Golden Manor Healthcare (Ealing) Limited

Upper Halliford Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8 January 2015, at which breaches of legal requirements were identified. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to recording and people's care and welfare.

We undertook this focused inspection to check that they had followed their plan and to confirm that they had met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Upper Halliford Nursing Home on our website at www.cqc.org.uk.

At our previous inspection we found that there were not enough staff to keep people safe and meet their needs in a timely way. People had to wait for long periods when they needed care. People's medicines were not always managed well and people were not kept safe by the provider's recruitment procedures.

People did not receive consistent care from staff who knew their needs well. Some staff did not have sufficient knowledge of people's needs to ensure that they received the care they required. Some people did not receive the support they required as their care plans were not up to date and did not reflect their needs. The service did not have adequate management or leadership. The

Summary of findings

provider's quality monitoring system was not effective as concerns identified during our inspection had not been captured through monitoring visits. Where the provider had identified shortfalls through the quality monitoring process, they had failed to take action to address these concerns.

On this inspection we found that the provider had taken action to address some of these concerns but that people were still not safe at the service. The service was not effective in meeting people's needs and was not well-led.

People's safety was compromised because staff were not aware of fire procedures or of the individual support people required in the event of a fire. A member of care staff told us that they had not received fire safety training since they started working at the service in July 2014. None of the nursing staff on duty had received fire training at the service.

One person had required a hospital admission due to poor care. A GP had prescribed medicine which had not been administered as prescribed. The condition became infected as a result and the person had to be admitted to hospital for antibiotic treatment. Some of the staff who cared for the person were not aware that a medicine had been prescribed for them. One person had been put at risk of choking as they were left without supervision or support to eat their meal from their bed.

All of the nursing staff and many of the care staff employed at the service were supplied by an agency. As a result, people did not receive their care from regular staff who knew their needs well. Some staff did not know people's needs well enough to provide the care and treatment they needed. Staff provided uncertain and conflicting responses when we asked about the care and support people needed. For example staff were not clear about how often people should be repositioned in bed.

Staff did not share information about people's care and welfare effectively. Handovers between shifts did not always take place and, where they did, they were not effective in sharing important information about people's care. People's care plans did not reflect their needs. In some cases, care plans had not been developed to address risks that had been identified.

The registered provider had not monitored the service adequately to protect people from the risks of unsafe care. Where problems had been identified through internal quality monitoring, action had not been taken to address these concerns.

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?

We found that insufficient action had been taken to improve the safety of people living at the service.

People's safety was compromised because staff were not aware of fire procedures or of the individual support people required in the event of a fire.

People's individual support needs in the event of an emergency had not been assessed.

Inadequate

Is the service effective?

We found that insufficient action had been taken to improve the effectiveness of the service.

Some staff did not know people's needs well enough to provide the care and treatment they needed.

People's care plans did not reflect their needs. In some cases, care plans had not been developed to address risks that had been identified.

Staff did not share information about people's care and welfare effectively. Handovers between shifts sometimes did not take place and, where they did, they were not effective in sharing important information about people's care.

Inadequate

Is the service well-led?

We found that insufficient action had been taken to improve the leadership of the service.

Internal quality monitoring systems were not effective in identifying and managing risks to people's care and welfare.

Where the quality monitoring system had identified problems, action had not been taken to address these issues.

Inadequate

Upper Halliford Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Upper Halliford Nursing Home on 13 March 2015. This inspection was carried out to check that action had been taken to meet legal requirements. The team inspected the service against three of the five questions we ask about services: is the service safe, effective and well-led. This is because the service was not meeting some legal requirements.

The inspection was carried out by two inspectors. During our inspection we spoke with the Regional Manager, two peripatetic managers, three registered nurses and four care workers. We also spoke with four people who used the service and a visiting relative. We checked care documentation and risk assessments for eight people.

Inadequate

Is the service safe?

Our findings

At our inspection on 8 January 2015, we identified that the service was not safe. There were not enough staff to keep people safe and meet their needs in a timely way. Nurse call bells were not responded to in good time and people routinely had to wait for long periods when they needed care or support. People were not kept safe by the provider's recruitment procedures. The provider had not considered the risk to people of employing applicants previously convicted of criminal offences. Medicines protocols were not always followed and people's medicines were not always managed appropriately. Staff did not have adequate knowledge of the equipment available for dealing with medical emergencies or sufficient training to use the equipment effectively.

