Care Quality Commission

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Southcrest 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 2 October 2014 and was unannounced.

Southcrest Nursing Home is registered to provide accommodation and nursing care for up to 40 people who have nursing needs. At the time of this inspection there were 33 people living at the home.

The provider is required to have a registered manager in post. The registered manager had left their post on 19 August 2014. The provider had taken action and an interim manager was recruited but they left their post on 14 September 2014. The provider had recruited a deputy manager to start at the home on 6 October 2014 and the provider is taking further action to recruit another registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

Staff told us they had not received training to support them to understand the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This law sets out to support the rights of people who do not have the capacity to make their own decisions or whose activities have been restricted in some way in order to keep them safe. We found there was an inconsistent approach in applying the MCA in order to support people's rights when specific decisions needed to be made so that the right people were involved.

A DoLS application had been made to the local authority for an assessment to be carried out. This is done by professionals who are trained to assess whether the restriction is needed to meet the person's needs effectively and keep them safe. This showed that this person's rights were protected by the proper authorisations when this was required.

We found that the provider needed to make improvements to ensure people's needs were always met and they were safe. We observed one member of staff used inappropriate moving and handling methods and staff practices did not reduce the risk of cross contamination when handling food.

Staffing levels were sufficient to meet people's needs but the way in which staff practices were checked needed to be improved. Despite the provider having induction and training procedures in place there was a lack of consistency in identifying staff practices that needed to be improved.

People's health care needs were assessed, planned and delivered to meet their needs. People had access to healthcare professionals such as doctors and dieticians who provided treatment, advice and guidance to support their health needs.

We received varied comments about the standard of meals people received. However, the provider had recruited an agency cook to assist in raising the standard of meals. People were supported to eat and drink enough to keep them healthy. Where people had special dietary requirements we saw that these were provided for.

Relatives and people who lived at the home told us that staff were caring towards them. We saw staff respected people's privacy and dignity whilst they provided and supported people with their care. Staff chatted with people who lived at the home in a kind and caring manner.

We received mixed views from some relatives about how responsive staff were in meeting people's individual needs. Although we saw staff responded to some people's individual needs as planned for, there were some improvements needed so that people's needs and preferences were consistently met. This included supporting people to have opportunities to take part in fun and interesting things to meet their social wellbeing.

People and their relatives were not fully involved in giving their views about the services they received. This was because they had not had opportunities to attend regular meetings to express their views about the home. Work had had begun in addressing the issues we had raised and a meeting had been arranged for people to attend.

There had been a lack of consistent effective leadership in the home and there had been significant changes in the staff team. The quality of some aspects of care was checked and improvements made. However, we could not evidence a consistent approach to the monitoring and management of the home on a day to day basis. This was an area where further improvements were needed to show good standards of care were always maintained and the services were well led on a daily basis.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the requirments of the MCA were not being met to promote people's rights and best interests. You can see what action we told the provider to take at the back of the full version of the report.

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

Some aspects of the service were not safe.

Staff practices did not always reduce risks when supporting people to move and the handling of food.

Written guidance was not always evident for all 'when required' medicines to ensure people received their medicines in a safe way.

Staff knew how to recognise and report abuse so that people were protected from harm.

There were systems in place to make sure staffing levels were maintained at a safe level.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The requirements of the Mental Capacity Act 2005 had not been consistently followed to ensure decisions had been made in people's best interests.

There were systems in place to make sure people received care and support in the least restrictive way to meet their needs.

There were arrangements in place so that new staff received an induction and training. Despite this areas of staff practices were not always effective in meeting people's needs.

People had enough to eat and drink during the day and were supported to manage their health and social care needs.

Is the service caring?

Good

The service was caring.

People were supported by staff who were caring and compassionate in their role.

Staff provided care and support to people so that their privacy and dignity were fully respected.

Staff involved people in their everyday care which showed people were treated as individuals.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Summary of findings

Some of the people and relatives we spoke with said they were happy with how staff responded to their care needs. However, other people and relatives said staff did not always respond to their individual needs and provide them with more fun and interesting things to do.

People and relatives had opportunities to share any concerns and complaints so that these could be responded to in the most appropriate way for people.

Is the service well-led?

Some aspects of the service were not well-led.

People and visitors opinions were not always actively sought by the provider to help develop and improve the service provided to people.

There were arrangements to check the safety and quality of some aspects of care. Improvements were needed to the day to day monitoring and management of staff practices and the care people received, to ensure their needs were always met.

