Waverley Care Homes Limited

Autumn House Nursing Home

Inspection report

37 Stafford Road
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Staffordshire
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19 July 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 19 July 2016 and was unannounced. At our previous inspections in August 2015 and March 2016 we found that people did not or were not supported to consent to their care, treatment and support, there were insufficient staff to keep people safe and the service was not well led. We had issued the provider with three warning notices and a requirement action and asked them to improve. We had rated the service as 'Inadequate' and placed it into special measures. At this inspection we found that no improvements had been made and people were still not being supported to consent to their care. We found that there were insufficient suitably trained staff to keep people safe, care being delivered was not always safe and the systems the provider had in place to monitor the quality of the service were ineffective. The overall rating for this service is Inadequate which means it will remain in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There was no registered manager in post. Since the last inspection the manager had left the service. A new manager had been appointed and was being supported by an acting manager. 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.

Autumn House Nursing home provides accommodation, personal and nursing care for up to 67 people. There were 64 people using the service at the time of the inspection. The service was in administration.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so and the DoLS ensures that people

are not unlawfully restricted. We found that no improvements had been made since our last two inspections and people could not be assured that decisions were being made in their best interests when they were unable to make decisions for themselves.

There were insufficient suitably trained staff to keep people safe and meet people's care needs in a timely manner. Staff felt unsupported and their training was out of date. The provider could not be sure that staff were competent in their role.

Systems to manage people's medicines were not safe. Some people were not receiving their medicines as prescribed.

People did not always receive care that reflected their preferences. When people complained about this, action was not always taken to reduce the risk of the complaint occurring again.

Systems in place to monitor the quality of the service were ineffective. No improvements had been made since the last inspection.

People's nutritional needs were met, however some people experienced delays in receiving their food and drink.

People had access to a range of health care professionals when they needed it, however professional advice was not always followed and this put people at risk.

Opportunities for people to engage in hobbies and interests of their choice had reduced. Staff did not have time to spend talking to people.

Staff we spoke with all knew what constituted abuse and told us they would report it if they suspected abuse had taken place. However allegations of neglect were not always investigated.

People's privacy and dignity was respected. Staff knocked before entering people's bedrooms.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People who used the service were not always taken seriously when they made allegations of abuse.

There were insufficient suitably trained staff to meet the needs of people in a safe and timely manner.

Risk to people were not always minimised as staff did not always follow people's risk assessments.

People's medicines were not managed safely.

Is the service effective?

Inadequate

The service was not effective. People were not always supported to consent to their care treatment and support.

Staff training and supervision was out of date, the provider could not be sure that staff were competent in their roles.

People received support from health care professionals, however their advice was not always followed.

People were offered a choice of food and drink, specialist diets were catered for.

Is the service caring?

Requires Improvement

The service was not consistently caring. Staff did not have time to spend quality time with people.

People's privacy was respected.

People were encouraged to have a say in how the service was run.

Is the service responsive?

Requires Improvement

The service was not consistently responsive, People did not always receive care that reflected their needs and respected their preferences.

Complaints were not always acted upon to reduce the risk of the complaint arising again.

Is the service well-led?

Inadequate

The service was not well led. The provider had not made any improvements to the quality of the service since our last inspection.

The quality assurance systems the provider had in place were ineffective.

Autumn House 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. We had previously inspected the service and judged them as Inadequate and placed them into special measurers.

This inspection took place on 19 July 2016 and was unannounced. This inspection was undertaken by three inspectors.

We inspected to look for improvements since our last inspection. We used the providers action plan to inform the inspection.

We spoke with eight people who used the service and three relatives. We observed people's care in the communal areas. We spoke with the acting manager, the newly appointed manager, five members of care staff and two nurses.

We looked at five people's care records, staff rosters and the provider's quality monitoring systems. We spent time going through the providers action plan following the last inspection. These records helped us understand how the provider responded and acted on issues related to the care and welfare of people, and monitored the quality of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found there were insufficient staff to keep people safe and meet their needs in a timely manner. At this inspection we found that the number of care staff had been increased. The provider did not have a dependency tool to ascertain the safe amount of staff required to meet people's needs and staffing had only been increased due to the closure of their sister home and the need to redeploy the staff. However people told us and we saw records of complaints that recorded that people still did not receive care at the times they needed it.