On this inspection we found that the provider had taken action to address some of these concerns. For example recruitment procedures had improved and the provider had investigated how the failure to adhere to the recruitment policy had occurred. However we found that people were still not kept safe at the service.

People's safety was compromised because staff were not aware of fire procedures or of the individual support people required in the event of a fire. To ensure that appropriate plans were in place in the event of an emergency, each person using the service should have a personal emergency evacuation plan (PEEP). Two of the staff we spoke with told us that they did not know what plans were in place to deal with emergencies and none of the staff we spoke with knew how to access people's emergency evacuation plans. Staff told us that they were not confident that they knew how to use the home's firefighting equipment correctly. One of the care workers we spoke with told us that they had not received fire safety training since they started working at the service in July 2014. None of the nursing staff on duty had received fire training at the service. None of the care plans we checked contained a PEEP, which meant that there were no recorded plans for staff to use in the event of an emergency.

One person had required a hospital admission due to poor care. The person had developed a rash which the GP advised had been caused by the affected area not being properly cared for. The GP had prescribed medicines to treat the rash but this had not been administered as prescribed. The rash became infected as a result and the person had to be admitted to hospital for treatment. We spoke with the person's relative, who told us that some of the staff who cared for their family member had not been aware that a medicine had been prescribed for them. One of the care workers that provided care for this person told us that they were unaware that a medicine had been prescribed for them. The nurse on duty showed us two tubes of cream that had been prescribed for this person. We saw that only a small amount had been used from one tube and the other remained un-opened. The regional manager told us that she found these two tubes of cream in the person's bathroom instead of the medicines trolley the previous day and had questioned staff about why it had not been used.

We observed that one person had been left at risk of choking. As we passed the person's bedroom, we noticed that staff had left their meal on a table next to their bed. Staff had left the person lying flat in bed without supervision. The person had attempted to eat their meal from a supine position, which they told us had almost caused them to choke. We called a staff member, who raised the person to an upright position and assisted them to eat their meal. The staff member said that staff were told to raise the person to a seated position when supporting them to eat. The staff member said of the position in which the person had been left, "They should not have left her like that." We advised the senior member of staff on duty of our concerns and the senior member of staff referred the incident to the local authority as a safeguarding alert.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our inspection on 8 January 2015, we identified that the service was not effective. The service had a high turnover of permanent staff and high usage of agency staff which meant that people did not receive consistent care from staff who knew their needs well. Staff had not been adequately supported through training, supervision and appraisal. The provider had not always obtained people's consent to the care and treatment they received or consulted relevant others to ensure that decisions were made in people's best interests. Staff were not sufficiently aware of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The premises had not been adapted to meet the needs of people living with dementia. There was no personal identification on bedroom doors. There was no evidence of colour coding, signage or visual aids to assist orientation.

At this inspection we found that insufficient action had been taken to address these concerns and the service was still not effective in meeting people's needs. At the time of our inspection, the service employed no permanent nursing staff, which meant that the nursing staff on all shifts were supplied by an agency. Many of the care staff employed by the service were also employed by an agency. Whilst the agency staff were appropriately qualified, they had not cared for people long enough to have a good understanding of their needs and preferences. The nursing staff we spoke with acknowledged that people's care was affected by the vacancies on the permanent staff team and the lack of consistent support. One registered nurse told us, "Every day they [people who use the service] see different people who provide their care. It's not ideal for them."

Some of the staff we spoke with did not have an adequate knowledge of people's care needs. One person's care plan stated that they were unable to move themselves in bed and so staff should carry out hourly checks, repositioning the person if necessary and recording the care they had provided. We asked two care workers who provided support for this person how often they needed to be checked and whether they needed to be repositioned in bed. One care worker said, "We check sometimes three hourly, sometimes four hourly. I think it's three hourly. I think maybe it's stopped now [regular monitoring]." The other care worker told us, "I'm not sure. I think it's every three hours." The care worker told us that the guidance for repositioning the person would be kept in a folder in their room. When we checked the person's room, there was no evidence of guidance for staff about the person's repositioning regime.

The nursing staff we spoke with told us that people's care plans did not reflect their needs.

