Complete Care Homes Limited

Rambla Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 22 and 30 May 2018 and was unannounced on the first day.

At our last inspection in June 2017 we rated this service as good. However, we found at this inspection that there was a deterioration in the standards of record keeping which meant the service has been rated as requires improvement.

Rambla Nursing Home provides care and support for up to 30 people who may have nursing needs. The service is registered to provide care for older people and younger adults as well as people who may be living with a physical disability or dementia. At the time of this inspection there were 29 people who used the service and all required nursing care and support.

Rambla Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager who registered with CQC in December 2017. 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 quality of the record keeping varied and some care records we looked at were not personalised and were inconsistent or incomplete. This meant staff did not have an up to date record of people's care and treatment.

Although we found there was a good level of day to day monitoring and overview of risks and quality of the service by the registered manager, there were few up to date audits to record their observations and demonstrate that they acted on shortfalls in a timely way. The frequency of staff supervisions and staff meetings had dropped below the provider's expected standards. Action was taken during and following the inspection by the registered manager to rectify this.

People told us they felt safe and were well cared for. The provider followed robust recruitment checks, to employ suitable people. There were sufficient staff employed and on duty that they were able to assist people in a timely way. Medicines were given safely and as prescribed by people's GPs.

Staff had completed an induction and attended relevant training to meet people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were able to talk to health care professionals about their care and treatment. People could see a GP when they needed to and they received care and treatment when necessary from external health care professionals such as the district nursing team and speech and language therapists (SALT).

People were treated with respect and dignity by the staff. People said staff were caring and they were happy with the care they received. They or their relative (where appropriate) had been included in planning and agreeing the care provided.

People had access to community facilities and a range of activities provided in the service. People and relatives knew how to make a complaint and six out of the seven relatives who spoke with us were happy with the way any issues they had raised had been dealt with.

People told us that the registered manager was approachable, open and honest. People and staff were asked for their views and their suggestions were used to continuously improve the service.

At this inspection we identified a breach of regulation 17 with regard to poor record keeping.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed safely in the service.

The provider had effective recruitment procedures in place and there were enough staff on duty to meet people's needs.

People were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Is the service effective?

Good

The service was effective.

Staff supervisions were not always carried out regularly, but staff received relevant training to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs.

People received appropriate healthcare support from specialists and health care professionals where needed.

Is the service caring?

Good

The service was caring.

The people who used the service had a good relationship with staff who showed patience and gave encouragement when supporting individuals with their daily routines.

We saw that people's privacy and dignity was respected by staff.

People who used the service were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day-to-day needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were patient and kind when delivering care, but care records were not always person-centred and care and treatment was not consistently documented.

People had access to a range of activities and enjoyed those on offer.

There was an effective complaints policy and procedure in place and people felt their concerns were listened to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although action was taken by the registered manager during our inspection, their oversight of the service had not identified the shortfalls in record keeping beforehand.

There was a clear leadership structure with identified management roles.

The registered manager had submitted notifications to CQC in a timely way.

People, relatives and staff members were asked to comment on the quality of care and support.

Rambla 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.

This inspection took place on 22 and 30 May 2018. Day one of the inspection was unannounced and we told the provider we would be visiting on day two.

The inspection was carried out by one inspector and an expert-by-experience on day one. Day two of inspection was completed by the inspector alone. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to older people.

Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when providers send us information about certain changes, events or incidents that occur. We also received feedback from local authorities that contracted services with Rambla Nursing Home and reviewed information from people who had contacted CQC to make their views known about the service. This information was used in the planning of our inspection.

We had not asked for a 'provider information return' (PIR) from the provider. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We carried out a Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with ten people that used the service, seven relatives and the registered manager. We spoke with six staff who worked at Rambla Nursing Home. We looked at care files belonging to five people that used the service and at recruitment files and training records for three staff. We viewed records and documentation relating to the running of the service, including the quality assurance and monitoring, medication management and premises safety systems that were implemented. We also looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. Staff protected people from avoidable harm and abuse, with systems and technology in place to monitor incidents. Staff were trained in safeguarding people from abuse and demonstrated good knowledge of the procedures to support this.

