Czajka Properties Limited

Currergate Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place 3 October 2016. This inspection was unannounced.

Currergate Nursing Home provides care for 38 people over the age of 65. The service is split into 24 nursing care beds and 14 intermediate beds. Established as a nursing home in 1982, it was purchased by the Czajka Care Group in 2003. On the day of inspection there were 35 people living in the home.

The service had 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.

People were supported by staff who had a good understanding of how to keep them safe, identify signs of abuse and report these appropriately.

Robust processes to check the suitability of staff to work with people were in place. There were sufficient staff available to meet the needs of people and they received support to ensure people were cared for in line with their needs and preferences.

Staff training was not always completed in line with the provider's date of expiry.

Medicines were administered, stored and ordered in a safe and effective way. Some documentation was not in place for peoples 'as required' medicines.

Risk assessments in place informed plans of care for people to ensure their safety and welfare, and staff had a good awareness of these. Incidents and accidents were clearly documented and investigated. Actions and learning were identified from these and shared with all staff.

People were encouraged and supported to make decisions about their care and welfare. Where people were unable to consent to their care the provider was guided by the Mental Capacity Act 2005. Where people were legally deprived of their liberty the service ensured their safety and appropriate guidance had been followed.

People received a wide variety of nutritious meals in line with their needs and preferences. Those who required specific dietary requirements for a health need were supported to manage these.

People's privacy and dignity was maintained and staff were caring and considerate as they supported people. Staff involved people and their relatives in the planning of their care.

Care plans in place for people reflected their identified needs and the associated risks. Plans were written in a person centred way listing peoples personal preferences.

Staff were caring and compassionate and knew people in the home very well. External health and social care professionals spoke highly of the care and support people received at the home. They were involved in the care of people and care plans reflected this.

Effective systems were in place to monitor and evaluate any concerns or complaints received and to ensure learning outcomes or improvements were identified from these. Staff encouraged people and their relatives to share their concerns and experiences with them.

The service had a good staffing structure which provided support, guidance and stability for people, staff and their relatives. Relatives spoke highly of the registered manager and all staff.

A system of audits in place at the home had identified improvements required with care plans and records in the home and these were mostly being addressed.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 assessments were in place to support staff in reducing and removing risks associated with people's care.

Staff had been assessed during recruitment as to their suitability to work with people and they knew how to keep people safe.

There were sufficient staff available to meet people's needs.

Medicines were managed in a safe manner.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported effectively to make decisions about the care and support they received.

Staff had not always received training to enable them to meet the needs of people.

People had a wide variety of nutritious food in line with their needs and preferences.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was maintained and staff were caring and considerate as they supported people. People were valued and respected as individuals and were happy and in the home.

People and their relatives were involved in the planning of their care.

Staff knew people well and could demonstrate how to meet people's individual needs.

Is the service responsive?

Good

The service was responsive.

Care plans reflected the identified needs of people and the risks associated with these needs.

People were encouraged to remain independent.

Systems were in place to allow people to express any concerns they may have and complaints were recorded and responded to in a timely way.

Is the service well-led?

Good

The service was well-led.

People spoke very highly of the registered manager and staff. Staff felt very well supported in their roles and displayed a good understanding of the values of the service.

Audits and systems were in place to ensure the safety and welfare of people in the home. These audits had identified areas of improvement within the service; however they had not always been addressed.

The service had a registered manager in place.

Currergate 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.

This inspection took place on 3 October 2016 and we made phone calls to a health professional on 10 October 2016. This inspection was unannounced. The last inspection took place on 18 September 2013 and the provider was meeting the regulations in all areas inspected against.

The inspection team consisted of one inspector and one specialist advisor for mental health.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with four people who used the service and two relatives to ask them for their views on the service. In addition we spoke with two care workers, one registered nurse, one visiting health professionals, a cook, a maintenance manager and the registered manager. We looked at four people's care records and other records which related to the management of the service such as training records and policies and procedures.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. 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.

