Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Crawfords Walk Nursing Home

Inspection report

Lightfoot Street
Hoole
Chester
Cheshire
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Tel: 01244318567

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09 August 2016

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Ratings

Overall rating for this service	Inadequate ●

Is the service safe?	**Inadequate** ●
Is the service well-led?	**Inadequate** ●

Summary of findings

Overall summary

This inspection was carried out on 8 and 9 August 2016 and was unannounced.

Crawford's Walk nursing home comprises of four purpose-built units in the Hoole area of Chester. The service is owned and operated by BUPA care homes. Northgate is a unit for people with enduring mental health illness issues, Watergate and Eastgate are units for people living with dementia and Bridgegate unit provides support for those with physical health needs.

The service does not currently have a registered manager in place. 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. The service has a manager in place who has recently applied for the registered manager's position.

A comprehensive inspection of the service was completed on the 16 and 17 May 2016 and we found that the registered provider was not compliant with the Health and Social Care Act 2008 (Regulated Activities) 2014. We issued the registered provider with a warning notice and told them to be compliant by the 3 October 2016. We conducted this focused inspection due to concerns that we had received following our last inspection regarding the safe care and treatment of people living at the service. We looked at the safe and well led domains. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. The registered provider submitted an action plan within 18 hours of our inspection visit highlighting the actions that would be taken to address immediate areas of concern we raised regarding the risks to the health, safety and welfare of people living on Watergate unit. You can see the action we have told the provider to take at the end of the report.

People on Bridgegate unit told us that they felt safe living at the service. Staff had an understanding of different types of abuse, such as financial, physical and verbal abuse. The registered provider had recently shared information with staff as to how to safeguard people from abuse and how and who to report concerns too. However, we identified institutional practices in place between the day and nights shifts on Watergate unit. People rights and choices had not always been respected and this had not been identified or addressed by the registered provider.

Areas we raised related to poor and restrictive practices that had not been identified or addressed. Mobility aids such as walking sticks and Zimmer frames were placed out of peoples reach. The environment had not been adapted to aid and support people living with a visual impairment. This meant people's movements were restricted in the environment and the registered provider had not recognised or addressed cultural restraint within the service.

Staffing levels were not sufficient to meet the needs of people supported. Staff sickness and cover had not been reported and staff told us that it was usual practice to work short staffed on night duty at the service.

People were left unsupported and not observed at times and this led to a number of situations were inspectors intervened to prevent accidents and incidents occurring. This meant that people had been placed at risk of harm due to a lack of staff, reduced observation and support.

Risks to people health and safety were not always identified by the service. We found on Watergate unit that the kitchen and sluice room doors were left open and accessed by people living with dementia at the service. Some people were unable to independently call for help or support from their bedrooms. There were no alternatives other than night time checks to ensure that people were safe and observations showed that these were not completed on a regular basis. This meant that people were placed at increased risk of harm and cross infection.

During our visit we found that sufficient checks were not made on pressure relieving equipment on Watergate unit. Seven pressure relieving mattresses were set at the wrong pressure settings and one pressure mattress was unplugged from the power. Staff referred to out of date and inaccurate information to complete checks on pressure mattresses. Following our inspection we were informed by the registered provider that the appropriate checks on this equipment had not been completed at the service.

Fire safety management at the home required reviewing. Staff were not confident in describing how to support people and undertake an effective evacuation of the units in the event of an emergency or a fire. This meant that people were at risk of not having the appropriate support they required in the event of an emergency.

People told us that the majority of staff were kind, patient and caring. However, observations showed that some staff were abrupt and dismissive in their manner and approach towards people. Staff did not always effectively meet people's needs and people were not always treated in a respectful and dignified manner. The registered provider has addressed areas of concern we raised with them relating to staff approach following our inspection.

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

Insufficient checks were completed on pressure relieving equipment.

Staffing levels on Watergate unit were not safe. People were not protected from the risk of harm.

Staff knowledge and understanding of fire safety and emergency evacuation procedures was poor.

Is the service well-led?