Staff were supported by each other and had arrangements in place so that concerns and or changes in people's needs were identified, shared and met.

Requires Improvement

Southcrest 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 October 2014. It was carried out by an inspection team that consisted of three inspectors.

We looked at the information we held about the service prior to the inspection. We looked at information received from relatives and from the local authority commissioners. Commissioners have the responsibility for funding people who used the service and monitoring its quality. We also looked at the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

We talked with six people who lived at the home, three relatives and the nursing director, one nurse, five care staff and an agency cook. staff. We also looked at seven people's care records as part of our pathway tracking process. We completed a Short Observational Framework for Inspection (SOFI). A SOFI is a specific way of observing care to help us understand the experiences of people. We also spent time doing general observations of the care and support people were given. We looked at the records the provider had to show how they assessed the quality of the service they provided and how they made sure there were enough suitably trained staff on duty to care for people.

Following our inspection the provider sent us further information which included the visits they carried out to check the standards of the services people received and the updated staff training planner. This information was used to support our judgment.

Requires Improvement

Is the service safe?

Our findings

Before our inspection we had received concerns from some relatives about the lack of management at the home and changes in staff. Three relatives we spoke with told us they felt the changes in staff impacted upon the standards of care and people's safety. One relative told us, "[The home] has gone downhill in the last few months." People who lived at the home told us they felt safe as staff were there if they needed anything. One person told us, "There have been a lot of changes here, it is hard to get to know the staff but I do feel safe." Another person said, "I feel safe here, if I need anything I can always ask the staff."

People's care records we looked at showed that there were risk management plans in place so that staff had information to keep people safe. We saw assessments had been carried out whenever a risk had been identified. For example, one person was unable to mobilise independently. There was a plan in place to tell staff how to support the person with their mobility. We saw staff practices reflected the plan in place so that the risks to the person were reduced.

However, we saw examples where risks to people's health, safety and wellbeing were not always reduced due to staff practices and improvements were needed. We saw one staff member use an inappropriate moving and handling technique whilst they supported one person to move from a wheelchair into a comfy chair. The method used could have resulted in injuries to both the person and staff. The member of staff told us they had recently undertaken their induction and had received training in moving and handling techniques. They told us the moving and handling technique they used was not taught on the training and was inappropriate. The nursing director told us decisions would be made as to whether this member of staff needed further training.

We saw one member of care staff entered the kitchen without any protective clothing on such as an apron and hat. The member of staff was not seen to wash their hands and did not use the right equipment to prevent cross infection. The agency cook told us that there were no management systems in the kitchen such as the monitoring of fridge temperatures. This meant we could not evidence that there were clear management procedures in the kitchen so that the risks of cross contamination from poor food handling practices were managed safely. The nursing director informed us the records in the kitchen would be reviewed immediately to ensure they were all in place.

The director of nursing told us that the numbers of staff on each shift was based on people's dependency levels. Staff we spoke with told us they had no concerns about people's needs being met and they felt there were sufficient staff to keep people safe. We observed people receiving care when they needed it without any delay. For example, we heard call bells during the day and staff responded to these so that people's needs were met and their safety maintained. One person who lived at the home told us, "Whenever I press the buzzer I always get help."

Staff we spoke with told us they had received training in how to identify abuse. Staff told us what actions they would take if they suspected abuse or harm to people. This showed staff recognised what actions to take if they suspected a person had been abused. The staff we spoke with told us they felt people who lived at the home were safe and before they started work at the home their suitability to work with people was checked. The staff records we looked at confirmed that this was the case. For example, there were records of interviews, references from their past work history and checks about whether the Disclosure and Barring Check (DBS) had any information about them. The DBS is a national agency that holds information about criminal records.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. The quality of record keeping for medicines held in blister packs was good and all medicines we checked showed people received their medicines as prescribed by their doctor. We observed staff supported people to take their medicines during the morning and found people received their medicines safely as prescribed to meet their needs. For example, we saw a nurse, checked people's medicines against their medicine administration records to make sure they offered people the correct type of medicine and dose. One person who lived at the home told us, "They [staff] know when I need my tablets and I am happy to leave it to them."

The appropriate safeguards for the administration of covert medicines (medicines the prescriber has agreed can be disguised in a person's food or drink) were in place. This

Requires Improvement

Is the service safe?

meant information was available to inform staff on how to administer covert medicines safely. We observed the nurse encouraged people to take their medicines. This practice showed us staff used their skills so that people received their medicines in the best possible way at the right time to meet their health needs.