Good

Is the service safe?

Our findings

People were safe in the home and were supported by staff who knew them very well and understood how to support them to maintain their own safety. Relatives told us their loved ones were safe and were supported by staff who had a very good understanding of their needs and how to ensure their safety. Health and social care professionals said they felt people were safe and well looked after at the home.

We saw the provider had a safeguarding policy and procedure in place that advised staff of the action to take if they suspected abuse. Staff had a good understanding of the safeguarding policies and procedures which were in place to protect people from abuse and avoidable harm. Staff we spoke with were able to explain what abuse was and their responsibilities to act on any concerns they had about people's safety. Staff also knew about the whistleblowing policy and were confident to use it if their concerns were not acted on. Staff told us they had received training in the safeguarding procedures; however the training matrix showed many staff required refresher training.

There were sufficient staff available to meet the needs of people. The registered manager told us they had a stable group of staff who worked at the home and staff rotas showed there were consistent numbers of staff available each day to meet the needs of people. The registered manager told us how they worked closely with the registered provider to support any staff absence. When a staff member was absent from work through sickness, rotas showed these duties had been supported by other members of staff who worked for the registered provider's group of homes. Relatives and staff told us there were always sufficient members of staff on duty at any time to meet the needs of people and our observations confirmed this. Call bells were answered in a timely manner and during mealtimes we saw sufficient staff available to support people in the main dining area and also to support those who chose to remain in their rooms. Staff carried out their duties in an unhurried and calm way and had opportunities to provide support for people without being hurried.

We completed a tour of the premises as part of our inspection. We inspected people's bedrooms, bath and shower rooms, the laundry, kitchen and various communal living spaces. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We saw upstairs windows had tamper-proof opening restrictors in place. We saw radiators were covered to protect people from injury of hot surfaces. We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant. We saw Control of Substances Hazardous to Health Regulations 2002 (COSHH) assessments had taken place to prevent or control exposure to hazardous substances. All cleaning materials and disinfectants were kept in a locked room out of the reach of people who used the service. .

The care records we looked at showed actual and potential risks to people had been identified and plans were in place of the action required by staff to mitigate these risks. For example, risk assessments were carried out on moving and positioning, falls and for health specific conditions which may lead to choking. The plan of care provided staff with the guidance to support the individual and protect them from harm. Risk management plans included a score which showed the number of staff required to deliver safe care. Staff with whom we spoke with were able to describe in detail how they supported people safely. This

matched the information we had read in care plans. Records showed advice was sought from health care professionals and risk management care plans were reviewed regularly. Each person had a comprehensive evacuation plan that detailed how to support the person in the event of an emergency. Regular fire safety checks were carried out.

People's safety was secured by the provider's recruitment policies and practices. Staff with whom we spoke described the recruitment process and told us relevant checks were carried out on their suitability to work with vulnerable people. Staff told us they were required to provide two references and to secure a Disclosure and Barring Service (DBS) check before starting work. All the staff details we looked at included references and DBS information. The DBS checks a person's criminal background for cautions or convictions.

The responsibility for medicine administration lay with registered nurses. We observed all oral medicines were administered by nurses with the responsibility for the application of creams delegated to trained care staff. We saw the application of creams was recorded on a topical medicine administration chart in the person's bedroom. We saw additional information in the form of body maps existed to direct care staff where to apply creams. Each person's medicines were stored in a locked cabinet in their rooms.

We looked at people's medicine administration records (MAR) and reviewed records for the receipt, administration and disposal of medicines and checked medicines to account for them. We found records were complete. However we found nursing staff were not carrying forward existing stocks of medicines from one MAR sheet to the next which made it difficult to accurately account for boxed medicines. We saw evidence in a past audit of this shortfall but no action had been taken. The registered manager assured us this would be rectified.

