Mosaic Care Group Limited

Fresh Fields Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

This inspection was a focussed inspection following on from further information of concern we had received from visiting healthcare professionals about the competence of the registered nurses working at the home and the impact this may have on the safety of people living there.

We had carried out a comprehensive inspection on 22 and 23 August which was done to check the progress and improvements the provider had said they had made, and as a consequence of the findings additional safety and welfare checks were carried out on the 30 August 2016 and the 12 September 2016 to ensure people were safe.

Fresh Fields Nursing Home is a purpose built home set in the grounds of Wythenshawe Hospital but the hospital has no association to the service. The home provides nursing and residential care for up to 41 people. At the time of the inspection there were 16 people living in the home.

The home still did not have a manager registered with the Care Quality Commission. The home had been without a registered manager since 2014. A manager had been recruited but had not registered with the commission. This was the sixth Manager to be recruited to the service during this time and we found on the safety and welfare check done on 12 September 2016 that they had also left the service. The service is required to have a registered manager and was therefore still in breach of this regulation. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the last inspection in April 2016 we found there were not enough qualified skilled or experienced staff to meet the needs of the people using the service. After that inspection we were made aware that only two nurses had been recruited. At this inspection we found the registered nurses did not demonstrate competence needed to meet the standards set out by the Nursing and Midwifery Council (NMC) and we made a referral to the NMC. We found the home was still in breach of the regulation relating to staffing.

We found people who were at risk of malnourishment did not have adequate food supplements to meet their assessed need which placed them at risk of harm. We found the home was in breach of regulation relating to nutrition and hydration.

We found the provider had not protected people from the risk of unsafe care and treatment and were in breach of regulation in relation to safety.

The provider had also failed to operate systems to identify improvement or to act on improvements that had already been identified. This was a continued breach in relation to good governance.

At the inspection in August 2016 we did not consider enough improvement had been made and the service

remained in special measures. At this inspection we found the risk to people had increased and considered urgent action.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely.

There were not enough suitably trained or qualified staff to meet people's needs.

Fresh Fields Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection on 26 September 2016 due to concerns that had been raised with us since our last inspection on the 22, 23, 30 August 2016 and 12 September 2016. The concerns raised were the competence of nursing staff at the home, the poor quality of care plans used to inform staff and lack of clinical oversight and management within the home. We inspected the service against one of the five questions we ask about services: is the service safe.

The inspection team consisted of two adult social care inspectors and a specialist advisor. The specialist advisor was a registered nurse.

At the time of this inspection there were 16 people who used the service. During the inspection we spoke with two people who were living at Fresh Fields Nursing Home and three visiting relatives. We also spoke with the provider, four care workers and two registered nurses.

We looked at a range of records including care plans recruitment files and medication records.

Inadequate

Is the service safe?

Our findings

At the inspection on 26 September 2016, we observed the medicine round taking place in the morning. We found serious errors in relation to medicine management. For example, we witnessed the administration of Lansoprazole to six people and noted that the prescription clearly stated the medicine was to be administered 30 to 60 minutes before food. However it was noted that five people received this medicine after breakfast and one received the medicine whilst eating their breakfast.
We also observed one person being given Azithromycin 250mgs after their breakfast, yet the pharmacist's written instruction on the medication administration record (MAR) sheet indicated the medicine had to be administered on an empty stomach. Failure to administer medicine in line with prescribed instruction increased the risk of harm.
Due to findings at the inspection carried out on 12 September 2016 in relation to poor medicine management, we carried out a full audit of medicines in stock at this inspection. We found improvements had not been made in relation to medicine management as people's medicine was out of stock. During the medicine round in the morning Inspectors had indicated to the nurse that one person was in pain and in need of paracetamol. We looked at this person's MAR chart at 15.15 which indicated analgesia had not been administered and so had been without pain relief since 10.00am. We carried out an audit of the medicine which confirmed the medicine was out of stock.