People and relatives had no concerns regarding the premises safety; there were buzzers on the front entrance doors which visitors had to press to gain entrance. Visitors to the care home had to sign in and out as part of the fire safety procedures. People told us, "I am safe here; my call bell is always near to hand" and "I feel safe. I have to use the hoist to go in my wheelchair. I feel safe when the staff transfer me." One visitor said, "There are staff around if you need them and they are always checking on my relative to make sure they are alright." We observed that call bells were available in bedrooms and were within easy reach for people who used the service.

There were care notes and risk assessments in place that recorded how identified risks should be managed by staff. The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed.

Sufficient numbers of trained and qualified staff were available on duty to meet people's needs and respond to any unforeseen circumstances. We looked at a copy of a dependency tool used by the registered manager and checked four weeks of the staff roster; this indicated there were sufficient staff on duty over the 24 hour period to meet people's needs. Staff told us, "Staffing levels are good" and "We cover any shortfalls as a team."

However, we received mixed comments from people and relatives who told us, "I think there are sufficient staff, when I press my call bell the care staff come within a few minutes", "I find that there are always fresh new faces, but they are all lovely and all have the same skills" and "I think the biggest problem is staffing, they are so busy most of the time." We observed that although the service was busy the staff were well organised and gave people choices about care, whilst ensuring daily routines were completed.

The arrangements for managing people's medicines were safe. People's medicines were kept under review and medicines were administered to people in a safe way. People were helped and supervised if they needed to be. Medications were given on time and people could request painkillers if required. People told us that staff always watched them taking their medicines and never left the room until they had swallowed them. This was to ensure medicines were taken appropriately. We noted that the medicine policy and procedure was not specific for the service; the registered manager told us they would review the policy and develop it so it reflected the current medicine system and working practice within the service.

The provider had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met.

Robust recruitment practices were followed to make sure new staff were suitable to work in a care service.

We observed that staff followed appropriate infection prevention and control practices and wore plastic aprons and gloves when giving personal care. We looked at the communal areas and a sample of bedrooms (with people's permission). Premises were clean and there were no malodours. Visitors told us, "My friend's room is always clean and their bed is always made with clean sheets" and "There is never any smells of urine or bad odours in here."

Records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The fire risk assessment was in the process of being updated with input from the local fire officer. Fire safety training was taking place with the staff and was included on the rolling programme of training. The registered manager had ordered window restrictors for the whole premises and these were due to be fitted on arrival to any window that opened more than 100mm.

Good

Is the service effective?

Our findings

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. Whilst we saw evidence of some supervisions taking place the last few recorded were in March 2018. Staff told us that they did not receive regular formal supervision, but did have daily support from the nurses and team leaders. The registered manager acknowledged that this aspect of practice needed some development. We were told that going forward the team leaders would provide six to eight weekly supervision with the care staff and ensure it was recorded. Other heads of departments would be responsible for their staff team supervisions.

We asked people and relatives if they thought the staff were well trained and did they think they were able to meet their needs. Comments included, "All the staff have the right skills to look after my relative, they know what they are doing", "My relative uses the hoist and all the care staff have very good skills to keep them safe" and "They are trained to help me if I require help."

Staff were competent and skilled to carry out their roles, which we evidenced through discussions with them and viewing their training records. Staff were required to complete a three day induction when they started working for the service. The induction included training that the provider considered to be 'essential', such as fire safety, infection prevention and control, dementia care and health and safety. Training was provided by the organisation's training department or external bodies and covered a wide range of care areas. There was an annual programme of refresher courses and new subjects for staff to attend.

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. Where people lack mental capacity to make 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 MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that people had been assessed for capacity, and DoLS referrals were being made to the supervisory body. Our observations of staff and people interactions showed that people were given daily choices and their wishes and decisions were respected by the staff. For example, we saw that people were able to get up when they wished with no pressure from the staff to do this within a set time limit. People told us that staff always asked for consent before they carried out any care task.

