Rosecare Homes Limited

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

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced which meant the manager and staff did not know we were coming. We last inspected this service in September 2013 and found some breaches of legal requirements. These were in respect of meeting people's needs, management of medicines, the safety and suitability of the premises and the support provided to workers. During this inspection we saw that some improvements had been made but further action was still required. You can see what actions we have told the provider to take on the back of the full version of the report.

Andrin House is a care home with nursing for up to 37 people and specialises in care for older people. It is located in a residential area of Derby, close to the city centre.

Summary of findings

The service had been without a registered manager but had recently appointed a new manager who had been in post for six weeks when we visited. The manager was going through our registration process to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Some people who used the service were unable to make decisions about their care, support and safety. The Mental Capacity Act (MCA) 2005 was introduced to protect people who lack the capacity to make decisions for themselves due to their illness or disability. Staff we spoke with were aware of the Act and their responsibilities however there was no clear process in place to ensure people were supported to make safe choices.

The provider had not recognised they were restricting a person's liberty and had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) until they were prompted to do so by a health care professional.

Some people presented with behaviour that challenged others but there were no management plans in place to ensure people were supported by staff in a positive and consistent manner.

The provider did not have appropriate recruitment systems in place to check staff were suitable to work with vulnerable people.

Assessment of people's risk was being undertaken however reviews did not reflect changes in people's circumstances.

People told us the staff were kind to them. We observed mostly positive interactions with staff however there was limited one-to-one interaction between people and staff at mealtimes. The care records provided limited information for staff to provide care which met people's preferences. Staff had not recognised the cultural needs of one person who used the service.

People were referred to healthcare professionals to support their health and wellbeing however we saw that some recommendations were not implemented.

There were no arrangements in place to monitor and improve the quality of the service.

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?

Requires Improvement

The service was not consistently safe.

There were no plans in place to manage people's behaviour that challenged others to keep them and others safe.

Staff were not protecting people's human rights as set out in the Mental Capacity Act 2005.

The recruitment process was not suitable to ensure staff were safe to work.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had not been involved in the planning of their care.

People's risk of harm had been assessed but changes identified during reviews were not used to update the way care should be provided. This meant people who used the service would not receive care that meant their current needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw some positive interactions between people and staff. Some staff had limited one-to-one engagement with people which did not promote a socially inclusive atmosphere.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The information recorded about people's likes, dislikes and preferences was sparse and did not reflect the care they received.

We saw people were referred to health care professionals but staff had not implemented some of the recommendations they received.

People living with dementia were not provided with an environment which supported their needs.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not returned the Provider Information Return (PIR) as required, to enable us to decide which areas we should focus on during our inspection.

The management had not responded to or investigated allegations of possible abuse made during a residents meeting in May 2014.

Summary of findings

There were no arrangements in place to monitor the quality of the service.

There was no analysis of adverse incidents to identify patterns or trends.

Andrin House Nursing Home

Detailed findings

Background to this inspection

This inspection was undertaken by one inspector and an expert-by-experience on 19 August 2014. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service, including the reporting of safeguarding and notifications. A notification is information about important events which the service is required to send us by law.

As part of our inspection process, we asked the provider to complete a PIR. This is information we have asked the provider to send us on how they are meeting the requirements of the five key questions and their plans for improving their service in the future however this was not completed and returned to us.

During the inspection we observed the care being provided and performed our Short Observational Framework inspection (SOFI) during the lunchtime period. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spent time speaking with people and observing the support they received.

There were 25 people living in the home on the day of our inspection. We spoke with seven people who used the service, three relatives, four members of staff and one healthcare professional during the inspection. We contacted one healthcare professional after our inspection and received information from another.

We looked at five care records to see if they reflected people's preferences and needs and four staff records to assess the recruitment processes. We also looked at information relating to the management of the service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint and practice under the Mental capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared we have rated since then, including in relation to consent, restraint and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of the report.

