Cedar Care Homes Limited

Saville Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Saville Manor is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Saville Manor provides accommodation with nursing and personal care for up to 42 people. The home operates on four floors. At the time of our inspection 36 people were living in the home.

At the last comprehensive inspection in May 2017, the service was rated Good.

We received concerns about the care and treatment of a person who lived in the home and sustained a serious and unexplained injury in October 2018. At the time of our inspection, the police were investigating this incident.

Following the above incident, we carried out a focused inspection. We inspected the key questions: is the service safe? and is the service well-led? This report covers our findings in relation to those two key questions. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Saville Manor on our website at www.cqc.org.uk.

There was no registered manager in post. A manager had recently started in post. They had not yet submitted their application to register with the Care Quality Commission. 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.

At this inspection we found the service was not consistently safe. Topical medicines were not always safely managed. Fluid thickening powders were not always stored or used in accordance with current NHS patient safety guidance. Pressure relieving equipment was not always used to provide optimum support and protection. Monitoring records were not always accurately completed to show that people had received sufficient fluids. Equipment such as hot surface temperature radiators were not used safely.

Staff had a good understanding of how to make sure people were supported and protected from the risks of abuse and avoidable harm. They had received safeguarding adults training and knew how to report concerns.

Staff had received moving and handling training and were clear about how to safely support people with walking aids and moving and handling equipment such as hoists.

There was no registered manager in post. A new home manager was in post and was planning to submit an application for registered manager with CQC.

Quality assurance systems did not always identify shortfalls and actions were not always taken when shortfalls had been identified.

At this inspection we found breaches in two 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 rating of the service has deteriorated to Requires Improvement in the safe and well-led domain. The overall rating for the service is now Requires Improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service has deteriorated to requires improvement.

Topical medicines were not always safely managed. Fluid thickening powders were not always safely stored or used.

People were not always provided with the support needed when they had insufficient amounts to drink.

People did not always receive the pressure relieving support in accordance with their assessed need.

Staff understood their responsibilities for safeguarding people from harm and abuse.

Sufficient actions were not always taken when health and safety shortfalls in the environment were identified.

People were safely supported with moving and handling. Hoists and moving and handling equipment was safely used and maintained.

Accidents and incidents were reported and recorded.

Is the service well-led?

Requires Improvement

The service has deteriorated to requires improvement.

Quality assurance systems did not always identify shortfalls and actions were not always taken to mitigate risks and make improvements.

Accurate records were not always maintained.

A registered manager was not in post. However, people could provide feedback and express their views.

The management team recognised their responsibilities about notifications required by the Commission.

Saville Manor 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. We inspected the service against the two of the five key questions we ask about services: Is the service Safe? and, Is the service Well-led? No further risks or concerns were identified in the remaining key questions through our on-going monitoring or during our inspection so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating for this service.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by one inspector and an assistant inspector on 13 December 2018.

Before the inspection visit we looked at the information we had received about the home. We looked at the notifications we had received. Notifications are information about important events that the provider is required to tell us about by law.

At the time of our inspection, there was an on-going police investigation following concerns raised about the care and treatment of a person who had lived in the home and sustained an unexplained serious injury.

During our visit we spoke with nine people who lived in the home and one visitor. We spent time with people in their bedrooms and in communal areas. We observed how people were being cared for and supported.

We spoke with the provider's head of operations, compliance manager, home manager and 10 staff that included registered nurses, laundry and care staff.

We checked how equipment, such as pressure relieving equipment and hoists, were being used in the home.

We looked at three people's nursing and care records in detail and checked other care records for specific

information, such as monitoring charts for change of position and fluid recording. We looked at medicine records, staff recruitment files, staff training records, equipment maintenance records, quality assurance audits and action plans, records of meetings with staff and people who used the service, survey results and other records relating to the monitoring and management of the care home. Some of the records noted above were sent to us after the inspection.

Requires Improvement

Is the service safe?

Our findings

The service was not consistently safe. This was because, as detailed below, recording of care interventions were not always accurate or timely, fluid thickening powders and topical medicines were not always safely managed. Pressure relieving mattresses were not always safely used, and hot surface temperature radiators were not sufficiently risk assessed.

Where people had been assessed and needed to have their fluid intake recorded, the records were not always completed in a timely manner. There was an inconsistent approach to where the daily monitoring records should be kept and there was a lack of evidence of actions taken when people had not had sufficient amounts to drink.

Two members of staff told us they kept notebooks in their pockets to 'jot down' notes they later transcribed onto the monitoring records at the end of their shift. This was because the records for people living on each of the four floors were all kept in the one office on the ground floor. Other staff told us that monitoring records should be kept 'with the person' when they were in their rooms or in communal areas. We checked at midday and the records for one person who was having their intake monitored had not been completed since 6am. In addition, where people's fluid intake had been insufficient on previous days, and people had not drunk the amounts of fluids they were noted to need over a 24 hour period, the records did not show actions had been taken in response. This meant people may not have received the amounts of fluid they needed in addition to the amounts that were recorded may not have been accurate.

People who were prescribed fluid thickeners were not always protected from the risks of choking because fluid thickeners were not always used or stored safely, or in accordance with current national patient safety guidelines. We found thickeners were stored in reach of people, on bedside tables. The national guidance recognises that thickeners need to be accessible, but also, they need to be stored safely. One container was stored in the room of a person for whom it was not prescribed. The consistency of thickening people needed was recorded, as a reminder for staff, on the tea trollies, in addition to being recorded in the nursing care files. Most staff demonstrated a good understanding of how they should be used and stored, but others did not. For example, one member of staff told us they used, "One scoop for [name of person] but if they cough we add a bit more."