The staff maintained records for medication which was not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor. Our scrutiny of the MAR sheets and our observations of the administration of medicines demonstrated medicines to be administered before or after food were given as prescribed. Some medicines had been prescribed on an 'as necessary' basis (PRN). No PRN protocols existed to help nursing staff consistently decide when and under what conditions the medicine should be administered. We saw blank PRN protocol sheets existed and the provider's medicine policy required the production of a protocol for each medicine. We also saw a past audit which had found there to be a lack of PRN protocols yet no action had been taken. The registered manager assured us the matter would be rectified. However staff were able to tell us when they would administer PRN medicines safely.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection a number of people were receiving controlled medicines. We inspected the contents of the controlled medicine's cabinet and controlled medicines register and found all drugs accurately recorded and accounted for.

We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Drug refrigerator and storage temperatures were checked and recorded daily to ensure medicines were being stored at the required temperatures. This showed us drugs that required specific storage instructions were being met.

Requires Improvement

Is the service effective?

Our findings

Staff knew how to meet people's needs effectively and offered them choice whilst respecting their wishes. They took time to allow people to make decisions. Relatives told us staff supported their loved ones to make decisions and they were involved in this process.

A program of supervision sessions, induction and training was in place for staff. Staff felt supported through these sessions to provide safe and effective care for people. The administration team monitored people's supervision and appraisal dates on a computerised system. We checked dates for some people and found their supervision had lapsed by a month or two. The services administrator was aware of the gaps and had created a plan to rectify this concern.

All completed training records for staff were logged and monitored by designated staff at the registered provider's head office. They liaised with the registered manager to monitor all training needs and ensure staff received appropriate training to meet the needs of people who lived at the home. Records showed staff had access to a wide range of training which included: moving and handling, fire training, safeguarding mental capacity and deprivation of liberty and health and safety. New members of staff were being supported to complete a four day induction completed by the providers training department. However some subject areas had lapsed for a significant portion of the staff team including dementia awareness, safeguarding and first aid. For example the services computerised system showed us that for 15 out of 52 staff their safeguarding training had expired, 24 out of 28 staff had expired with their dementia training and although 11 staff had completed 'first aid at work' training, 28 out of 43 staff had expired across both of the first aid training courses available.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

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 so that they can 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). We saw one person had a DoLS authorisation in place. We saw the supervisory body had attached conditions to the authorisation and these were being met. We discussed with the registered manager three other people who the manager felt may need an application to be made for DoLS. The discussion showed the need was unlikely but did demonstrate the registered manager's thorough knowledge of the legislation and the issues which had to be taken into consideration.

We spoke with the registered manager about the use of bed-rails. The registered manager demonstrated to us bed-rail assessments were used to ensure people who may roll out of bed or have an anxiety about doing so would be protected from harm. Our scrutiny of care plans showed the process to evaluate the need for bed-rails was well documented. The registered manager demonstrated a good understanding of how the inappropriate use of bed-rails may constitute unlawful restraint.

Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support. We saw staff seeking consent to help people with their needs. For example, when staff were administering medicines we observed people were asked if they would prefer their medicines at a particular time rather than medicines being administered at a time convenient for staff. People who were prescribed PRN medicines were asked if they required the medicine. We also observed at lunchtime people were asked where they would like to sit.

Records showed people had either given consent to their care and treatment or a care specific mental capacity assessment had been completed where people may not have the mental capacity to consent. For people with a 'lasting power of attorney' (LPA) for their care and welfare their representative made best interest decisions on their behalf. Care plans contained copies of the registered LPA with the Office of the Public Guardian.

We asked the registered manager about advocacy. Our discussion showed all people currently receiving care were able to be supported by family and friends when their care needs were being established or reviewed. The registered manager told us that any people who may be coming to the service without anyone to support them would be offered the services of an independent lay advocate.

