Care Quality Commission

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Quenby Rest 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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced inspection on the 3 June 2015. Quenby Rest Home provides care for up to 26 older people who may be elderly and or have a physical disability. Some people are living with dementia. There were 20 people living in the service when we inspected.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had recently been appointed and their paperwork was in the process of being submitted to CQC.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to protecting people by ensuring the premises was secure, well maintained, fit for purpose and safe. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

Staff were aware of the values of the service and understood their roles and responsibilities. Whilst there were sufficient numbers of staff, improvements were needed in the deployment and organisation of staff to ensure people's needs were consistently met. Supervision arrangements to support staff were not robust.

Not everyone was encouraged to pursue their hobbies and interests and participated in a variety of personalised meaningful activities. People who remained in their bedrooms or were cared for in bed received little social attention and were at risk of isolation as staff interactions were task focused.

The provider's complaints system was not robust. Not everyone knew how to make a complaint or report a concern. There were inconsistencies in how issues were reported; records did not always show that feedback had been acted on promptly and appropriately.

Systems in place to monitor the quality and safety of the service required further development to drive the service forward.

Staff interacted with people in a caring and compassionate manner. The atmosphere in the service was friendly and welcoming. Staff listened to people and acted on what they said. Staff understood how to minimise risks and provide people with safe care. Care and support was individual and based on the assessed needs of each person.

Appropriate recruitment checks on staff were carried out. Staff understood their responsibilities to protect people from harm and report any concerns about people's welfare. People were provided with their medicines when they needed them and in a safe manner.

People were encouraged to attend appointments with other healthcare professionals to maintain their health and well-being.

People voiced their opinions and had their care needs provided for in the way they wanted. Where they lacked capacity, appropriate actions had been taken to ensure decisions were made in the person's best interests.

People were provided with a variety of meals and supported to eat and drink sufficiently. People were encouraged to be as independent as possible but where additional support was needed this was provided in a caring, respectful manner.

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?
The service was not consistently safe.

Improvements were needed to ensure the premises were safe, secure and well maintained throughout.

Staffing arrangements were not consistent to ensure staff met people's care and welfare needs.

Appropriate recruitment checks on staff were carried out. Staff understood their responsibilities to protect people from harm and report any concerns about people's welfare.

People were provided with their medicines when they needed them and in an appropriate manner.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff supervision arrangements were not robust. Improvements were needed to ensure staff were supported in their role.

The Deprivation of Liberty Safeguards (DoLS) were understood by staff and appropriately implemented.

People were supported to maintain good health and had access to ongoing healthcare support.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

Requires improvement

Is the service caring?
The service was caring.

People's privacy and dignity was respected and maintained.

Staff were compassionate in their interactions with people.

People and their relatives were involved in making decisions about their care and these were respected.

Good

Is the service responsive?
The service was not always responsive.

People who remained in their bedrooms or were cared for in bed received little social attention and were at risk of isolation as staff interactions were task focused.

A robust complaints system was not in place.

Requires improvement

Summary of findings

People's choices, views and preferences were respected and taken into account when staff provided care and support.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Systems in place to monitor the quality and safety of the service provided were not robust. Improvements were needed to drive the service forward.

Staff were clear on their roles and responsibilities.

Quenby Rest 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 unannounced inspection took place 3 June 2015 and was carried out by two inspectors.

We looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with eight people who used the service, four relatives and visitors and one visiting healthcare professional. We used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people who may not be able to verbally share their views of the service with us. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the provider, regional manager and ten members of staff including an administrator, care, catering, domestic and activities staff. We reviewed feedback received about the service from two health and social care professionals. We looked at five people's care records, four staff recruitment and training files and the systems in place for assessing and monitoring the quality of the service.

Requires improvement

Is the service safe?

Our findings

Environmental improvements were needed to ensure the service was safe, suitable and fit for purpose. This included ground works maintenance where the external wood was damaged and the paint chipped and showing signs of wear and tear. Inside the service there were several areas that required maintenance attention, such as a missing lock on the door of the downstairs staff toilet which did not ensure people's privacy. Bathrooms where the paint had peeled away or chipped tiles making it difficult to effectively clean and reduce the risk of cross infection. We saw potential trip hazards where some of the carpets and flooring were stained and worn in places which compromised people's safety.

The provider told us that a schedule of improvement works was underway to give the service an overhaul. This included redecoration of paintwork throughout the service, upgrade and refurbishment of communal toilets and bathrooms and a 12 month rolling programme to change all the bedroom flooring that was carpeted and replace worn laminate flooring. Records seen confirmed what we had been told.