We saw that there had been numerous complaints made to the provider about the amount of time people had to wait to use the toilet or for their breakfast. One person had complained on two occasions of having to wait for up to an hour and a half to use the toilet and this had caused them pain. On one occasion they had rang the emergency services as they had not known what to do. The acting manager told us that this person had been assessed as making false accusations but on these two occasions it had been confirmed by staff that they had had to wait for their care needs to be met. We observed that people had to wait to have their care needs met. Some people were still in bed midmorning waiting to be assisted with personal care. One person told us: "I have asked to go to the toilet some time ago, but the staff are busy, you just have to wait and be patient". A member of staff told us: "It's just so busy, we can't keep on top of everything".

This issue constitutes a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was actively recruiting new staff. We looked at the way staff were being recruited and saw that pre-employment checks were generally carried out including a disclosure and barring service check (DBS) to ensure they were fit to work with people. However we saw that one volunteer who regularly attended the service had not had a DBS check. This meant the provider could not be sure that this person was safe to work with people who used the service.

Whilst there were staff vacancies the provider was using agency staff to fill the gaps. We saw that there were proforma's for these staff, however these did not have details of when their training had been completed. We also saw that the 'eligibility to work checks' were not evidenced on the proformas. We asked the new manager what assurances they had that the agency staff were adequately trained and checked to work at the service and they told us that the only assurance they had was verbally from the agency itself.

At our previous inspection we had concerns at the way in which people's medicines were managed; at this inspection we had further concerns. We observed that two people did not have their medicine at the prescribed times. Both these people's medicines should be given before food however they were administered their medicine after their breakfast. Some medicines need to be taken "before food" or "on an empty stomach". This is because food and some drinks can affect the way these medicines work. We found some people had not had their medicine as they had been out on a social visit at the time it was being administered. This medicine was prescribed to control their diabetes and blood pressure. Missing this medicine could cause harm to these people's wellbeing. We asked a senior member of staff why they were

not given their medication on their return and they informed us that it might have been because the senior staff had gone home when they returned. No plan was in place to ensure that people had their medication following a community visit and people had missed several doses of medication on a regular basis.

We found that some medicines were unaccounted for and there was no system to control and monitor the stock of medicines. We saw several people's medicines that were waiting to be returned, however it was not clear why people had not taken their medication. The manager and acting manager spent some time during the inspection trying to ascertain why the medicines were being returned but this took time as there were no systems in place.

We had previously seen that staff did not have clear instructions in how to administer topical creams when these had been prescribed. We saw that no improvement had been made and people's individual medication administration records just stated ' as directed', however there were no directions on the prescribing labels. There was a regular use of agency nurses and staff and this meant that they would not know where and when people's topical creams should be applied.

Risks to people were not always assessed and minimised. We had previously seen that some people did not have the equipment they needed to keep them safe. At this inspection we did not observe this, however we saw one person who was at high risk of falls and had fallen the night before our inspection who was sitting in their bedroom with a sensor mat in place. The mat was in place to alert staff if the person got up to move. We saw that they had a walking frame and this was out of their reach across the room. We discussed this with the acting manager who told us that this person often walked around the mat so the alarm would not be sounded. Because the person's walking frame was out of their reach this would encourage them to move and try and reach the frame. Staff had not considered ensuring that the walking frame was in reach of the person to minimise the risk of them falling.

We saw that this person had been assessed as at high risk of choking and required thickened fluids. The thickening powder was evident in the person's bedroom; however we observed that during the time of our inspection the person's drinks had not been thickened as is required. We saw that at lunchtime this person was left alone unsupervised although in their room with both their dinner and pudding. This person's care plan stated that this person should be monitored whilst eating. Although the food had been pureed they were left alone to eat and this put them at risk if they had choked on their meal.

One person's risk assessment recorded that two members of staff should support them at all times as they had previously made false accusations. We saw records that confirmed that one staff member had supported this person on at least one occasions and following the intervention the person had made an allegation of neglect. We later found out that the allegation the person had made had been found to be true. This put the person and the staff at risk and meant that an issue of potential neglect may not have been taken seriously as two staff were not present as the person's risk assessment required.

