Almondsbury Care Limited

Hatherley Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service effective?	**Requires Improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 20 October 2014. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements to gain consent of people in relation to their care and support and ensuring staff were trained to carry out regulated activities.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hatherley Grange Nursing Home on our website at www.cqc.org.uk.

At this inspection we found that some improvements had been made in staff development and gaining people's consent to their care and treatment. However there were still some shortfalls in staff training and support and gaining and recording people's consent.

Most staff had received update training in mandatory courses such as fire safety however there were no plans to address the training needs or evidence the competency of bank staff who mainly worked at the weekends. Whilst qualified nurses had carried some additional clinical training, they had not all completed and up dated their knowledge on the home's mandatory training such as safeguarding people.

People in the home lived with advanced dementia. Their care records did not specify which decisions about their

Summary of findings

care and treatment that they could make for themselves. Best interest decisions had been made on behalf of people however there was no evidence that people had been consulted in the process.

The home had been without a registered manager for several months however a new manager had recently been appointed and had been in post for six days at the time of our inspection. The new manager had started to assess and review the quality of the service and was aware that further improvement was required.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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 effective?

Not all staff had been trained and assessed to have the skills and knowledge to care for people with advanced dementia.

Assessments of people's mental capacity were general and did not provide staff with guidance on how to support people with specific decisions and choices.

Requires Improvement

Hatherley Grange 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 of Hatherley Grange Nursing Unit on 29 June 2015.

This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 20 October 2014 had been made. We inspected the service against one of the five questions we ask about services: Is the service effective? This is because the service was not meeting some legal requirements.

Our inspection team consisted of one inspector. We spoke with two members of staff and the management team, including the new manager. We reviewed the records of five people using the service and documents relating to staff training. People were unable to talk to us due to their complex needs and communication difficulties.

Requires Improvement

Is the service effective?

Our findings

At our inspection of 20 October 2014, we found people were cared for by staff who had not been trained in current care practices. Processes and records showed the consent of people who lacked mental capacity about their care and treatment was not in line with legislation. At this inspection we found that some improvements had been made to meet the regulations, however there were still some shortfalls in staff development and gaining and recording people's consent.

Whilst some staff had completed training in Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) we found the implementation of obtaining and recording people's consent lawfully was not fully understood by all staff. Therefore people's rights were not always protected by the correct use of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make certain specific decisions for themselves. The DoLS protect people in care homes from inappropriate or unnecessary restrictions on their freedom.

Most people who lived in the home were living with advanced dementia and were unable to communicate some decisions about their care and treatment. Their ability to make decisions and choices varied and fluctuated. People's care plans did not always reflect their lack of mental capacity and how they may need assistance to make choices about their day such as what they wished to eat or wear. However, staff knew people well and they were able to tell us how they supported people if they needed help to make certain decisions.

Records showed that people's mental capacity had been assessed and documented in general broad terms. Most people had been assessed by staff as not having the mental capacity to make any decisions about their care and treatment. The recorded assessments did not identify which parts of their care and treatment they were unable to make decisions about or take into account people's possible fluctuating capacity to make specific day to day decisions

Best interest decisions had been made on behalf of some people where specific decisions were required. However, there was no evidence of mental capacity assessments which identified people had been assessed as lacking capacity to make a specific decision. For example a best interest decision to move rooms for safety reasons had been made on behalf of one person. However, a mental capacity assessment had not been completed to evidence that this person was unable to make this decision for themselves. This therefore evidenced that although staff had been trained in MCA they did not fully understand the principles of MCA.

People's care records did not correctly record if they had legally appointed a significant other person to act on their behalf. This meant staff were not given clear recorded guidance on which people had an appointed legal guardian to act on their behalf when dealing with their personal welfare and finance. .

This was a continued breach of Regulation 11, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most care staff had received up to date training deemed as mandatory by the provider. However no clear plans were in place for staff who had not received training or who required refresher courses in line with the provider's procedures. For example six out of eleven staff had not received current training in safeguarding of people. The training of the other six staff had expired or was about to expire. Moving and handling training had expired or was about to expire for seven out of eleven staff. There were no plans in place to address this.

Bank staff were regularly employed by the home and worked mainly at the weekends. These staff were established and familiar with people's needs and the running of the home. We were told by the administrator responsible for training that bank staff received their training from their other employment or from college courses. However the provider was unable to evidence this training had taken place or how the competency and knowledge of bank staff was monitored and assessed to ensure they had the skills to meet the needs of people. This meant that people were supported at weekends by staff who may not have the current care practices required to meet people's needs. For example, only one out of six bank staff had received current training in Mental Capacity Act and Moving and Handling.

The qualified nurses had received some additional clinical training; however they had not received recent training

Requires Improvement

Is the service effective?

considered to be mandatory by the provider. For example, they had not received up to date training in health and safety and infection control. This meant nurses may not have the correct knowledge to observe and assess the skills of more junior staff. The competency levels and skills of the nurses to manage people's medicines had not been assessed or updated.

Improvements in the quality of induction training for new care staff was not inspected as there had been no new staff employed since our last inspection. Staff told us they felt supported by the team; however they had not received any formal personal development and support meetings. The new manager told us they were aware of this and had started to plan individual supervision and group staff meetings to support the staff.

Whilst improvements had been made relating to staff training and support, there were still some improvements needed to ensure all staff were competent and skilled to carry out their role.

This was a continued breach of Regulation 18, 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 legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The care and treatment of people who use services were not always provided with the consent of relevant people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service provider had not received appropriate support and training as is necessary to enable them to carry out the duties they are employed to perform.