The service used the Malnutrition Universal Screening Tool (MUST) to assess people. This is a screening tool to identify adults who are at risk of being malnourished. As part of this screening we saw people were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition. Where appropriate we saw fully completed charts to record people's fluid and food intake. We spoke with the cook to gauge their level of involvement in meeting people's nutritional needs. We saw the cook had a diet sheet for each person which showed their likes and dislikes. It also contained clinical information regarding people with such conditions as diabetes, lactose intolerance or coeliac disease. Where people were deemed to require a fortified diet the cook enriched food with cream and cheese. Our discussions with the cook demonstrated they had a thorough understanding of each person's nutritional needs.

We saw evidence in written records staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, community nurses, specialist nurses in the field of tissue viability, speech and language therapists and dentists. Care plans were clearly indexed to allow staff to easily access other health care professionals written advice.

We saw the home had ensured easy and safe access to secure gardens and patios, well furnished with outdoor seating. Easy access to outdoors gives people exposure to outdoor activities which have been shown to improve sleep patterns, mood and quality of life and reduce agitation and depression for people especially those living with dementia.

Good

Is the service caring?

Our findings

People were valued and respected as individuals and were very happy and content in the home. They clearly enjoyed the company of a group of staff who knew them very well and understood their needs. Staff provided a calm, caring and homely environment for people to live in. External health and social care professionals and relatives said people were well looked after and they had their privacy and dignity respected.

Staff spoke and interacted with people in a calm and friendly manner. People were treated with respect. Staff knocked on people's bedroom doors before entering. We saw staff took every opportunity to engage with people and paid particular attention to people who chose to remain in their rooms. We saw people's privacy, dignity and human rights were respected. For example, staff asked people's permission and provided clear explanations before and when assisting people with medicines and personal care.

People were encouraged to be as independent as possible and were able to roam around the home and garden as they chose. For example we observed people during lunch time and saw staff encouraging people to support themselves, and staff made adjustments to make this process easier. Another person was supported to walk by staff, but staff were led by the person so they decided where to go.

We saw people and staff had developed positive relationships with each other with staff having a thorough understanding of people's likes and dislikes. Staff knowledge had been enhanced by a thorough record being constructed at the point of admission which was taken from people's life stories.

People were able to express their views and be actively involved in making decisions about their care. The registered manager told us they had meetings with the people who lived at the home to discuss any concerns or changes around the home. People and their relatives told us they were involved in the planning or peoples care. We observed care records contained specific information regarding the level of support people needed. Relatives told us staff made every effort to support their family member and make their life as comfortable as they could. One relative told us, "The staff get on great with [person's name]", "Nothing is too much trouble" and another person said, "Staff do all they can and nothing else is required."

We observed staff were attentive to people's needs. For example, one person showed signs of being uncomfortable and staff quickly helped them to change position. Staff with whom we spoke were able to demonstrate they were aware of the need to protect people's dignity, particularly whilst helping them with personal care. They told us all new staff were given guidance during their induction period about how to maintain people's dignity.

Good

Is the service responsive?

Our findings

People were able to express their views and be actively involved in making decisions about their care. They were encouraged to be active and healthy in the home and were supported by staff who knew them very well. Relatives told us they were involved in supporting their loved one to make decisions about the care they received, although one relative told us they had not been involved in the planning of care for their loved one.

When people moved into the service their risk assessments fed information into a care plan covering, mobilization, toileting, nutrition, communications, mood, sleeping and personal hygiene. We saw staff on a daily basis had recorded outcomes of the care plans and took steps to modify the records as and when people's experiences or health care needs changed.

Through an assessment of dependency care plans recorded what the person could do for themselves and identified areas where the person required support. Where people required support the care plan described this in terms of numbers of staff and any equipment needs.

People's care records gave staff information about their daily routines. Care records showed people or those important to them had been consulted about their needs and wishes. Through our discussions with staff it was clear they knew people's individual support needs well and the daily records of care delivery reflected what we had been told. Staff described how they ensured people could choose how they were supported. They told us about people's right to have choices in respect of who should care for them, what and when they ate and when they went to bed.