Requires Improvement

Is the service safe?

Our findings

Some people were living with dementia and presented with behaviours that challenged others. During the inspection staff told us and we observed, a person whose behaviour challenged the safety of themselves and others. We saw staff reacted differently towards this person. One member of staff told us, "I usually say, let's have a cup of tea". Another member of staff said, "If we've got enough staff in, I'll take [the person] for a walk outside". There had been no evaluation of what might trigger this person's behaviour or guidance for staff on how to manage them. This meant the person was not being supported in a consistent manner.

Some people who used the service were unable to make decisions for themselves about their care, support and safety. The Mental Capacity Act (MCA) 2005 sets out requirements to ensure appropriate decisions are made in people's best interests. Some of the staff we spoke with displayed some knowledge about the MCA and their responsibilities in respecting and promoting people's human rights. There was not a process in place for assessing people's capacity when concerns about their understanding had been highlighted. Care record entries we looked at contained inconsistent information about people's level of capacity. We saw that one person had been given a choice about whether or not to fit a protective bedrail to their bed and it was recorded in their daily records ' [the person who used the service] only wants one bedrail in place today'. We saw that staff had recorded that the person did and did not have the capacity to make decisions without support. A formal assessment had been undertaken by a healthcare professional which had concluded the person did not have the capacity to make decisions for themselves. It was not clear from the care plan whether this person had been supported in the decision which could affect their safety or if staff felt a best interest decision was appropriate. This meant people's safety was compromised inconsistent judgements.

At the time of our inspection one person was subject to a Deprivation of Liberty (DoLS) restriction. This person had been attempting to leave the home on a regular basis and was being returned by staff, against their will. The manager had referred this person to a specialist health care professional for a mental health assessment. We spoke with the healthcare professional after our inspection who told us that the manager and staff had not recognised they were acting illegally under the DoLS legislation. The health care professional told us they had made an urgent referral and a DoLS assessment had been undertaken as a matter of urgency. The assessment supported the need to which had been implemented before our inspection.After our inspection, we received information of concern from an adult social professional who raised concerns about the manager's understanding were contacted by an adult social care professional who raised concerns about the provider's knowledge of the DoLS referral process. This meant the manager did not understand their responsibility in protecting people's human rights.

These are breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with told us they felt safe living in the home. A person who used the service said, "I am very well and safe here". A relative told us, "They are safe and well cared for".

We looked at recruitment records for four members of staff including one who had recently been employed by the service and found the recruitment process was not safe. The file for the most recently recruited member of staff contained no evidence of interview notes, references, identity checks, explanation of gaps in their work history or that a satisfactory disclosure and barring check had been received. We spoke to the manager who told us the information had been obtained and was with the provider who would be at the service later that day. The provider did not have the file and the manager was unable to offer further evidence to us on this person's recruitment process during our inspection. In three other files we saw references had been requested from friends, work colleagues or written to 'Whom it may concern' and undated. This meant that there was not a suitable recruitment process in place.

When we last inspected this service on 17 September 2013 we found that the provider had not taken all reasonable steps to manage the risks associated with unsafe use and management of medicines. During this inspection we observed medicines being administered and saw this was completed in a safe manner. Medicine was offered to people on a one by one basis, people were observed to ensure they had taken their medicine and the medicine administration record (MAR) was updated accurately. We

Requires Improvement

Is the service safe?

did a check of one regular medicine and found the amount recorded corresponded with the stock available which meant the provider had a suitable stock control process in place.

At our last inspection we also found the provider was not protecting people from the risks of unsafe or unsuitable premises. During this inspection we checked to see if improvements had been made and found the issues we had highlighted regarding the maintenance and repair of the home had been or were being addressed. Repairs to cracked and damaged tiles in the bathrooms had been undertaken and there was an on-going re-decoration programme in place. Regular inspections on the fabric of the home, including paintwork, floors, windows and fittings had been introduced. Staff we spoke with told us, “Things have improved. We’ve got some new equipment, which is great”.