Inadequate

The service was not well led

Cultural, institutional and restrictive practices had not been recognised and addressed at the service.

The environment did not always meet the needs of people supported. There were no adaptations or equipment in place to support people living with a visual impairment.

People were not always treated in a respectful and dignified manner. This has not been recognised or addressed by the registered provider.

Care Quality Commission

Crawfords Walk 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 visited the service on the 8 and 9 August 2016. Our inspection was unannounced and the inspection team consisted of three adult social care inspectors. Our inspection focussed on the safe and well led domains and took place during the evening and night time shifts.

Before the inspection, we received concerns regarding the provision of care at the service. We therefore decided to bring forward our inspection. We reviewed information provided by the local authority and safeguarding teams before the visit. We also looked at information we hold about the service including previous reports, notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

As part of the inspection we spoke with and spent time with 10 people living in the service. We spoke with nine staff including the company and area director and the home manager. We observed staff supporting people and reviewed documents at the service. We looked at nine people's care records and we spent time observing care and support in communal areas and staff interaction with people during suppertime.

Inadequate

Is the service safe?

Our findings

People living on Bridgegate unit told us that they felt safe living at the service. They told us, "I feel safe here. The staff assist me with everything as I can't do a lot for myself. I feel safe when they are helping me into the bath" and "The staff know what they are doing here. Although I do feel at risk of falling as my bedroom floor isn't carpet. I have mentioned I need better gripping footwear to the staff".

Staff on Bridgegate were patient and caring towards people supported. Observations showed that staff took time to listen to how people preferred their care and support to be delivered. However, observations and discussions held on Watergate unit showed that people were not always provided with safe, respectful care and treatment and protected from the risk of harm.

At our last inspection in May 2016 we noted that Bridgegate and Watergate units supported a number of people who used pressure relieving mattresses. We raised concerns that records relating to the safe use of pressure relieving mattresses was not in place and we issued a warning notice to the registered provider. The registered provider is required to be compliant by 3 October 2016.

Nursing staff on Watergate unit presented inspectors with a document that outlined the names of people currently using pressure relieving mattresses. The list identified the assessed pressure mattress settings required for each person and staff confirmed that it was currently used to check and ensure that pressure mattress settings were correct. We found that the mattress settings for seven people were incorrect. One pressure relieving mattress had been unplugged and this had not been noticed by staff on duty and one person was not recorded on the list. We brought this to the immediate attention of the nursing staff and action was taken to ensure that all mattresses were set at the correct settings. The company director later confirmed that the list had been written in May 2016 and required updating. Care plans we viewed did not identify the pressure mattress settings required. Following our inspection the registered provider confirmed that the appropriate checks on pressure relieving equipment had not been completed. This meant that people were not being adequately protected from the risk of developing pressure ulcers. We found no concerns relating to pressure mattress settings on Bridgegate unit.

Staff on the evening shift had begun to serve supper to people who were in the lounge area on Watergate unit. One person was observed drinking from other people's cups and eating the food from their plates. Inspectors intervened and distracted the person as staff were not in the vicinity. This may lead staff to believe people had consumed food and drink and placed people at risk of dehydration and malnutrition.

Observations showed that the handover procedure completed by staff on both units was thorough, detailed and important updates and information about people was shared. On Watergate unit the handover procedure highlighted that one staff member had not turned in for their night shift. No action was taken to alert senior manager's to the shortage of staff. Through discussions with both nursing and care staff it was identified that it was usual practice not to cover the sickness shift and to utilise the staff who were working with people on a 1:1 basis when they were asleep. Following our inspection the registered provider shared records that identified for July and August 2016 the service has been appropriately staffed for 96.83% of

shifts. The registered provider confirmed that there had been a shortage of staff on two night shifts during the period due to sickness or short notice cancellation.