We found a fire exit gate was padlocked which meant people using the service and others were at risk of not being able to exit safely in the event of an emergency. We reported this to the provider who took action to ensure the exit gate was not locked

However these improvements will need to be sustained to ensure people are consistently provided with a safe and suitable environment to live in.

This is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient numbers of staff to meet people's basic care needs but not their social needs. We saw that people in the two lounges were left alone for long periods of time with limited interaction whilst care staff were answering requests for assistance or writing up care records. The deployment and organisation of staff did not always mean people received the support they needed consistently and in a timely way. This included people living with dementia who were observed for long periods staring ahead showing signs of being withdrawn and disengaged.

The area manager advised us they would review and monitor the systems in place with the new manager to provide sufficient numbers of staff with the right skills and competencies to meet people's care and welfare needs.

Staff had received training in safeguarding adults from abuse. Staff understood the provider's policies and procedures relating to safeguarding and their responsibilities to ensure that people were protected from abuse. They were able to explain various types of abuse and knew how to report concerns. Staff also had an understanding of whistleblowing and told us that they would have no hesitation in reporting bad practice.

People had their health and welfare needs met by staff who had been recruited safely. Staff told us the manager or provider had interviewed them and carried out the relevant checks before they started working at the service. Records we looked at confirmed this.

Staff told us that people's care records were regularly reviewed and updated to inform and guide them about changes to people's care. Individual assessments covered identified risks such as nutrition, moving and handling and pressure ulcers, with clear instructions for staff on how to meet people's needs safely and effectively. For example, people cared for in in bed were on suitable mattresses with repositioning charts used to ensure people were comfortable and to reduce the risk of pressure ulcers.

People told us they received their medicines as prescribed and intended. One person said, "The [staff] are ever so good at applying my creams and giving me my tablets when I need them." Another person described how the staff told them what each tablet was for and answered any questions they had. They said, "They [staff] explain what I am taking as there are so many I can't keep track and remember what each one [tablet] is for. They [staff] give me a little drink and wait until I have taken them all. Ever so patient. They [staff] also ask if I am in pain and will give me something to help if I am."

Medicines were stored safely for the protection of people who used the service. We observed a member of staff appropriately administering medicines to people. They dispensed the medicines safely and explained to people before giving them their medicines what they were taking and were supportive and encouraging when needed. Medicines were provided to people as prescribed, for example with food..

Requires improvement

Is the service effective?

Our findings

People told us that staff had the skills to meet their needs. One person said, "They [staff] are more than capable and know what they are doing. Never had any problems. One person's relative commented that staff were, "Accommodating, competent and very caring."

Staff told us that they felt supported in their role, received supervision and attended staff meetings. These provided staff with opportunities to discuss the ways that they worked and to receive feedback on their work practice and identify areas for improvements to provide people with quality care. However records showed that robust arrangements were not in place to provide staff with effective and regular supervisions. Supervisions were not planned in advance and were carried out by the administrator and not the management team who were responsible for care delivery. We discussed this with the area manager who was not aware of these supervision arrangements and said this was not in line with the provider's policy and procedures. Following our discussion the area manager submitted an improvement plan to address the shortfalls we found. This included a supervision schedule for staff carried out by the management team.

Staff told us they were provided with core training and received refresher updates in health and safety, moving and handling and fire safety. People had different levels of dependency for staff to help and support them and the training they had reflected this. We saw a member of staff support a person who was distressed in a consistent and calm manner. They demonstrated their understanding of the person's needs and the best way to interact with them in a reassuring manner that settled them.

Several care staff told us they would like further training in dementia care to develop their understanding of how to further meet people's specific needs. The area manager told us that further training was planned including person centred care and dignity workshops which would include training in dementia. They also said that support would be provided to staff to assist them with the roll out of new care plans and recording information.

We saw that staff acted in accordance with people's wishes. For example, one person told a member of staff when they came to assist them to lunch in the dining room they had changed their mind and wanted to eat in their bedroom. The member of staff agreed to bring their lunch to their bedroom.

Staff understood the Mental Capacity Act 2005 (MCA) and were able to speak about their responsibilities relating to this. The Deprivation of Liberty Safeguards (DoLS) were being correctly followed, with staff completing referrals to the local authority in accordance with new guidance to ensure that any restrictions on people, for their safety, were lawful. Staff recognised potential restrictions in practice and that these were appropriately managed, for example, staff understood that they needed to respect people's decisions if they had the capacity to make those decisions.

Where people did not have the capacity to consent to care and treatment an assessment had been carried out. People's relatives, health and social care professionals and staff had been involved in making decisions in the best interests of the person and this was recorded in their care plans.

People told us they had plenty to eat and drink, their personal preferences were taken into account and there was a choice of food at meal times. One person said, "The food here is tasty and good. What more do you want." Staff made sure people who required support and assistance to eat their meal or to have a drink, were helped sensitivity and respectfully.