The fire officer had recommended a fire evacuation exercise should be performed and we saw this had been undertaken with staff, in a timely manner. However there were no personal emergency evacuation plans in place to ensure staff and the emergency services were fully aware of the support people would need to leave the building safely, should an emergency, for example a fire, occur. This meant people might be at risk in an emergency.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they were happy with the care they received. One person told us, "I'm happy with the care here. They're very good". A relative told us, "My [the person who used the service] is happy and feels supported".

People's care records provided information about their individual care needs and the level of support they required but did not demonstrate that people had been actively involved in planning care. During the inspection we observed the manager turn the radio on in the lounge area without asking the people sitting there if they were happy for her to do so. This meant people were not supported to maintain some control over their lives.

There were personalised risk assessments in place which were subject to review. However we saw that incidents or changes which had occurred did not trigger a review of the way people's risks were managed. For example we saw that a person had sustained a fall but their level of risk had not been reviewed to ensure the arrangements in place were still appropriate for them. This meant the assessments did not reflect people's current risks.

People who used the service were provided with a choice of food and adequate fluids to maintain their health. Some people had specific dietary needs including the use of supplements to provide additional nutrients and food provided in either a pureed or fork mashed format to assist people who had problems with swallowing and we observed their food was provided appropriately. Everyone we spoke with told us they enjoyed the food. A relative said, "I have meals here and the food is good. My [the person who used the service], likes the food". This meant people had access to sufficient food and drink to maintain their well-being.

Some people needed assistance from staff to eat their meals. We observed staff had to leave the people they were supporting several times, to help others as there were not enough staff to offer help to everyone who needed support. We observed one person trying to make eye contact with the member of staff supporting them but the member of staff was conversing with a colleague, discussing how busy they were and did not engage with the person they were sitting with. This meant some people were not supported to enjoy a sociable mealtime experience.

There was an on-going training plan in place which was specific to staff roles and their level of responsibility, for example only trained staff received training in medication. Staff told us they were able to access suitable training to provide them with the skills required to care for the people living in the home. We saw there had been a recent update on manual handling. This was delivered by a member of staff. The member of staff told us, "I have a special interest in manual handling and have taken on the role of trainer for the home". We saw the member of staff had, themselves, received additional training to provide the training to staff. Another member of staff told us, "The training she [the staff trainer] provides is good". We observed people being moved from chair to wheelchair and saw this was conducted in a safe manner.

Several of the people who used the service were living with dementia and the provider had recognised staff would need training to enable them to support people appropriately. The training was available as distance learning which meant staff completed the training independently at either work or home. A member of staff told us, "There are still quite a lot of staff who need to do this because it's difficult to find the time". Another member of staff told us, "I'm struggling to complete this training because there's never time at work and I'm too tired when I get home". This meant the way training was provided was not meeting staff needs.

New members of staff followed an induction process. Staff we spoke with said in addition to providing initial training they would be supported by senior staff and not allowed to work alone until they were competent to do so. A member of staff told us, "When I started here I had support from a senior member of staff for several shifts before I was allowed to work alone". This meant the provider had arrangements in place to support new staff.

During our last inspection we found the provider was not offering staff supervision on a regular basis. At this inspection, staff we spoke with told us their access to supervision had improved and they were offered regular opportunities to discuss their personal development. One member of staff told us, "The frequency of supervision has improved. We feel more supported". The staff records we looked at confirmed that consistent arrangements for staff supervision had been restored.

Requires Improvement

Is the service caring?

Our findings

A person who used the service told us, “The staff are nice and they’re all kind “. Another person said, “The care is good”. A relative told us, “I am very happy with the care”.