Some people were prescribed medicines on a 'when required' basis. We saw there was not sufficient written guidance for staff to follow to show when these should be given. For example, the medicines prescribed for pain relief as part of one person's end of life care. When speaking with the nurse on duty we found they were aware of how to manage the 'when required' medicines sampled. However, the lack of written information about how medicines should be managed may result in people experiencing an inconsistent approach. For example, this may result in people not getting their medicines when they need them.

Requires Improvement

Is the service effective?

Our findings

We looked at how the Mental Capacity Act (MCA) was applied. We saw staff supported people to make some everyday choices. People were offered choices of drinks, where they wanted to sit and what they would like to do. Most of the staff we spoke with were able to describe how they supported people to make decisions about their everyday care. However this was not always demonstrated in the care records we looked at. The director of nursing had knowledge about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). However, staff we spoke with were not aware of the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

We found that there was a lack of consistency in the approach taken to record people's mental capacity. We could not evidence that all specific decisions about aspects of people's care were made in the best interest of the person with people who were involved in their care and treatment. For example, there was no indication in four people's care records of the person's capacity to consent to their care. Where best interest decisions had been recorded these only showed the involvement of the previous registered manager as making the decision about aspects of people's care.

We found that there were 'do not resuscitate' agreements in the care records we looked at for four people. These agreements provided staff with the information about what action should be taken in the event of people having heart attacks or their health conditions deteriorate. One of the agreements did not indicate the person, their representatives and or a medical practitioner such as their doctor had been part of the decision made. This meant should the person's health condition deteriorate there was a risk inappropriate action could be taken by staff which had not been consented to by the person, their representatives and or their doctor. The director of nursing told us that they would take immediate action so that all people who had 'do not resuscitate' agreements in place were validated by the appropriate people.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

An application to deprive a person who lived at the home of their liberty had been made to the supervisory body [local authority] for their consideration under the Deprivation of Liberty Safeguards (DoLS). Although the documentation for this could not be found during our inspection the person's rights were protected as the supervisory body had received an application. This meant an assessment would be carried out by professionals who were qualified to do this to ensure the person's liberty was not restricted by staff practices unlawfully.

People gave us a variety of answers when we asked them about the effectiveness of the care they were provided with. One person told us the staff had a good understanding of their needs and "They were very well looked after." Relatives we spoke with had mixed views about the quality of care provided. The director of nursing had plans to arrange a meeting to follow up on people's views of the care provided.

Care staff told us they had an induction which included a week's training in key areas of their work. They also told us they had the opportunity to 'shadow' more experienced staff to ensure they could carry out tasks confidently. However, we saw staff did not always respond to people's needs effectively for example when moving or transferring people. This meant staff had not consistently applied their training to their work to meet people's needs effectively. There were no systems in place to check new staff were competent in meeting people's needs. We also found one member of staff was not able to understand English sufficiently to fully talk with us. This could impact upon the ability of this staff member to fully communicate with people in order to meet their needs effectively. The nursing director told us that they would take action so that all staff had the support and training they needed to effectively carry out their roles and responsibilities.

We found the training planner had not been updated and there had been significant changes in staff. This made it difficult to assess the effectiveness of the planning, arranging and reviewing of staff training. Following our inspection an updated training planner was sent to us and it identified training for staff had been arranged which included MCA and DoLS.

We received mixed responses from staff about the levels of supervision they received but most staff told us they felt supported by each other and the nursing director. They told us they worked well as a team so that they could

Requires Improvement

Is the service effective?

provide appropriate care that met people's needs. One staff member told us all the staff working at the home would, "Help one another." We saw staff were supportive of each other whilst they carried out their roles and responsibilities.

Before our inspection we received some concerns that described the standard of meals as 'declining'. At the time of our inspection people's views varied about the food they ate. One person told us, "Food is pretty good. I am an unfussy eater. I have enough to eat." Another person said, "There is a good choice regarding sweets. My daughter brings in food because I don't like the way some of the food is done." A further person said, "Sometimes, I don't get breakfast until 10am or 11am and I only have a Weetabix. That's a long time to wait for that." A relative told us, "The evening meal is sometimes cold toast and barely warm baked beans." The director of nursing told us the standard of the meals people received was being reviewed.