People's dietary needs were assessed with guidance in their care records to inform staff on how to meet people's individual dietary needs. This included where people were identified at risk of choking, staff used prescribed thickeners for liquids to support them to drink safely.

People said that their health needs were met and had access to healthcare services and ongoing support where required. One person said that there were regular visits from nurse practitioners and that staff, "Were quick to call out the doctor when needed." One person's relative told us that their relative had regular visits from the GP and other professionals and were reassured by the approach of staff who were quick to act. They said, "The staff are very alert to changes in people's health and moods and act fast. I have no issues and am kept very well informed of what is going on."

Records showed routine observations such as weight monitoring were effectively used to identify the need for

Requires improvement

Is the service effective?

specialist input. Documentation showed that staff worked closely with nurse practitioners when required and dieticians in relation to swallowing needs and people identified underweight on admission to the service.

A visiting healthcare professional stated that the staff made appropriate referrals to the surgery and were able to accurately report signs and symptoms to enable effective telephone triage. They confirmed that prescribed treatment plans were followed by the staff.

Good

Is the service caring?

Our findings

People told us that the staff were caring, kind and treated them with respect. One person said. “The carers [staff] are good they treat me right kind.” Another person said, “I think the staff are absolutely wonderful and can’t do enough for you.” Relatives described the staff as welcoming, knowledgeable, approachable and helpful. One person’s relative said, “I pop in all the time and haven’t a bad word to say about any of the staff here. Even though there have been lots of changes [registered] manager recently left, it hasn’t affected the care that has been given. I can’t fault the care here at all.” Another relative told us, “The staff are extremely patient and compassionate.”

We observed the staff and people together. The atmosphere within the service was welcoming, relaxed and calm. People were at ease with each other and the staff showed genuine interest in people’s lives and knew them well, their preferred routines, likes and dislikes.

We saw that staff adapted their communication for the needs of people living with dementia. Staff used a variety of techniques to engage with people through appropriate use of language and also through non-verbal communication such as using reassuring touch to encourage or show understanding and compassion. All the staff referred to people by their preferred names including nick names where appropriate. Three people were seen to particularly enjoy the company and conversation with two members of staff. They were seen laughing and joking with each other as they made their way to the dining room for lunch.

People told us the staff respected their choices, encouraged them to maintain their independence and knew their preferences for how they liked things done. Staff took time to explain different options to people around daily living and supported them to make decisions such as what they wanted to eat and drink, where they wanted to spend their time and whether or not to join in group activities. Staff listened and acted on what people said. Three relatives told us they were kept, “Up to date,” about the daily routines and wellbeing of people.

People told us they felt they were involved in their care planning and that staff engaged with them and supported them to make decisions about what they wanted. One person said, “[Member of staff] went through everything with me after I saw the doctor. It was a lot to take in. We talked about what I could do and I said I would prefer the nurse came to see me here then have to go to hospital and that is what happens.”

Staff knocked on bedroom and bathroom doors before entering and ensured bathroom and bedroom doors were closed when people were being assisted with their personal care needs. When staff spoke with people about their personal care needs, such as if they needed to use the toilet, this was done in a discreet way. These actions respected people’s privacy.

Requires improvement

Is the service responsive?

Our findings

Improvements were needed to ensure people who were more dependent including those living with dementia consistently had their social and cognitive needs met. People who remained in their bedrooms or were cared for in bed received little social attention and were at risk of isolation as staff interactions were task focused.

There was one activity co-ordinator on shift responsible for providing activities and engagement for all 20 people and whilst we observed that there were some areas of good practice with regards to activities and social stimulation in the service we found inconsistences. This included where some people were left for long periods of time with little or no stimulation. Staff told us that regular safety checks were in place for people who spent their time alone and they tried to spend quality time with people but acknowledged that records did not reflect the engagement and activity provided. Whilst we did see one member of staff sitting talking to someone in their bedroom for a period of time we were not assured that an effective system was in place to ensure everyone received quality interaction to reduce the risk of isolation.

People were supported to maintain relationships with the people who were important to them and to minimise isolation. People told us that they could have visitors when they wanted them; this was confirmed by people's relatives and our observations.

People and relatives were not aware where the complaints process was displayed in the service or who to speak with if they needed to make a complaint. Some people told us they had spoken with the previous manager when they wished to raise a concern but did not know who they would speak to now the manager had left. People told us that as they had spoken to staff when issues emerged and these had been dealt with satisfactorily and therefor they had not escalated matters further. One person's relative told us that they found the staff were, "Receptive," and, "Accommodating" when they had spoken with them about a problem with laundry management. Processes for recording compliments, comments, concerns and complaints did not consistently document the issue, reflect the actions taken, how this was fed back to the person and used to develop the service. Improvements were needed to ensure people's feedback is valued and acted on.