During the medicine round in the morning we observed the nurse signing the MAR chart suggesting that creams had been administered to people at the home when they had not. For example, one person was prescribed shower emollient to be used daily and Eumovate ointment twice daily. We spoke with care workers who told us the creams were given when the person had a shower or bath and they confirmed they had not been administered for a number of days. Furthermore we could not locate a supply of the ointment. We checked the MAR chart for this person and we found entries on, 19, 20, 21, 22, 23, 24 and 25 September which had been signed with an "O" by the nurses and not by the the staff designated to administer this medication. A key at the bottom of the MAR chart indicated O = Applied by HCA. (Health Care Assistant) This meant that this person was at risk of harm as they were not receiving medicine in line with prescriber's instruction.

On 26 September 2016 we observed that one of the medicines prescribed was Glycerine Trinitrate (GTN) for chest pain management. We noted the medicine was prescribed on a PRN basis. During the medicine round we observed the nurse asking the person if they received their GTN medication. We saw the person pointed to their abdomen and said they had discomfort. We then witnessed the nurse administer GTN spray sublingually (that is, under the tongue). We asked the nurse if this person had any symptoms of angina. The nurse confirmed the person had complained of abdominal discomfort. We asked the nurse if any PRN protocols existed to guide them as to when the medicine should be administered or why the medicine had been prescribed and we were told it was prescribed for angina. We found this to be a concern as the person receiving the medicine had clearly stated their discomfort was in the abdomen – pointing to the right lower abdomen and the nurse had ignored this indication and therefore administered PRN for a reason it was not prescribed. This meant this person was exposed to unnecessary pain or discomfort as appropriate nursing interventions had not been received. Additionally the person had received medication that she was not

necessarily in need of.
We therefore found a continued breach in Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were placed at risk of inappropriate care and treatment because critical supplements, pain relief medicine was not available to them and prescribed medicine was not administered in the correct way.

At inspections carried out in April 2016, August 2016 and September 2016, the provider had been in breach of the regulation relating to medicine management. We found this was the case in part because there were no protocols in place for the administration of PRN medicine. In action plans sent to the Commission in May 2016, August 2016 and September 2016, the provider told us that improvements had been made in this area. During this inspection we asked the nurse if any medicines prescribed on a PRN basis were underpinned by a written protocol. We were told "no".
We asked the provider if any protocols were currently being prepared. The provider told us, "no but there were plans to do so". This meant people were exposed to an increased risk of harm because the provider had failed to ensure the correct protocols were in place to help ensure people received PRN medicine safely. This was a continued breach in relation to good governance as the provider did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity or mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.
We found the food supplement for one person was unavailable. The nurse confirmed the supplement was out of stock. We checked the care records for this person and noted that they were assessed as "very high need" and needing "substantial support at mealtimes." We found this was a continued breach in relation to Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities)Regulations 2014 because the provider did not ensure people nutritional needs were met.

Throughout the previous inspections on 22. 23 30 August and 12 September 2016 we found examples of people receiving unsafe care and treatment because the home did not have a permanent team who knew about the care needs of the people they supported. We had received further information of concern from the nursing home team that there was not a regular staff team which they felt continued to compromise the quality of care provided to people living at the home.
We checked the rota, which were done weekly, and found for week commencing 26 September 2016, of the six nurses on the rota only one was employed on a full time permanent basis by the home.
This meant that there was insufficient nursing staff deployed to safely and appropriately provide care and treatment to residents at the home. Along with the concerns identified in the management of medicines the Commission found this increased the potential for risk of harm because people were being supported by staff who did not manage or accept responsibility for the continuity of the service or demonstrate a level of competence in line the requirements of the Nursing and Midwifery Council and had not demonstrated sufficient competencies during the inspection.