Some people were prescribed topical creams for application to their skin. These were kept in people's rooms. Although staff could tell us how creams and ointments should be safely stored and used, this was not happening in practice. We found creams that were not labelled with people's names, not dated when opened, and for two people had creams in their rooms that were labelled for other people. Topical medication administration records sheets (MARs) were stored in files in the nursing office on the ground floor. The creams recorded on the topical MARs did not always match the actual creams in people's rooms. This meant people's skin was not always being protected from deterioration or breakdown because they did may always receive the skin protection they had been prescribed.

Portable radiators were being used to provide additional heating for two bedrooms where the fixed

radiators did not provide sufficient heat for the rooms. We touched one of these radiators and it was extremely hot to touch. After the inspection, the provider sent us risk assessments for the use of hot surface temperature radiators. However, there were no risk assessments in place for the people and rooms in which they were being used. This meant people were not sufficiently protected from the risks of burns.

People at high risk of skin damage or pressure ulcers were assessed and provided with pressure relieving mattresses. Some of the mattresses were operated with pumps that needed setting according the weight of the person, to provide the required pressure relief. The records did not always state the settings required although staff had signed the monitoring charts each day that stated, 'make sure the weight settings are correct.' For example, one person's most recent weight was 61.6kgs and the mattress was set for a person with a weight of 45 kgs. Another person's weight was 59kgs and the mattress was set at 70kgs. This meant people were not always provided with the pressure relief they needed.

The above all amounted to breaches of Regulation 12 Heath and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan after our inspection, telling us how they were addressing the shortfalls we identified on the day of our inspection.

The provider also sent us an explanation of how the ramps on two floors of the home, were being used. On the day of our inspection, we were not provided with a satisfactory explanation of how the ramps were being used. A detailed risk assessment completed in August 2018 stated they could not be used safely to move people who used the service. The provider confirmed, after our inspection, the ramps were not used to move people from one level to another. They told us comprehensive risk management plans were in place for the movement of equipment such as portable trollies. They told us they had provided additional signage for staff to ensure they followed safe working practices.

Everyone we spoke with told us they felt safe in the home. Comments included "Yes, they make me feel safe and there's always someone about," "They are very good here, although sometimes we have difficulty understanding each other but we manage," "The staff make me happy here. They're so kind," and, "I love living here. I feel really safe." People also told us they felt safe when they were being supported to move with a hoist with one person commenting, "It's very comfortable, they hoist me up if I need the loo or to go into the armchair."

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They could give examples of signs and types of abuse and what they would do to protect people, including how to report any concerns. All staff we spoke with were confident they could report their concerns openly and the management team would take appropriate action. One member of staff added, "If the nurses and managers hadn't acted on it I would report it to CQC."

Risk assessments and risk management plans were in place. The care plans provided guidance for people who needed equipment, such as walking aids and hoists. The sizes of slings people needed was recorded and people were allocated their own slings which were mostly kept in their bedrooms. Staff told us they had received moving and handling training and this was confirmed in the training records. They said they referred to care plans if they needed a reminder about how people were to be moved. They also said there was always someone to ask if they were unsure or needed support or guidance.

Accidents and incidents were recorded and actions taken to reduce future risks of injury. A section of the accident report noted the conclusions of accident investigations and update entries were made 24hrs, 48hrs

and 72hrs after the accident/incident. Staff were clear about what they needed to do, and actions they needed to take, if a person had an accident, fall or sustained an unexplained injury.

People told us there were sufficient staff to meet their needs. One person commented, "The staff are very friendly and when you ring the bell they come quickly." Staff told us they had sufficient staff to provide the personal care people needed. During the day of our inspection, staff were not rushed and people told us they had received the support and care they needed.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well-led. A range of audits and monitoring checks were completed by the management team. However, we found the quality assurance systems did not always identify the shortfalls we found and where shortfalls were identified actions were not always taken to mitigate risks or to make improvements. In addition, accurate records were not always maintained, as we have reported on in the safe section of this report.

Medicines checks were completed on a regular basis. Checks of topical medicines in November 2018 did not show shortfalls. The audit did note that, 'All RN's and Care Coordinators need re-training.' The checks in December identified some, but not all the shortfalls we found. At the time of our inspection, actions had not been taken to address the shortfalls the provider had identified.

The provider's monthly care audit did not identify the shortfalls with the safe and correct use of pressure relieving mattresses, safe use and storage of thickening powders and insufficient recording of fluid intake. Accurate records were not always maintained.

This lack of effective quality assurance systems that identified and mitigated risks and made improvements was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post. We were told by the head of operations that the previous registered manager had left in June 2018. We met with the new home manager who started in post two weeks before our inspection. They told us they were planning to apply to CQC to be the registered manager.

Although most people who used the service were not sure who the new home manager was, as they were new in post, they all told us they felt comfortable with the management of the home. They told us they could speak about concerns and felt they could express their views. As one person said, "I know if I needed anything I would be accommodated."

People were asked for their views and feedback was collated at annual resident surveys. The results had been collated for 2018, and an action plan was being agreed. We read the 'results analysis report' and noted there were no specific areas where urgent actions were required. Most of the feedback was positive across the eight areas, that were: leisure and social activities, mealtimes, personal care, healthcare, home environment, laundry services, staffing and management.

Staff spoke positively about the new home manager, that they were approachable and that staff were feeling more supported and listened to. A member of staff said, "Staff morale is good right now. If you had asked me two months ago the answer would have been different." Another member of staff told us, "At the moment it's fine as we have a new manager. If I have concerns I can go to [name of home manager], but I didn't feel like that before."

The management team were aware of their obligations in relation to the notifications they needed to send

to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always provided with safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems did not always identify shortfalls and actions were not always taken to mitigate risks and to make improvements to the care people received. Accurate records were not always maintained.