Care plans and risk assessments were reviewed and updated to reflect people's changing needs and preferences. They contained information about people's likes, needs and preferences. This included details about what they liked to wear, how they liked to be approached and addressed. Information about people's life history and previous skills and abilities were used to inform the care planning process. There were some inconsistences in people's daily records. Several seen were task focused and generic. The area manager explained how they were introducing a new format to enable staff to record their observations and comments about people's personalised care and wellbeing. They added that new documentation would highlight people's ongoing involvement and decisions about their care arrangements. Additional support for staff including training and internal communications had been planned and would address the discrepancies we found.

Staff talked with us about people's specific needs such as their individual likes and dislikes and demonstrated an understanding about meeting people's diverse needs, such as those living with dementia. This included how people communicated, mobilised and their spiritual needs. They knew what was important to the individual people they cared for. This was reflected in their care records. Staff were alert to people's feelings and concerns, responding if anyone seemed unsure or worried. One person's relative said, "I would recommend this place and have said when it is my time I will come here. I trust the staff and think they understand how to look after people really well."

Relatives told us they were kept up to date about changes in their relative's wellbeing. This was reflected in the communication logs in people's care plans. This included being advised of upcoming appointments with professionals such as the doctor and optician and in the adverse event of a fall what actions had been taken. One relative said, "They [staff] call the doctor out straight away if they have any concerns or notice changes."

Requires improvement

Is the service well-led?

Our findings

The provider had recently restructured the senior support and management arrangements after independently recognising the need to improve the quality and safety of the service. At the time of our inspection the provider's plans to take the service forward had not been fully embedded.

People, relatives and staff told us that, in the absence of a registered manager, the area manager was a visible presence in the service and was supporting the acting manager until the new manager started. They said that the area manager and acting manager were accessible to them and they had confidence in their ability.

People told us they felt valued, respected and included because the staff were approachable and listened to them. One person said, "[Acting manager] is always around and will listen to you if something is wrong and do what they can to help." One person's' relative said, "Yes there have been several management changes but they [staff] do let you know what is going on and it hasn't affected the care that is given."

The area manager told us they were new in post and as part of their induction had been working with the staff and provider to understand the processes and systems in place and identify where improvements were needed. They explained how they had developed an action plan to address the shortfalls they had found and would be working with the new manager to implement their recommendations. This included planned refurbishment works and redecorating of the service. Improving the environment to make it 'dementia friendly' for people, developing a person centred culture in line with best practice and supporting and developing staff through effective training and supervision.

Existing quality assurance processes needed to be further developed. The shortfalls we had identified had not been picked up through the provider's internal quality monitoring arrangements. This included records and staff behaviours that did consistently ensure that people's dignity was promoted in line with best practice. In addition the provider had not identified concerns around lack of social interaction or explored the reasons for this. The area manager submitted to us an improvement plan that took account of the shortfalls we had found and actions in place to mitigate the risk. These improvements will need to be sustained to ensure people receive a safe quality service.

People, relatives and visitors told us they had expressed their views about the service through regular meetings and through individual reviews of their care. A satisfaction survey also provided people with an opportunity to comment on the way the service was run. We saw that action plans to address issues raised were in place and either completed or in progress. Meeting minutes showed people were encouraged to feedback about the quality of the service. For example, people contributed towards decisions that affected their daily life such as menu choices, the environment and variety of activities offered. This showed us that people's views and experiences were taken into account and acted on.

People, their relatives and staff were comfortable and at ease with the management team. Staff were clear on their roles and responsibilities.

Systems were in place to manage and report accidents and incidents. People received safe quality care as staff understood how to report accidents, incidents and any safeguarding concerns. Records seen showed that staff followed the provider's policy and written procedures and liaised with relevant agencies where required. When accidents had occurred risk assessments were reviewed to reduce the risks from happening again. Incidents were monitored to check if there were any potential patterns or other considerations (for example medicines or environmental obstacles when falls had occurred) which might be a factor.

The area manager advised us they were developing a quality monitoring tool to take account all the projects and actions undertaken to improve the service and people's experiences. This included outcomes from their recent internal audits, the satisfaction survey and visits from the local authority and other professionals where relevant. They explained how this tool would pull together all the different systems used to monitor and quality assure the service, reporting on the progress made and outstanding issues on a regularly basis. This would be used to make sure that people were safe and protected as far as possible from the risk of harm, with attention given to how things could be done differently and improved; including what the impact would be to people.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People were put at risk by premises which were not secure, well maintained and fit for purpose. Regulation 15 (1) (b) (c) (e)