Staff spoken with understood people's dietary needs and any support needed at meal times. We saw some people enjoyed meal times with friendly chatter between people who lived at the home and staff. We saw staff supported people with their meals where needed. However, we saw some people were offered porridge and toast which one person told us was, "Luke warm." There were also missed opportunities for people's experience of meal times to be improved and be more pleasurable. For example, staff had made an effort to ensure the dining table on the second floor was nicely laid with napkins and cutlery. However, we saw people had their meals on side tables in communal lounges or in their rooms and were not encouraged or supported to use the dining table. One person told us if they had known the table was laid they would have had their meal there. This meant improvements were needed as people had variable experiences at meal times which did not always fully promote their nutritional needs.

Staff had completed nutritional risk assessments and people had been weighed regularly as required. Advice had been sought from health professionals when necessary. Fluid and food intake charts had been completed for people assessed as being at risk of poor nutrition or dehydration. We saw staff had taken action to promote people's nutritional needs. For example, one person had lost weight and staff had contacted the doctor who reviewed the person's treatment.

We looked at how people's health needs were met. Records showed when appointments had been made and what advice had been given by medical professionals. We saw advice given had been followed by staff to ensure people's health needs were met. People who lived at the home told us about times when they had asked to see a doctor and how staff had made arrangements. One person who lived at the home confirmed to us, "The staff would get the doctor if I need one." Concerns had been shared with us that one person had not received effective care and treatment. We saw this person's needs had improved with the care and treatment they had received. This confirmed that people who lived at the home were supported with their health needs and medical professional's advice was sought when people wanted and needed it.

Good

Is the service caring?

Our findings

People we spoke with told us staff were caring towards them whilst helping them with their care. One person said, “They [staff] are good to me, I like them all.” Another person said although they sometimes waited for staff to come to assist them, they were always kind and caring.

We observed staff spoke positively with people, showing them kindness and respect. Our observations demonstrated staff had positive relationships with the people they supported.

All our observations reflected that the communications between staff and people, although staff were busy, they were polite and responded to people as quickly as they could. For example, one staff member offered a straw to a person so that they did not struggle to drink. One person told us, “I am always offered biscuits with my tea.” We also saw staff supported people in a caring manner during their lunch time meals. We saw one staff member made sure one person had the right meal to meet their dietary needs. These practices reflected that staff felt responsible for meeting people’s needs and cared.

We saw people who remained in bed were dressed in loose, clean clothing so that they were comfortable. Staff entered people’s rooms and checked on people to make sure they were cool or warm enough and had drinks. We saw people were repositioned in their bed to make sure they were kept comfortable.

We found people were treated and respected as individuals. We observed staff practices where they communicated with people in a way where people were enabled to make choices about their care. Staff ensured that where tasks, such as personal care, were going to be delivered people were always given an explanation of what was happening and why. We saw staff supported one person to the toilet and staff asked the person, “Would you like to come now?” This was done discreetly so that the person’s dignity was protected and enabled staff to obtain the person’s consent before they carried out the support they needed.

We saw people’s care delivered in a caring manner and people told us they were involved in day to day decisions about their care. For example a person told us if they asked staff to support them in having a shower they would at any time of day not just in the morning. They said, “They [staff] are kind to me.”

We spoke with two staff about how they ensured people’s privacy and dignity was respected. Both members of staff had a clear understanding of the role they played to make sure this was respected. One member of staff explained how they knocked on people’s doors and waited for permission before entering their bedrooms. Staff helped people with their personal care in the privacy of people’s rooms or bathrooms with doors closed. One person who lived at the home told us, “They [staff] always knock the door and they shout my name.” We observed this happened in practice.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people about the care and treatment they received. One person told us the staff had a good understanding of their needs and "They were very well looked after." Relatives we spoke with had mixed views about the quality of care provided. One relative told us, "Staff are caring and patient." Another relative told us they found most of the staff to be caring towards their relative but felt they did not always provide the care and assistance their relative needed. This relative had spoken with the management team about their concerns and actions were being taken to resolve the issues raised.

We spent time observing the care and support people received. We saw people were supported appropriately at different times and by different staff. This support was not rushed and staff gave people their full attention. We saw staff mostly provided support and care that reflected the care plans in place, responding to people's needs as assessed and planned for.

However, improvements were needed as we also observed some staff practices that were not always responsive to meet people's individual needs at the right time and in the right way. For example, one person did not receive personal care which supported them to have appropriate clothing on for sitting in a communal lounge. The person's relative was unhappy about the support their relative had received and gave us further examples of care they felt had not been given in a personalised way. When we spoke with the member of staff who had assisted the person with their personal care they told us they did not know the person that well. This meant there was a risk of this person not receiving consistent care to meet their needs in the right way for them.

