Nutten Stoven Residential Home

Nutten Stoven Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Nutten Stoven Residential Home is a care home providing personal care to up to 30 people. The service provides care to elderly people and people living with dementia. At the time of our inspection there were 20 people using the service.

People's experience of using this service and what we found
Care staff were not adequately trained. This meant people were at risk of receiving care from untrained staff. A safeguarding system was in place; however, some safeguarding concerns had not been appropriately addressed or followed up by the provider. This meant people were not always kept safe or protected from the risk of abuse. Safe recruitment processes were in place, however, they were not always adhered too.

Although people using the service told us they were happy with the care they received and they felt safe, we found people were at risk due to poor quality risk management and a lack of effective monitoring systems. Staff lacked knowledge on risks related to people's individual care needs and this information was not always available in people's risk assessments and care plans. The environment at the care home was not always made safe by the provider.

Information regarding risks related to the use of medicines and potential side effects was not always available to staff. Medicine administration records were not consistently completed. Opportunities to improve quality of care and people's safety were missed.

Visitor COVID-19 test results were not always requested. This meant people were not kept safe from the risk of visitors bringing COVID-19 into the home. Some care staff were observed not wearing face masks or wearing them incorrectly, such as below the nose. Some areas of the kitchen, including cooking equipment, were found to be dirty. People had access to visitors, and we found the service was working within the principles of the Mental Capacity Act.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published: 24 March 2021).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding and managerial responsiveness. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. You can read the report from our last inspection, by selecting the 'all reports' link for Nutten Stoven Residential Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing and good governance at this inspection. We issued the provider with a warning notice detailing the required improvements. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Nutten Stoven Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by one inspector.

Service and service type
Nutten Stoven Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Nutten Stoven Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our

inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and five relatives, to learn about their experiences of the service provided. We spoke with seven staff members including the registered manager and the provider. We also received feedback from one health and social care professional who knew the service.

We reviewed a selection of care records for five people including medicine administration records, care plans, risk assessments, daily notes and incident forms. We reviewed four staff files and records relating to training, recruitment, performance management and support.

We reviewed a selection of records relating to the management and quality monitoring of the service. These included complaint management, accident and incident monitoring, quality audits, meeting minutes and provider oversight. We also reviewed a selection of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Staffing and recruitment

- Care staff were not adequately trained in safeguarding. Some care staff had not received training in safeguarding and they lacked knowledge on how to identify and report abuse. Some staff that had received training in safeguarding also lacked the required knowledge. This meant safeguarding concerns potentially going unidentified or unreported due to staff not receiving the required training or knowledge.
- Although people using the service told us they were happy with the care they received, we found the provider had failed to provide training to meet people's specific needs. For example, some people using the service had dementia, but staff had not received training to understand and meet these needs. Staff knew the people they supported well but lacked knowledge regarding the symptoms and potential impact of dementia. This meant people were at risk of receiving care from untrained staff who lacked the skills and knowledge to meet their changing needs.
- Mandatory training was not always completed by care staff. For example, some staff had not received training on moving and handling, fire safety and infection prevention and control, despite this training being identified by the provider as mandatory. This meant people were at risk of receiving unsafe care due to untrained staff who lacked the skills and knowledge to meet their needs safely. For example, staff did not follow safe infection prevention and control practices in relation to the use of personal protective equipment.
- Where staff needed additional support to meet training requirements, there was no evidence this was taking place. This meant the provider could not be assured the training needs of all staff were being met.

Staff were not provided with relevant training to provide safe care. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Safe recruitment processes were in place; however, they were not always adhered too. For example, Disclosure and Barring Service (DBS) checks were not completed for one staff member. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This meant the provider could not be assured this staff member was safe to work at the service. We raised this with the provider, they applied for a new DBS check and notified us when it had been completed.
- A safeguarding system was in place to ensure concerns of abuse were recorded. This process was outlined within the provider's organisational policy. However, some safeguarding concerns had not been appropriately addressed or followed up by the provider. This meant people were not always protected from the risk of abuse or harm.

● There were enough staff present to meet peoples' needs, however, people were not always kept safe due to poor staff deployment. For example, staff were not always available for one person who required regularly monitoring.
● People using the service and their relatives told us they felt safe.

Assessing risk, safety monitoring and management
● We found people were at risk of potential harm due to poor quality risk management. For example, risk assessments and care plans related to people's swallowing abilities and mealtime support needs were disorganised or lacking information. Staff lacked knowledge on these support needs and related health conditions; so therefore, did not fully understand how to keep people safe. This meant people were not always kept safe from the risks of aspiration or choking as staff did not have access to the required information or guidance.
● People's care needs relating to falls were not always effectively assessed in order to mitigate risk. One person was at an increased risk of falls due to lack of staff supervision as a result from poor staff deployment. The provider had not considered the benefits of using assisted technology.
● The environment at the care home was not always made safe. Magnetic door release mechanisms presented a risk of injury and a wall mounted electric heater presented a risk of burning. We raised these concerns with the provider, and they told us they would complete works to remove these risks.