Evidence in the care files showed that people had good access to healthcare professionals such as the dentist, optician, and practice nurses. We saw that input from these specialists was recorded on the multi-disciplinary visit records. People were clear about how they could get access to their GP and said that staff would arrange this for them.

We received feedback from a healthcare professional who had expressed concerns that so many people in the service were nursed in bed. However, people who spoke with us indicated this choice was theirs. The service supported a number of people with end of life or palliative care needs; for these people the choice to stay in bed or get up was very dependent on their day to day health.

We observed that people who stayed in bed had appropriate pressure relieving mattresses in place. Technology was available to assist staff in the effective support of people with physical needs and those living with dementia, so that they maintained independence while ensuring their best interests. For example, where people were assessed as at risk of falls they had sensor mats to alert staff when people moved around, so appropriate support could be given.

Staff offered people appropriate support with eating and drinking. People were offered different options of meals until they found one they liked. The food smelt appetising and there were ample portions. Most people chose to have lunch in their bedrooms. We observed pureed diets for some people, which smelt lovely and were arranged nicely on the plate. Assistance with eating and drinking was observed and we saw that staff did not rush people.

Discussion with the staff revealed that people were provided with meals that respected their religion, culture and dietary preferences. People, especially those with complex needs, were protected from the risk of poor nutrition, dehydration and swallowing problems that affected their health with support from dieticians and speech and language therapists. Care staff informed us that people's nutritional intake was monitored and documented in their daily records, which we reviewed.

Whilst we recognised that the service was a nursing home and not a specialist dementia unit, we observed that the provider had not made many adaptations for people living with dementia, memory loss or the visually impaired. All bedroom doors were the same colour which would make it difficult for people to differentiate between rooms. There were no pictorial signposts showing the way for the dining room, lounge and toilets/bathrooms. Individual signage was not on communal doors for example the toilets and bathrooms. However, as many people stayed in their rooms or were nursed in bed the impact on people was minimal. The registered manager told us that this was an aspect of the service that the provider was looking to develop in the future. People did have access to a well maintained garden area, and for those people who smoked there was a smoking area on the patio.

We observed on the notice board near the entrance hall, leaflets on Alzheimer and Memory Loss and details for the Dementia Action Week. There was also information to families that memory boxes were going to be made, each individual and personal to the people who used the service.

Good

Is the service caring?

Our findings

We received very positive comments about the care received by people who used the service. We observed staff interacting with people at every opportunity and saw them chatting to people calmly and reassuringly in a kind and friendly manner.

The atmosphere within the service was pleasant and staff had respect for the people they supported. Staff addressed people by their preferred name and it was very noticeable that there were affectionate and meaningful relationships amongst them.

Relatives told us, "Nurses always sit and chat to my relative when encouraging them to drink" and "My relative has told us that they are very happy here with the way they are supported and how they are treated by staff." One person said, "I am very well looked after, the nurses are very good here. They are caring and I get on well with them all."

People were treated with dignity and respect without discrimination. This was at the heart of the culture and values demonstrated at Rambla Nursing Home. We received positive comments on how staff promoted people's privacy and dignity. People told us that toilet and bathroom doors were always closed, and staff always knocked on the doors before entering their bedrooms. We saw 'Please Do Not Enter' on bedroom doors when personal care was being given. Visitors told us, "I hear staff asking my relative 'can we do this; can we do that' when I am waiting outside during personal care" and "Curtains and doors are always closed when giving personal care. Once staff have finished they always come to find me to let me know that they have finished, so I am not left waiting."

We observed that where possible people could make their own decisions and choices for themselves. Some people preferred to stay in their rooms for long periods of time, but this was their choice and staff respected this. Some people didn't want to join in with activities preferring to watch television or read in their bedrooms.

People could get up and go to bed when they wanted and made decisions about their daily lives. They told us, "I like my breakfast in bed first and then the care staff wash me. I have only been in the bath once and I didn't care for it much, I prefer to have a bed bath" and "I like to go to the dining room for my lunch, I like to have my breakfast and evening meal in my room."

We observed that staff promoted people's independence; we saw people walking independently with their walking aids and they could mobilise freely around the service. One person said, "I walk to the bathroom with the nurse so that I can get a little exercise."