Inspectors also noted that one nurse had recently been employed for 36.5 hours a week as a day nurse and was deployed within the service. Inspectors found that notes within the recruitment files which had been completed by the previous manager advised not to recruit this person into post. This was because they had not disclosed that they had undergone disciplinary actions in their previous role. Since that time, despite the previous acting manager's written directions that this nurse should not be recruited as they could not satisfy the fitness requirements of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations, the nurse had been recruited by the provider and was on the rota as working 12 hour shifts on 27 and 28 September 2016. There was nothing contained within their recruitment file to outline that the provider had ensured the correct checks had taken place. For example we found a typed reference suggesting it was from the last employer outlining that they were a "good worker". We found no evidence to

suggest the reference had been further explored or corroborated by the home and there was no evidence that this nurse had been checked as suitable or competent in terms of their nursing and clinical skills. This placed people at significant risk of harm as the appropriate checks by the Registered Provider on the findings of the acting manager, on their leaving, had not been carried out to ensure staff were suitable to work with vulnerable people and that they were capable of undertaking this role. This exposed residents at the home to the risk of harm.

During the inspection we noted two new staff members at the home. The provider advised us they had been recruited from an agency and had been recruited to support the general management of the home such as housekeeping, cooking, and laundry.

We checked their recruitment files and we found there were no application forms, no references and no Disclosure and Barring Service (DBS) checks present within their files. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions or cautions noted against the applicant by way of demonstrating they were fit and proper persons to be employed by way of Regulation 19 of the 2014 Regulations. We found, there was not a complete work history and the identity check was taken from a bank statement from 2014. We observed that during the inspection both of these employees were observed to be in the administration office for the duration of the inspection and they would have had access to all personal and confidential information stored there for service users and staff such as rotas, personnel files and care records for people living at the home.

Principle 7 of the Data Protection Act states "One of the most important aspects of security is making sure that you are not disclosing personal data to someone who does not have a right to receive it. This can be done inadvertently simply by allowing a computer screen to be seen through the window of your office or reception".
This meant the provider had failed to protect the rights of people living at the home and exposed them to a potential risk of harm by recruiting staff who may not be suitable or safe to deliver the regulated activities, and allowing them to access information which they should not be privy to. As a registered provider, failure to carry out proper checks places vulnerable people at significant risk of harm and/or abuse and was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to this inspection we had been made aware of concerns that staff may be following instructions to weigh people when it was not appropriate to do so, for example when they were at the end of their life.
At this inspection we asked the registered nurse who made clinical decisions in the home about this. The nurse told us that the provider had given instruction . We asked the registered nurse to give a specific example of instruction which had come from the provider. They told us about an incident involving a resident who was on end of life care and should not have been weighed according to the instructions from the nursing home team. The registered nurse told us that the provider had instructed the nurses to weigh everyone. We checked the care plan for this person and we noted their care summary had an evaluationcompleted on September 22, 2016 stating that the person was not to be weighed and care should focus on comfort and dignity. Despite this and on the direction of the provider this person was being weighed daily. This meant this person was exposed to an increased risk of harm because nursing staff were not following instructions as outlined in their care plan.

We had received information of concern before the inspection from the family of one of the people living at the home about the inability of a registered nurse to understand what they were saying to them in relation to the care needs of their relative. This was because this nurse did not have English as a first language.
We looked at care records for this person to ascertain what had been recorded in relation to the incident. We

noted care records were poor, did not contain sufficient detail to outline the nature of the incident or what action had been taken or was necessary. We spoke to the registered nurse on duty, who accepted the records were poor. They said the records had been written by a nurse whose native language was not English and who did not understand written or spoken English. This meant people were exposed to an increased risk of harm as the nurse responsible for their care and welfare was not able to understand spoken English and was unable to make accurate records in care files.

We considered this to be a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not protect people from the risk of harm.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition
Treatment of disease, disorder or injury	The provider did not recruit a manager in line with regulatory requirements

The enforcement action we took:

NoD

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not protected against unsafe care and treatment

The enforcement action we took:

NOD

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People at risk of malnourishment were not offered food supplements in line with their assessed need which placed them at risk of harm.

The enforcement action we took:

NoD

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not ensure systems were operated effectively to keep people safe.

The enforcement action we took:

NoD

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care

Treatment of disease, disorder or injury

proper persons employed

The provider did not ensure proper checks were done to ensure new staff were competent and of good character.

The enforcement action we took:

NoD