These issues constitute a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with knew what constituted abuse and told us they would report any suspected abuse to a senior, nurse of manager. The provider had raised previous safeguarding concerns with the local authority as they occurred. However not all concerns raised by people were taken seriously and issues of alleged neglect were not always investigated.

Inadequate

Is the service effective?

Our findings

At our previous two inspections one person had been prevented from managing their own money as the staff were concerned that the person did not have the capacity to keep it safe and it may be at risk of being mislaid. The person had been unhappy about this and it caused them to become anxious. At this inspection we found that a mental capacity assessment had been completed and it stated that this person had capacity to manage their own finances, however the person had still not been supported to manage their money and they were still experiencing periods of anxiety about it.

We had previously seen Do Not Attempt Resuscitation (DNAR) forms which had been completed without the consent of the person or the representative. At this inspection we saw that there were still DNAR forms in place which had not had involvement from people or their representatives. The provider was not following the principles of The Mental Capacity Act 2005 (MCA) and ensuring people consented to their care. The 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.

These issues were a continued breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 are called the Deprivation of Liberty Safeguards (DoLS). We found that people were being lawfully restricted of their liberty because DoLS referrals had been made. However the acting manager was unable to evidence when people's authorisations had expired and needed further review as there was no system in place to monitor the DoLS authorisations to ensure they were still applicable.

Staff we spoke with told us that they did not feel supported. One staff member told us: "No I don't feel supported, we are overworked and they (management) don't listen". We saw that one member of staff's performance was supposed to be being monitored over a two week period. This had not happened which meant that the provider could not be sure they were completing their role effectively. The new manager informed us that they were not able to be confident that staff were trained and effective in their role as the systems currently in place were ineffective.

Staff we spoke with told us that their training was out of date and we saw records that confirmed this. The new manager told us of their plans to implement staff supervision and up date training, however staff told us that they had not received supervision or appraisals to enable them to carry out their duties. One staff member said: "They (the provider) are asking more and more of us, sometimes I'm at a loss as to what to do first". We saw several members of staff required up to date moving and handling training. We observed some of these staff actively participating in moving and handling tasks. This meant that people were at risk of harm as staff were not trained to complete the tasks being asked of them.

Both the managers and a member of staff told us there were more complaints from people who used the service over the weekends. They had identified that there was no clear leadership and staff were not always completing their roles. One staff member said: "I don't know what it is at the weekend, I think it must be the skill mix but things don't get done". The acting manager and manager told us this was something they were going to address.

These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered a choice of meals and specific diets were catered for. One person who used the service told us: "The staff come round with the menu and I choose what I want, If I don't like what is on the menu I can have a sandwich". Another person told us: "The staff know I like a toasted bacon sandwich in the morning and that's what I get". We saw pureed diets were presented nicely. Some people's food and fluid intake required monitoring and we saw records were completed following meal times. However an expected amount total of fluid to be drank was not recorded and we saw some records that stated that some people were appearing to drink a small amount per day.

People received support from other health care agencies when they required it, such as their GP, consultant and speech and language therapist (SALT). However we saw that advice from SALT of thickened fluids for one person was not being followed and this put the person at risk.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we had seen staff had not always respected people's right to privacy and had walked into people's rooms without knocking. At this inspection we did not see this and staff knocked before entering. A member of staff told us: "I always respect people's dignity; I will shut the doors when helping someone and make sure they are covered".

People who used the service and their relatives had mixed views on how they felt they were cared for. One person told us: "The staff are generally nice, you get the odd bolshie one". Another person told us: "The staff are lovely, they do their best, they are just so busy". Staff we spoke with told us that they did not have enough time to spend quality time with people. One person who used the service told us: "I wish staff would pop in and see me from time to time; I'm at the end of the corridor and seem to get missed". We saw one person was left alone at mealtimes and observed they poured tea onto their Weetabix and ate a spoonful of both their dinner and pudding at the same time as staff were not available to support them. This meant staff were not always available to provide people with the care and support they needed as the service being provided was task led and staff were too busy to take time to spend with people.

People were encouraged to have a say in how the service was run. There were regular resident's meetings where people were able to discuss their ideas for improvements. People moved freely around the service and we saw friendships had been formed between people. Some people spent time visiting their friends in their bedrooms and we saw minutes of residents meetings where people had asked for other people who they felt were isolating themselves to come and join them in the lounge areas.