One registered nurse told us, "They all need to be updated. People's needs have changed and the care plans have not been reviewed." Six of the eight care plans we checked had not been reviewed in the last six months and three had not been reviewed in the last 12 months. We found evidence that people's care plans did not reflect their needs. For example one person's risk assessment stated that they were at "very high risk" of developing pressure ulcers. The care plan stated that when an assessment had identified a high risk of pressure ulcers, there should be "a corresponding care plan." There was no care plan to address the risk of pressure ulcers in the person's care file.

The Regional Manager confirmed that, at the time of her arrival in post, people's care plans had not been reviewed frequently enough to ensure that they accurately reflected people's needs. The Regional Manager advised that 11 care plans had been had been reviewed and rewritten since they took up their job a week prior to the inspection. This meant that 36 of the 47 people living at the home had care plans which were out of date and may not have reflected their needs and preferences.

We found that staff did not share important information about people's needs, treatment and welfare. Nursing staff told us that handovers took place between shifts so that staff beginning work were aware of any changes to people's needs or the care and treatment they required. However we found that handovers sometimes did not take place and, where they did, they were not effective in sharing important information about people's needs. For example one of the care staff who began work at 2pm told us that they had not received a handover when they started their shift. The staff member told us that they did not read people's care plans but relied on verbal information given to them at handovers. Another staff member told us that they had not been made aware at handovers that one of the people they cared for had been prescribed a medicine for administration daily. We asked the staff member if they

Inadequate

Is the service effective?

would not have also found the information in the person's care plan. The staff member told us that they relied on handovers for updates on people's care as they did not have time to read their care plans.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our inspection on 8 January 2015, we identified that the service was not well-led. A culture had developed within which some staff felt bullied by others and refused to take instruction from their managers. Staff did not feel supported by effective leadership and were not confident that any concerns they raised would be dealt with effectively by management. The provider's quality monitoring system was not effective as concerns identified during our inspection had not been captured through monitoring visits. In addition, where the provider had identified shortfalls through the quality monitoring process, they had failed to take action to address these concerns. The quality of recording was inadequate. Care documentation was not up to date and did not always reflect people's needs. Staff completed records retrospectively, which meant they could not be sure that the information they recorded was accurate.

At this inspection we found that the provider had taken action to address some of these concerns. For example staff alleged to have bullied others and refused to take instruction from their managers had been suspended pending investigation. However we found that insufficient action had been taken to address other concerns and the service was still not well-led. The provider had failed to assess, monitor and mitigate the risks relating to people's health, safety and welfare and to maintain accurate, complete and contemporaneous records in respect of each person.

The provider's monitoring systems were ineffective in identifying risks to people and areas in which their safety was compromised. There was no evidence that the provider had identified the risk to people's safety posed by staff being unaware of fire procedures or of the individual support people required in the event of a fire. The provider had also failed to identify that people were at risk because staff on duty had not attended fire training at the service.

The risk of choking posed by staff leaving one person lying flat while trying to eat their meal had not been identified or mitigated by the provider. The provider had failed to identify that staff did not have an adequate knowledge of people's care needs, for example how often they needed to be repositioned in bed. The provider's monitoring systems had not identified that staff did not share information about people's care and treatment effectively or that handovers between shifts had not been taking place. As a result of staff not sharing information about one person's change in needs, the person required admission to hospital for treatment.

The quality of recording remained inadequate. Some people's care plans contained contradictory information, which meant they were at risk of receiving unsafe care. For example the nursing assessment carried out for one person recorded that they had a history of falls. However the moving and handling assessment carried out for this person recorded that they had no history of falls. The person's care plan stated that they should be weighed each month to identify any significant change in weight. There were no weights recorded for the person on their care plan.

A Waterlow risk assessment identified one person to be at high risk of developing pressure ulcers. The Waterlow risk assessment stated that, as a result of this risk, a separate care plan should be developed for the person to mitigate the risk of developing pressure ulcers. There was no evidence in this person's care documentation that a care plan had been developed to mitigate this risk, which meant that the person was at risk of developing pressure ulcers.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had failed to ensure that care and treatment was provided in a safe way for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had failed to assess, monitor and mitigate the risks relating to people's health, safety and welfare and to maintain accurate, complete and contemporaneous records in respect of each person.