Using medicines safely
● There was a lack of guidance available to staff in relation to the use of medicines. For example, the risks and potential side effects related to people taking blood thinning medications were not recorded within care plans, and staff lacked this knowledge and information. This meant people were not always kept safe from potential risk of harm in relation to the use of medicines, due to a lack of information and guidance available for staff.
● Medicine records were not consistently completed. Some medicine administrations had not been recorded. We raised this with the registered manager who stated they checked administration records weekly. However, there was no evidence to indicate this recording error had been identified or addressed. This put people at risk of medication mismanagement due to poor record keeping.

Preventing and controlling infection
● We were not assured the provider was preventing visitors from catching and spreading infections. COVID-19 test results were not always requested by care staff or the registered manager. This meant people were not kept safe from the risk of visitors bringing COVID-19 into the home.
● We were not assured the provider was using personal protective equipment (PPE) effectively and safely. Some care staff were observed not wearing face masks. When care staff were wearing face masks, they were often worn incorrectly, such as below the nose. Care staff were also observed lowering their masks to talk to other staff, visitors or people using the service. This created an increased risk of the spread of infection due to incorrect use of PPE.
● The provider was not consistently promoting safety through the layout and hygiene practices of the premises. Some areas of the kitchen, including cooking equipment, were found to be dirty. This meant the provider could not be assured risks of cross contamination during food preparation were minimised, which placed people at risk of harm.
● We were not assured the provider was making sure infection outbreaks can be effectively prevented or managed, due to staff not wearing PPE correctly or the provider failing to implement safe visitor checks.

● The provider's infection prevention and control policy was up to date, however, practices at the home did adhere to the policy to ensure peoples safety.

Poor risk management, unsafe medicine practices and a lack of effective infection prevention and control was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was accessing testing for people using the service and staff.

Visiting in care homes
● People had access to visitors. We observed visitors entering the home during our inspection and relatives told us they visited regularly.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Some monitoring records were not being used effectively including; quality assurance check lists, cleaning schedules and staff training and supervision monitoring spreadsheets. For example, we found cleaning schedules had been completed before the cleaning activities had taken place. This demonstrated a culture of paperwork being used as a tick box exercise rather than accurately recording and improving care practices to ensure good outcomes for people.
- Although feedback from staff and people using the service about the registered manager was positive, we found there was a lack of opportunity for staff to formally raise concerns. Staff supervision meetings were not completed regularly or in-line with the provider's organisational policy. A lack of opportunity for staff to raise concerns or communicate with the provider is a warning sign of a closed culture. We define a closed culture as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was a lack of effective environmental audits in place to keep people safe. For example, there was no process in place to ensure people had access to a safe environment. This was of concern as we found people to be at risk of potential harm due to environmental hazards, such as an unstable and overloaded shelf or an electric heater located close to a lounge chair. In addition, infection prevention and control audits were not completed regularly and were ineffective at identifying associated risks. For example, they did not identify poor kitchen cleanliness or that staff were not wearing face masks. A lack of robust systems and processes meant the provider could not be assured people were kept safe from environmental hazards.

- There was a lack of quality assurance processes in place to ensure safe and effective care. For example, there was no audit process in place to ensure care plans were up to date and appropriate for people's needs. We found care plans to be disorganised and lacking information about people's health and care needs. For example, one person had sustained an injury due to a fall and the care plan was not updated to include this information or guidance on how to support them. A lack of quality assurance processes meant the provider was unable to identify these concerns to make and sustain improvements.
- Risk oversight was poor. Risks related to people's specific health and care needs were not always

identified or sufficiently mitigated due to a lack of risk oversight systems. For example, systems and processes for assessing falls risk were not always effective and care plans were not kept up to date. This meant people were not always kept safe from the risk of falls. In addition, the registered manager lacked knowledge regarding risks associated with people's needs. A lack of risk oversight meant the provider could not be assured risk was sufficiently mitigated.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider's systems and processes failed to ensure staff conduct and performance issues were consistently addressed. This meant staff were not always supported to develop their skills and improve care practices.

● Staff told us the registered manager was approachable and they felt comfortable raising concerns. However, there was no evidence to suggest issues raised by staff had been addressed to make improvements to care delivery.

● Feedback from relatives of people using the service was mixed. One person said, "The service has gone downhill recently."

Poor risk oversight, the absence of effective systems for staff performance monitoring, and a lack of quality assurance systems was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager was not forth coming during the inspection when documents had not been completed. For example, the registered manager was unable to locate an infection prevention and control audit document. They were not initially forth coming with this information with the inspector.

● Some safeguarding concerns had not been appropriately addressed or followed up, however, our records showed that appropriate notifications were made to the Care Quality Commission as required.

Working in partnership with others

● We observed community district nurses entering the home to complete nursing care activities. Care staff and management facilitated visits by health and social care professionals. We spoke with a local GP surgery that confirmed the service facilitated access to healthcare.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Poor risk oversight, the absence of effective systems for staff performance monitoring, and a lack of quality assurance systems, was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not provided with relevant training to provide safe care. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 HSCA RA Regulations 2014 Good governance Poor risk oversight, the absence of effective systems for staff performance monitoring, and a lack of quality assurance systems, was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Served Warning Notice