People and relatives said they had good communication with the staff. Staff had a communication book for daily appointments and the nurse on duty completed a verbal handover with staff between each shift. Handover sheets were also available to look at and staff found these useful to read when they had been off duty. Staff we spoke with were knowledgeable about the people they supported and had a good

understanding of their current needs.

The provider had a policy and procedure for promoting equality and diversity within the service. Discussion with staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and we saw that equality and diversity information such as gender, race and religion, was recorded in the care files.

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager. An advocate is an independent person who supports someone so that their views are heard and their rights are upheld.

Staff maintained confidentiality of information, supplying details to other stakeholders and professionals on a need to know basis only. An equality, diversity and human rights approach to supporting people's privacy and dignity was embedded in the service. We saw that all interactions were discreet, respectful and reflective of needs.

Requires Improvement

Is the service responsive?

Our findings

During our inspection we found that care file paperwork was not always completed or up to date. One file, for a person newly admitted to the service, lacked information. The pre-admission assessment was insufficiently completed and the consent form was blank. There was no photograph for identification and their body map was blank although the person had been admitted with a pressure sore. We noted that there was no wound care record, the nutritional risk assessment was not completed and there were no care plans in place. We found there was no information in the care file about mental capacity, deprivation of liberty or power of attorney so it was difficult to understand if the person was able to make their own choices and decisions around their care and support or if they required an advocate to do this for them.

We spoke with the nurse on duty who told us, "Normally the staff would try to have care plans completed within 48 hours of admission, but this is difficult to achieve at the moment due to workload pressures." We fed this back to the registered manager who said they would speak with the staff. By day two of our inspection the care file had been updated and the relevant documents completed.

The second file we looked at had some wound care records but it was unclear if the wound was now healed as it was last recorded on 27 April 2018. We discussed this with the registered manager who said they would speak with staff and ensure the wound care records and care plan were updated. This was done by day two of inspection. We found that the wounds had healed but staff had not amended the documentation and filed the records.

The information in the care files were not clear about the current needs of each person who used the service. This could make it difficult for any new staff or people not familiar with the person's care and support needs to give consistent care. We found that changes to care were put onto the review sheets within each care file, but the care plans were not updated to reflect people's new needs. On day two of inspection we saw that work had taken place to improve the care file documentation. However, this could be improved further.

We spoke with one visitor who had concerns about their relative's care. We looked at the person's records on day two of our inspection and found that care was given appropriately, but their records were not always up to date. Their food and fluid charts often recorded no fluids or care interaction between 17:30 and 21:00. However, observations of the individual showed that they were hydrated and had no pressure sores. This indicated that appropriate fluids and pressure care were being given. Staff also told us about the care they gave to the person on a daily basis.

Oral assessments were in all of the five files we looked at but only two were completed. The registered manager told us, "Going forward the team leaders will be supporting the nurses to ensure that documentation is in order and documents are an accurate reflection of the care being provided."

The above evidence showed that there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we had concerns about the documentation within the care files we observed people received appropriate care and support during our inspection. Relatives told us, "Staff are very good, they are kind, caring and very helpful. You can't fault them at all. My relative gets good continuity of care" and "The care is very good, superb. Staff are very friendly and take time out to speak to my relative."

Staff ensured that people and their families were involved, listened to and informed in developing their care plans with regards to their preferences and decisions for end of life care. The process included support from appropriate professionals, where necessary. Staff consulted professionals about a dignified and pain-free death and facilitated the receipt of anticipatory medicines that could be administered at short notice.

Staff had the skills to support people particularly in relation to their diverse needs on the grounds of protected equality characteristics, and had knowledge about, for example, people's religious rituals and customs for end of life support. Staff made sure people's dignity and comfort were maintained by ensuring they had appropriate equipment, nourishment, medication and personal care to keep them free from pain and discomfort. One person who we met said they were very comfortable in their bed and we noted that staff attended to their needs on a regular basis.