We saw another person was shouting for staff on two occasions within a ten minute period of time but no staff responded. The person told us the only way they knew how to summon staff was to shout for the nurse and hoped they came. We spoke with one staff member about the monitoring checks for people in this area; they told us that they did look into the room as they walked past. However, this practice had not been effective as they had not noticed the person who was asking for staff. This meant some people who were not able to summon assistance and did not have call bells to hand may not have their needs responded to and met at the right time.

A further person who lived in the home told us that they were unhappy. This was because recently they felt staff had not always responded to their needs in the mornings at the times they wanted them to be. This person spoke with staff about this at the time of our inspection so that improvements could be made where needed to suit the person.

People who lived at the home and their relatives told us life at the home could be more interesting. People told us that there was not much to do and improvements were needed. One person told us, "I am bored sitting here and I want to go back to my room." A relative said, "There's no activities, [my relative] stays in bed, playing with their bedding." Another relative told us there used to be activities for people but these were not happening now. Staff we spoke with told us that providing people with fun and interesting things to do was an area they would like to see improved. We found no evidence that hobbies and interests for people to do were routinely planned to give people a quality of life and to maintain their individual interests. When we spoke with the director of nursing they confirmed a new staff member had been recruited to enable people's interests to be further promoted.

Relatives we spoke with told us they could visit when they wanted and we saw that some friends and relatives visited throughout the day. This showed people were able to maintain relationships they cared about with people who were important to them.

We saw there was a system in place that ensured complaints were investigated and responded to appropriately. We asked people and their relatives how they would complain about the care if they needed to. People who lived at the home were aware they could tell staff if they were unhappy. One person told us, "Generally speaking I don't have any complaints about the place." Before our inspection we were made aware some relatives had raised complaints with the manager which were being investigated so that improvements made where required. This meant people were aware of how and who to complain to so that action could be taken to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager in post. The registered manager had left their post on 19 August 2014. A manager had been appointed, but had left the home after a short time. The provider had recruited a deputy manager to start at the home on 6 October 2014 but until their employment began the nursing director was responsible for the management of the home. The provider informed us they were actively seeking a registered manager. It is important that there is a registered manager as this is a requirement of the provider's registration and shared responsibility with the provider to ensure the services people received were well led.

There were no planned opportunities for people who lived at the home and their relatives to be fully involved in developing the services that were provided. One person told us they had spoken to staff about the way some meals were cooked but felt that no improvements had been made. They told us, "I would like meetings so we can talk about the meals." During our inspection some people and relatives told us they continued to be unhappy about the inconsistency in the standard of meals. Three relatives also told us that they were unhappy with some aspects of the care their relative received as they felt it did not fully respond to their individual needs. We could not find any evidence of actions being taken so that people's suggestions and views could influence the care and meals people received. The nursing director told us they had arranged a meeting for people who lived at the home and their relatives. This showed that actions were being taken to improve planned regular opportunities to ensure people and their relatives were able to share their views about the development of the services people received.

Staff we spoke with had an understanding of their role in reporting poor practice regarding staff members conduct or where abuse was suspected. They knew about the whistle blowing process and how to report any concerns which they felt would be listened to.

Staff told us they were informed of any changes to people's needs at handover meetings. Staff also knew that they could speak with the nursing director or the provider if they had serious concerns whilst there was no permanent manager in place. Staff told us and we saw that when incidents occurred staff reported these so that investigations could take place. For example, when a person had a fall their medicines were reviewed by the GP. Staff also told us they were made aware of actions taken to reduce further incidents. Despite this we could not find evidence that accidents and incidents were analysed through the management arrangements to ensure actions to reduce the risks to people of reoccurrences were not missed.

We saw that the previous managers had completed audits and the provider regularly visited the home and completed audits of different aspects of the service. This included talking with people who lived at the home. This was to highlight any issues in the quality of the service people received, and to drive forward improvements. Audits included health and safety, medicines and care plans. We saw that some previous audits noted what action needed to be taken to ensure improvements had been achieved. For example, some of the bed remote controls needed some attention. When we checked the remote controls with one member of staff we saw that they were now working. However, the arrangements for the monitoring and management of the home needed to be improved as they did not always ensure that day to day risks and performance issues were identified and responded to. For example, during our inspection we saw improvements were needed in some staff practices and there were shortfalls in staff knowledge and training.

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 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 in relation to the care and treatment provided for them.** Regulation 18