The main lounge area was left unobserved by staff for a period of 30 minutes. Inspectors had to intervene and encourage one person to leave the kitchen area as the door had been left ajar and they had entered the room unsupported. Inside the kitchen we found a tea urn which was switched on and fully accessible. The sluice door had been left unlocked and one person who was living with dementia had started to enter the room. A sluice room is where disposable items such as incontinence aids are dealt with and reusable products are cleaned and disinfected. Inspectors encouraged the person to leave the room and come and sit in the lounge area to relax. One person who was very active was seen entering three different bedrooms on the unit. Two of the bedrooms were empty however, inspectors intervened to ask the person to stop waking one service user up as this may have alarmed them or caused them distress. This meant that people had been placed at risk of harm and cross infection due to a lack of staff, reduced observation and support.

We notified senior managers at 9pm to the shortage of staff as we had identified a number of concerns about the health, safety and well-being of people supported. Immediate action was taken to ensure that additional staffing was sourced. Whilst waiting for the additional staff member to arrive senior managers remained on Watergate unit to offer support to staff. An additional member of care staff arrived at 11.30pm.

Staff were observed attempting to move and lift one person from under their arms as they were struggling to stand up from their chair. The company director intervened to support staff to use appropriate prompts and techniques. A decision was then made for the person to be safely transferred using a wheelchair. We noted that where people experienced difficulty mobilising they were not always able to access their mobility equipment independently. We saw that one person who used a walking stick could not mobilise without staff support as their walking stick had been placed behind their chair out of reach. Another person was heard shouting from their bedroom by inspectors. On entering the person's room we found that they had attempted to get out of bed and the duvet cover had become entangled around their feet restricting their movement. They were unable to access their walking aid as it had been placed out of reach. Care plans stated that the person felt safer with their bedroom door open, however we found that the door had been closed shut. Records identified that the person had been assessed as lacking the capacity to use an alarm call bell. We saw that there was no alternative system in place to alert staff to the person being in difficulty or danger. This meant that the person could not summon help when they required assistance. People were at risk of increased falls due to being unable to access appropriate mobility aids. Staff told us that night time checks were completed on a regular basis, however, observations showed that these were not regularly completed during our visit. We raised concerns with the registered provider and asked them to take immediate action to reduce the risk of harm and to protect people from the risk of falls.

The service practiced horizontal and compartmental evacuation procedures on each unit. Whilst we found records were in place on both units that identified what actions staff were required to take, staff were not confident in describing what actions they would take in the event of an emergency or unexpected fire. We found no evidence in fire records of how staff would safely evacuate people from the building in the event of being under staffed. Staff on Bridgegate when asked where they would find personal emergency evacuation plans (PEEPs), began to look in individual care plans for the information. Staff, later confirmed that there was a separate fire information file that they could access quickly in the event of an emergency.

The registered provider had introduced a system using 'door stickers' to identify how people were required to be supported in the event of an emergency. These were in the form of colour coded stickers, red, amber and green which were used to outline what level of support a person may require during an emergency evacuation. We found that across both units there were a total of nineteen of the stickers that were incorrect

and stickers on five bedroom doors could not be clearly identified. This meant that people were at risk of not having the appropriate support they required in the event of an emergency.

This was a breach of regulation 12 and 18 of the Health and Social Care Act as people were placed at risk of harm and receiving unsafe care and treatment as there was insufficient levels of staff to meet their individual needs. Staff were not familiar with the emergency evacuation procedures for the service and information regarding levels of support required during an emergency was not always correct.

We spoke with five members of staff and found that their knowledge and understanding of safeguarding people was varied. Staff were more familiar with the more commonly known types of abuse such as physical, verbal, financial and sexual abuse. Knowledge relating to emotional abuse and neglect was limited. We raised this with the registered provider who following our visit has confirmed that safeguarding training and refresher training has been arranged for staff in August 2016.

Inadequate

Is the service well-led?

Our findings

The service is not currently managed by a person registered with CQC. There was a manager at the service who has recently applied to become the registered manager. The home manager, area director and company director visited the service during our inspection.