Families were made welcome in the service and were able to assist their loved ones with their care and support as wished. A visitor told us, "Staff are lovely with our family and include us in our relative's life. They [relative] receive excellent care, the staff love them and are respectful and courteous. We are really happy with the care being given by the staff."

The provider employed two activity co-ordinators, one working full-time and alternate weekends and another who worked Thursday and Friday for six hours a day. A lot of the people we spoke with didn't join in with any of the activities on offer. They preferred to stay in their rooms although they were always asked if they wanted to join in. One activity co-ordinator said, "The majority of my time is spent doing one to one work with people in their bedrooms. When it is good weather we try to encourage people to spend time in the gardens having tea and cake or playing games."

People told us, "I don't care much for joining in the activities, I prefer to read or have a sleep", "I go into the garden if it is nice; I went to Scarborough the other week" and "I watch television or just lay in bed. I do get asked if I want to join in with the activities, but I don't have the energy." One person said, "I like to read and sometimes join in with the activities. [co-ordinator] is brilliant and always asks if I want to join in."

People were able to maintain friendships with friends and family. They told us, "My family come to visit me and take me out", "My family take me to the shops over the road" and "My relative comes to visit me four times a week, so I rarely join in with any activities…me and my family had a picnic in the grounds last week when it was a nice day."

People knew how to complain and who to approach. They said that they would feel comfortable to make a complaint if they needed to. Comments included, "Yes, I know about the complaints procedure, I would not hesitate to complain if I had to" and "I have never had any concern to complain about." One relative said, "Yes, I would know who to contact if I had any issues." We observed in the reception that there was a complaints procedure on the wall and information was provided to help people understand the care and support available to them.

The provider complied with the Accessible Information Standard (AIS), which sets out a specific approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people with disabilities, impairment or sensory losses. They achieved this by assessing and identifying and

then managing people's individual communication needs.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was successful in registering with CQC in December 2017. They were supported in their role by the nurses and team leaders within the service. The registered manager of the service had a good understanding of their role and responsibilities with regard to the running of the service. However, they were extremely busy as they held the role of both registered manager for the service and nominated individual for the company. The impact of this meant that although they were duty on a regular basis, they lacked time to document their monitoring and oversight of the service.

During our inspection we spoke with the registered manager about the quality of the documentation and records within the service. In this report we have mentioned that records we looked at were not personalised and were inconsistent and incomplete at times. Although we observed staff gave empathetic care, on-going assessment, review and updating documents needed to become a proactive process to take account of and respond to people's changing needs in a timely way. Following our discussion with the registered manager, on both day one and two of inspection, they took swift action to make improvements to the documentation and spoke with staff about what was needed to change practices.

We found no evidence of formal quality monitoring and oversight through completion of audits since January 2018. However, the registered manager was knowledgeable about the service and the people who used it. They completed a walk-a-round the service each day and this was confirmed by people who told us, "Yes I know the manager they are very approachable" and "I see them around the home." People told us they would have no concerns in approaching the registered manager if they had any worries or concerns.

Staff supervisions had lapsed slightly and staff said they did not have regular meetings with the registered manager. They told us this meant they were not easily able to discuss issues with other staff or find solutions. The lack of supervisions also meant another opportunity to voice their opinions was lost. Following the inspection the registered manager held two staff meetings to discuss the inspection. At the meetings staff decided they would hold monthly meetings which would be self-directed where any issues could be raised and solutions proposed. Regular supervisions were also recommenced led by team leaders and heads of departments.

People we spoke with were not aware of any resident/relative's meetings, however displayed on the notice board to the entrance of the home, was information of the 'Manager's Open Door Meeting' on a Friday between 2 – 4pm. This indicated that people were given opportunities to have their say about the service and/or their care. We also saw evidence that the registered manager kept families up to date through emails.

There was no feedback from stakeholders such as people, relatives, staff and healthcare professionals through the use of satisfaction questionnaires. The registered manager said these were sent out in March 2018, but none were returned. We were informed that these had been reprinted and were being handed out to people and their relatives.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to the person and of decisions taken in relation to the care and treatment provided. Regulation 17 (1) (2) (c)