns about the noise levels at the service. The registered manager told us that noise levels had been decreased and they were monitoring this during twice daily walk around. People had asked for a documentation sheets for relatives to record information. This was still outstanding and had not yet been implemented.

There were records of the registered manager's twice daily walk around. Various aspects of care were checked such as general care and infection control. We saw that feedback from people who used the service was not always recorded.

There was a registered manager in post. The registered manger was not aware of all of their registration requirements such as notifying CQC of all the incidents they were required to. For example they were unaware of the requirement to notify CQC when a deprivation of liberty authorisation was applied for.

There was a quality monitoring programme in place and this consisted of a set of audits where different aspects of the service were checked. The quality monitoring programme had not been effective in identifying the shortfalls and breaches to regulations we identified as a result of this inspection. We looked at audits carried out and saw that these were not always used to make changes or drive improvement. For example, the medicines audit carried out in April 2017 was recorded as failed because of a missed signature in the controlled medicines records. There was no record of action taken regarding this. A care plan audit carried out in April 2017 identified that a person's plan of care required review and update and this included risk assessment and management plans. We saw that none of this identified required action had been taken. This meant that while the audit had identified shortfalls in the persons plan of care action had not been taken to address these shortfalls and the person may have been at on-going risk of harm.

People who were at risk of dehydration did not have the amount the drank each day monitored. Fluids had not been totalled and clinical staff and the registered manager were not monitoring how much or little people were having.

These matters were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

During our inspection there was a quality audit being carried out by the provider's quality inspector. The

provider's area director sent us an action plan following our initial feedback of our inspection. This showed that action was being take to address the issues we raised.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Staff did not follow the principles of the Mental Capacity Act or Deprivation of Liberty Safeguards. People did not have decision-specific mental capacity assessments or best interest decisions. One person had their liberty deprived without the required authorisation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not always given their prescribed medicines and protocols for 'as required' medicines were not always in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	Complaints were not investigated thoroughly or appropriate action taken to resolve them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality assurance systems were not effective in identifying shortfalls or levering improvement.