A range of activities were provided in the communal areas of the home including music events, games, jigsaws and dominos. Staff told us they tried to encourage people to participate in activities they chose or which may be of interest to them. The garden of the home allowed people to access the rear grounds with follower beds, lawn and a pond with fish in. A large patio area allowed people to sit outside in the nicer weather. External entertainers visited the home and included musicians and visiting pets and animals. For people who preferred to remain in bed for their care the activities staff told us they would visit them in their rooms and encourage them to participate in any activity they chose including reading with them and sharing photographs and memories. Regular social activities such as tea parties to celebrate birthdays and trips out were organised. On the day of inspection we saw one person was supported to access the community for a walk with a staff member.

We spoke with people to see if they knew how to make a complaint. One person said, "Whilst I have no complaints I would happily speak with [registered manager] if I had any concerns. " The provider had a complaints procedure which informed people what they needed to do to make a complaint and the timescales for the complaint process to be completed. We saw over the previous two years that seven formal complaints had been received. We found none were concerned with matters of safety, no recurrent patterns were noted and all had been resolved within the provider's timescales. We saw letters acknowledged matters of poor performance, told complainants of the course of action to be taken and how

the provider would reflect on the matter to improve quality overall.

Good

Is the service well-led?

Our findings

Relatives felt the service was very well led and spoke highly of the registered manager and all the staff at the home. External health and social care professionals said the service was very well led and they received a good response from all staff who knew people very well.

There was a clear staffing structure in place at the home which was supported by further managers at the registered provider's head office. A robust network of support for all staff was evident in the home. The registered provider had clear systems and processes in place to ensure the safety and welfare of people. The nominated individual for the registered provider visited the service regularly. An administrator in the home supported with all clerical duties, whilst registered nurses within the service supported the clinical day to day running of the home.

We saw the registered manager and senior nursing staff were continually reviewing the service and introducing new and innovative ways of service delivery. For example it was found the responsiveness of taking people's bloods was not always able to meet their needs. The registered manager had arranged for a member of care staff to be trained at the local hospital to be competent in this procedure and to be able to meet people's needs. We spoke with the trained member of staff who told us of the benefit to people and how it had enhanced their experience of working at the home.

A program of audits was in place at the home to ensure the safety and welfare of people, including audits which were completed by managers from the registered provider's head office. Audits to ensure the safety and welfare of people included: medicines, infection control, the environment, equipment checks and fire records. For example we saw hand washing and infection control audits took place monthly to ensure compliance with good practice. We saw the infection control audits had identified areas which were required improvement. For example to ensure sharps boxes were not over-filled and to ensure staff closed the lid. Our observations showed all sharps boxes were used safely. However one audit identified many areas to improve which had been rectified, apart from identifying the need for a PRN medicine protocol which was not in place at the time of inspection and stock balances to be carried forward. We mentioned this to the registered manager who agreed to input the providers existing paperwork and remind staff about the importance of bring the stock balances forward.

We saw accidents and incidents were fully documented. We saw no indications of accidents being repeated which may indicate a lack of managerial oversight. The accident and incident records were checked by the registered manager, who assessed whether an investigation was required and who needed to be notified.

Staff described the home as a happy place. They told us it was small enough to be able to get to know people and for them to get to know the staff. They told us they worked as a team and were complimentary about the registered manager. One staff member told us, "When I came to live in the area I looked at a number of care homes with vacancies; I have no hesitation to say I chose the right place to work."

Staff felt supported through supervision, appraisals and team meetings. These were used to encourage the

sharing of information such as learning from incidents, changes in documentation following review of care plans or records and new training and development opportunities.

We saw staff had clearly defined areas of responsibility. This ensured care staff were solely responsible for care delivery with no requirement to supplement the catering, cleaning and laundry responsibilities of others. We saw there to be adequate administrative staff to enable the manager to effectively discharge their responsibilities.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always up to date with training in line with the providers system.