At our last inspection on the 16 and 17 May 2016 we had concerns that the registered provider did not have effective systems and processes in place to monitor and improve the quality and safety of the service. In addition we found that care plans did not contain accurate and up to date information and people were at risk of receiving care and support that was not suited to their needs. We issued a warning notice to the registered provider and informed them that they were required to be compliant by the 3 October 2016.

During this inspection we found a number of areas of concern relating to poor care and poor practice that had not been highlighted, identified or addressed by the manager or registered provider.

The registered provider's statement of purpose states that 'Crawford's Walk aims to help residents and relatives to have all the information they need to understand the care, treatment and support choices available to them'. On arrival to Watergate unit at 7pm we noted that there were five people sitting comfortably in the lounge area, two of which were in their nightclothes. Through further observations we found that seventeen people were in bed in various stages of undress. Through discussions with staff on the evening duty we were informed that this was usual practice and that they would start getting people ready for bed from 6.30pm. Night staff confirmed that the morning routine of bed bathing people started at 5am and that all but two people would be washed, dressed and ready for the early shift when they arrived. We were told that if people did not want to get up to go to the lounge then they would go back to bed after having a wash and getting dressed. Staff confirmed that two people did not like getting up early so they would leave supporting them until nearer to the end of their shift at 8am. This showed that there were cultural and institutional practices in place at the service and people's right to choice, respect and dignity was not always considered or respected. This had not been identified through any of registered provider's audits.

Observations showed that staff were at times firm and brash in their manner and the tone of voice they used when supporting people. We observed staff asking a person to stand up and transfer from a chair into a wheelchair. We noted that they were rough when placing the person's feet on the footplates. We observed two staff that were abrupt and dismissive in their manner towards people they supported. One staff member told a person to 'sit down' when they wanted to go for a walk and another staff member ignored a person when they commented 'it's not very warm in here' and walked off as they had finished their shift. We raised our concerns with the company and area director who have confirmed that refresher training has been arranged in dignity and person centred care for staff.

The registered provider states that their philosophy of care and care planning process is based upon people being 'as actively involved in their care as possible', and 'staying as independent as their care and treatment needs will allow'. Staff were not always respectful and responsive in meeting the needs of people supported.

During supper time on Watergate unit staff were observed leaving a cooled cup of coffee and some food in front of a person who had a visual impairment. Staff did not attempt to prompt or guide the person's hand to the drink or food which meant that the person was unaware of what had been placed in front of them. We saw that another person had been incontinent of urine and this was not noticed by staff for a period of one hour. We spoke with staff and advised them of the support the person required and they addressed this immediately. We found another person had been incontinent of both urine and faeces and we supported them to use their call bell and request support from staff. This meant that people's human rights were not always respected and people were not treated in a dignified and respectful manner.

The environment on Watergate unit had not been adapted to meet the needs of all people supported. The service currently supports a person with a visual impairment and we saw that movement was restricted without staff support as the environment was not adapted to meet their needs. No considerations had been taken regarding the adjustment of lighting, use of braille, sound or touch items for way finding, contrast of colours or placement of furniture in the environment. We raised this with the registered provider who confirmed that following our visit contact had been made with a range of agencies for specialist advice and support.

This was a breach of regulation 10 of the Health and Social Care Act as the registered provider had not recognised or addressed cultural and institutional practice within the service and people's right to choice, respect and dignity were not respected.

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 18 HSCA RA Regulations 2014 Staffing People were placed at risk of harm and receiving unsafe care and treatment as there was insufficient levels of staff to meet their individual needs. Staff skills and knowledge in relation to their roles and responsibilities required improvement. 18(1)(2)(a)

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had not recognised or addressed cultural and institutional practice within the service and people's right to choice, respect and dignity were not respected. 10(1)(2)(a)(b)

The enforcement action we took:

A warning notice for regulation 10 dignity and respect was issued to the registered provider with a compliance date of the 3 October 2016

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 protected from the risk of unsafe care and treatment. 12(1)(2)(a)(b)(c)(e)

The enforcement action we took:

A warning notice for regulation 12 was issued to the registered provider with a compliance date of the 3 October 2016