Relatives told us they were kept informed of their relatives welfare. One relative told us: "The staff will tell me what the doctor has said and what medication has changed". A relative's meeting had been arranged to introduce the new manager.

Visitors were free to visit when they wished, and we saw lots of visitors coming and going freely. The acting manager had put a lock on the front door so that visitors now had to ring before just entering the service as previously people could just walk in. This meant that people's right to privacy was being encouraged.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we saw that people's individual preferences were not always met due to a lack of staff. People were not receiving the care they required at the times they needed it. At this inspection we found that despite staffing being increased there were further improvements to be made. People told us and we saw that people were still not having their personal care needs met and meals at the times they wanted them and there had been several complaints made about this. We saw that following one complaint the acting manager had said they would implement a check list to ensure that people who wanted it had their breakfast before 9.30am. We saw the check list but it had not been implemented by staff.

People and their relatives told us that they would complain to the manager if they needed to. We saw that the acting manager had formally responded to all the complaints they had received. However action had not always been taken to minimise the risk of the complaint arising again or plans to minimise were not always implemented.

Staff did not always respond to people's individual needs. We spent time with one person who used the service who was partially deaf. We observed on two occasions that two different staff members interacted with them and they were unable to hear them. On one occasion the person said: "I can't hear what you are saying". However the staff member did not respond and continued on with the task in hand.

People were not always offered activities and hobbies of their choice. Previously people told us they were able to access the community. At this inspection people told us that there were not as many community activities. One person told us: "I don't ask the staff to take me out any more as they are too busy".

Group activities within the service were arranged and we observed some people enjoying a game of bingo and sitting in the grounds of the garden listening to music on the day of the inspection. However, the activities coordinator had said that they did not have the time to spend one on one time with people who spent time in their bedrooms. This meant that these people were at risk of social isolation

People told us that staff respected their choices. One person told us: "I choose to stay in my room to eat", another person told us: "I don't normally go to the activities but the staff always ask".

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Inadequate

Is the service well-led?

Our findings

There was no registered manager in post. Since the last inspection the previous manager had left prior to registering with us. The service had been managed by an acting manager. At this inspection a new manager had been appointed and had been in post for a week supported by the acting manager. The new manager told us they were in the process of registering with us (CQC).

No improvements had been made since our last inspection. Although staffing levels had been increased, people were still experiencing a delay in having their care and support needs met. People's dependency needs had no been assessed to ensure that staff were effectively deployed throughout the service. The principles of the MCA were still not being consistently followed and one person was being deprived of their right to manage their own finances even though they had now been assessed as having the capacity to manage their own finances. Risks to people were not consistently assessed and minimised through regular reviews of risk assessments and care plans, and people were at risk of harm.

Systems in place to monitor the quality of the service were ineffective. The acting manager had implemented two new systems since our last inspection, one to ensure people have their breakfast at the time they wanted it and one to complete safety checks of people's equipment, such as pressure mattress checks. However these systems had not yet been implemented by the staff.

At our previous inspection we found that people were at risk of not receiving their medication due to the lack of systems the provider had in place to ensure people had their medication safely. At this inspection we found that people were still not always receiving their medication or they were not having it at the prescribed times. Medication systems in place were ineffective as there were several medicines that could not be accounted for. The medication administration sheets were not audited to check for missing signatures. Other records within the service such as food and fluid monitoring records were not audited to ensure people had the required amount to eat and drink. The lack of effective systems was putting people at risk of harm.

Staff training was out of date and they had not been supported and assessed as being competent in their roles. The service was still in administration and staff and relatives expressed concerns over the current management situation. Staff told us that their morale was low. The acting manager had made changes to their working patterns and they felt that their needs were not being considered. The acting manager told us that the changes had been required to meet people who used the service's needs and they had been consulted with staff throughout the process.

People's care records were not always audited to ensure that people received the care they required. For example, fluid monitoring charts were in place but no one checked that people were receiving the right amount of fluids at the end of a day. Some records had recorded that people were drinking small amounts of fluid on a daily basis and nothing was being done to address this. This meant that these records were ineffective.

These issues constitute a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and the management told us that there was a negative staff culture within the service especially at the weekends when there was no visible clear leadership. The new manager told us they were working on inputting a clear management structure throughout the seven day period.