As some people could not tell us about their experience of living in Andrin House we observed the care being provided in the communal living room. We saw mostly positive interactions between staff and the people who used the service with staff speaking kindly and respectfully to people. One member of staff spent the morning of our inspection in the lounge area where several people were sitting. We observed the member of staff spent long periods without engaging with people or encouraging people to interact with each other. This meant that people were not supported in a socially inclusive manner.

Some people were brought to the table by the activity coordinator, at the end of their morning card game session, to wait for their lunch. This was up to an hour before the meal was served and we saw people fidgeting and showing signs of discomfort whilst sitting in their wheelchairs or on hard chairs as they waited for their meal. One person said, “I hope it’s worth it after all this time”. When asked if they would have preferred to sit in a comfortable chair whilst waiting, they said, “Yes but I wasn’t asked”, which meant people’s comfort had not been considered.

We saw people received the support they needed to maintain their personal hygiene and appearance. Whenever personal care was delivered staff ensured the person’s dignity and privacy was maintained by closing doors to bathrooms and toilets. Requests for attention and staff response to call bells were met in a timely manner. This meant people’s dignity was maintained.

We saw members of staff gaining consent from people before providing care. We saw one person being shown a choice of shirts to wear to a party they were going to later in the day. People we spoke with told us, “They [the staff] always tell me what’s going on”. At lunchtime some meals were served by the kitchen staff and we observed that these staff did not engage with or gain consent from people before putting their protective aprons on and meals were put in front of people without comment. This meant some staff did not promote people’s choice and dignity.

Requires Improvement

Is the service responsive?

Our findings

We asked a person who used the service if staff asked them what time they'd liked to get up as there was no preference recorded in their care plan. The person told us, "They've never asked me. I get up when the staff wake me to get dressed". This meant that people's preferences were not recognised and recorded.

Some of the care records we viewed contained information about people's likes, dislikes and preferences but the information provided was limited. We observed one person walking from the bathroom to the lounge without footwear. The manager and a member of staff told us this person did not like wearing shoes however this was not recorded in their care record, nor had any risks associated with unprotected feet been assessed.

There was no information provided in a person's care record to show that their cultural needs and preferences had been assessed or considered. Staff told us this person, who was living with dementia, was able to speak and understand English but was increasingly reverting to their first language of Punjabi. Staff had not recognised this is common for people living with dementia. The manager told us she was able to converse in Punjabi and she had known this person for a long time. The manager said that, to her knowledge, they had never regularly attended a place of worship. The expert by experience on this inspection was able to converse with this person in their chosen language. The person indicated, through gestures, that they would like the opportunity to attend services occasionally. The manager told us the person did not have any specific dietary needs. Staff we spoke with told us, "[The person who used the service] puts hot chilli sauce over all their food. I think they like spicy food". There was nothing recorded in the person's care plan to indicate they'd been asked about their food preferences. This meant staff had not explored the best way to provide the person with support that met their cultural needs.

This demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

One member of staff was employed solely to support people to participate in their hobbies and interests. In the morning we saw six of the people who used the service playing cards with this member of staff. Later, people sitting in the communal lounge were encouraged to participate in a game with a bean bag. A person who used the service told us, "There are things to do if you want, like listening to music". Staff told us the activity room was locked when the activity coordinator finished work. A member of staff told us, "Some people like to be busy all the time but we can't get anything out of the room for them to do". A person who used the service told us, "Sometimes there's not much to do". This meant people were not being supported to spend their time as they wished.

Some of the people living in the home had a diagnosis of dementia. We saw there was some signage so people could identify what was behind closed doors, for example toilets and bathrooms. There was some pictorial information providing people with information about the day of the week, season and weather displayed in the room used for activity but this was only accessed by some people. There was limited pictorial information provided for the other people who used the service. This meant some people were not provided with information in a format that was suitable for their level of understanding.

We did not see people encouraged to be involved in housekeeping tasks, such as table setting. We saw in a care plan that a healthcare professional had recommended, following a persons assessment, that staff tried to engage one person in tasks as a way of managing their behaviour which challenged. The health care professional suggested that if staff were writing or sorting linen, the person should be asked if they'd like to help. We spoke with the healthcare professional after our inspection who told us, "The staff seemed really keen to implement the changes I recommended". We did not see this in practice and the member of staff responsible for providing activity support was unaware of this recommendation. This meant the provider had not ensured the recommendations had been communicated to staff and implemented..

People were supported to maintain their relationships with family and friends. We spoke to three visitors during our inspection and they told us they were able to visit whenever they wanted which meant visiting was not restricted.

The home had a complaints procedure but this was not visible, which meant people were not informed about who to speak with if they were unhappy with any element of

Requires Improvement

Is the service responsive?

their care. A person we spoke with said, “I suppose I’d speak to the staff”. A relative told us, “I know how to make a complaint because of my professional background but I haven’t seen any information for other people”.

Inadequate

Is the service well-led?

Our findings

The registered manager was no longer working at the home and there had been no registered manager in post for some time. A new manager had been appointed six weeks before our inspection and they were going through our registration process to become the registered manager.

In May 2014, we had sent the provider an information document to be completed and returned to us by the end of June. The completion of the provider information return (PIR) is an opportunity for the provider to give us additional and detailed information about their service which we will consider as part of our inspection. We had not received the completed PIR by the time of our inspection and the provider was unable to give us a reason why they had not responded to our request. At the time of writing this report the PIR had not been received. This demonstrated a lack of management response to our request.

There was a meeting programme in place to give people who used the service opportunities to speak about what they liked and discuss any changes they might want in the future such as food choices and availability of staff. We noted that people who used the service had raised concerns at a residents meeting earlier in the year about the attitude of some staff, including raised voices and rough handling. There was no indication that this had been investigated or referred as a concern to the local authority which meant people's views were not listened to or taken seriously.

Throughout our inspection we observed that the manager did not ask people for their views before taking actions such as turning the radio on or the television off. We observed interactions between the manager and people who used the service. We heard the manager offer a person a chapatti at lunchtime but then laughed and said they were only joking as there weren't any.

There were no quality assurance processes in place to monitor the delivery of the service and identify how the service could be improved. We saw that some audits had been recorded but those we saw were not dated and therefore it was not possible to see when the information related to or if it was still current. This meant the provider was not maintaining information about the standard of care they provided.

There was a system in place for staff to report adverse incidents and we saw, for example, falls were reported and investigated appropriately. There was no system in place for the provider to learn from incidents by identifying patterns and trends, for example if people fell at a particular time of day or when they were unobserved by staff which meant some incidents which could be prevented were not identified.

The provider had not responded to concerns we raised at our previous inspection regarding the lack of protocols for the administration of 'as and when required medication' (PRN), such as pain relief. PRN protocols are used to demonstrate the decision making process for administering when required medication and should provide staff with clear guidance on when and why these drugs should be given. Their use is particularly important for people who are unable, or find it difficult to communicate their pain or discomfort. This meant the provider had not acted upon concerns already identified and highlighted to them.

During our inspection we observed staff were busy with tasks throughout the day. A member of staff said, "Sometimes we just don't have time to support people to bathe or shower, as they'd like and we have to give them a flannel wash instead". Staff told us the level of staffing had been increased recently but they struggled because the needs of some people had become more complex. One member of staff said, "Staff are working extra hours to try and cover the gaps but then they go off sick because they're exhausted". Another member of staff said, "We're not full at the moment and we're struggling because people need more support. We're worried because the new manager is assessing a lot of people to come into the home and some of us don't know how we'll cope". what it will be like when we have more people in". A relative we spoke with said, "There have been staff shortages in the past". The provider was not using a dependency tool to determine how many staff were required on a day to day basis. This meant there was no planning to ensure there were sufficient staff available to meet people's needs.

These are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to monitor the quality of the provision.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not assist people to express their views.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.