Sonesta Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 9 March 2016. It was an unannounced inspection. We last inspected the home on 5 November 2015 and breaches of legal requirements were found. This was because we found that people were not always treated with dignity and respect, risk assessments to help staff to manage risks were not always detailed enough, and there were not always effective systems in place to manage the service well.

We undertook this unannounced focused inspection of 9 March 2016 to check that the provider had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to these matters. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Sonesta Nursing Ltd on our website at www.cqc.org.uk .

Sonesta Nursing Limited is registered to provide accommodation with nursing and personal care, diagnostic and screening procedures and treatment of disease, disorder or injury for up to 32 people. The people living at the service are older people, many with dementia and physical health needs. There were 24 people living at the service at the time of inspection.

During this inspection we met the registered manager who had run the home for over 16 years, and was also the owner. The conditions of registration for the service state that a registered manager is required. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection, there was good feedback about the caring nature of staff and we saw good interactions between staff and the people using the service. We saw people were treated with dignity and respect and this was confirmed by people living there.

We found risk assessments had been updated and were thorough so staff were aware of people's needs and were given detailed guidance on how to keep them safe.

We saw the registered manager had begun to put in place more effective audits to monitor the quality of the service. She had been supported to do this by officers from the local authority and told us she was committed to undertaking these on a regular basis. We found evidence of the registered manager discussing the breaches identified at the inspection in November 2015 with staff, people living at the service and relatives, and action had been taken to improve the quality of the service.

As a result of the above, we found that the provider was no longer in breach of the regulations identified at the inspection on 5 November 2015.

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

We found that action had been taken to improve safety.

Medicines were safely administered

Staff knew about safeguarding and how to report it.

Risk assessments had improved and were now detailed and up to date.

Is the service caring?

Requires Improvement

The service was not consistently caring. People said they found staff caring and we observed caring interactions.

The service had focused on improving people's experience of care since the last inspection and care records held information on people's likes and dislikes.

People were supported with their cultural and religious needs.

Is the service responsive?

Good

We found action had been taken to improve the responsiveness of the service. Care plans had been updated and were now comprehensive.

There were limited activities in the home and opportunities for people to go out of the service.

We saw people's health and care needs were met.

Is the service well-led?

Good

The service was not always well led. The manager had a hands on approach and was involved in day to day lives of people.

The registered manager had started to undertake comprehensive audits to check the quality of the service provided.

Sonesta Nursing Home Limited

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 inspection of Sonesta Nursing Home Ltd on 9 March 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 5 November had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, is the service caring, is the service responsive and is the service well led. This is because the service was not meeting some legal requirements.

The inspection team consisted of one inspector, one specialist nurse adviser and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the inspection we looked at information we already held about the service. We reviewed previous inspection reports for this service and reviewed notifications made to the CQC.

We talked with eight people using the service, one relative, and four staff members including the registered manager. We looked at eleven care files, two care records relating to moving and handling, and 15 medicine administration records. We looked at audits in relation to medicines, care plans and infection control. We look at files in relation to Deprivation of Liberty Safeguards (DoLS) and staff meeting minutes since the last inspection in November 2015.

We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also inspected the building.

Good

Is the service safe?

Our findings

At our inspection on 5 November 2015 we found the clinical room door in the entrance hallway was open on a number of occasions. This was of concern as there were three freestanding oxygen cylinders which were not attached to the wall which could put people at risk if they fell over.

At this inspection we found the clinical room was locked at all times and the oxygen cylinders were attached to the wall.

At the last inspection we found risk assessments did not have a good overview of risks and did not contain enough detail about how to support people to manage risks.

At this inspection we found there was evidence of comprehensive risk assessments, including those relating to falls, moving and handling, pressure ulcers and nutrition. We saw evidence the risk assessments were regularly reviewed and updated. There was evidence of the development of appropriate care plans to mitigate the risks, with guidance provided to staff members on delivery of that care. The care plans were clear and instructive.

There were sections in the front of the files, entitled "Nursing Assessment" that gave staff members a brief description of care need. This meant that a carer could understand the basic needs of individuals, without having to read every section of the care plan. The assessment form included detail on mobility (including equipment and staff numbers required), sleeping, washing and dressing, eating and drinking (including food and fluid consistency), skin and pressure sores (including creams and turning regimes), pain management, mental state and maintaining a safe environment.

We saw that regular reviews were taking place and all records had been reviewed within the previous four weeks. There was evidence of responding to risk with referral to appropriate services, for example, tissue viability service and dietician. There was evidence of seeking out personal preferences, routinely in the care planning.

At the last inspection we found that there were some gaps in records regarding medicines. We looked at 15 medicine administration records and found them to be appropriately completed, identify known allergies and contain photographs of the named people. We observed the nurse administering medicines to people and noted that this was done appropriately. We checked signature initials that confirmed appropriate administration of the medicines, and noted routine prescribed medicines were noted to have been signed for, with the exception of one entry the evening before the inspection. Where 'as needed' medicines were administered, the time was noted. We looked at four prescribed cream containers and noted that, as appropriate, the date of opening the medicine was recorded on the container.

We noted that in the records for one person who was at the service on a respite basis there was no front sheet identifying key details, allergies or photograph for the purposes of medicine giving. We also noted there were no as needed, PRN protocols to guide staff on the reasons for the PRN use and any other

guidance that might be considered before administering the PRN medication. The registered manager undertook to address both of these issues.

At the last inspection we saw that carpets in the hallways and on the stairs were heavily stained and worn in places. On the lower ground floor the lino flooring was torn in places and held together by tape. The lino was peeling away from the walls in some areas and there was a tear in the lino causing a trip hazard coming out of the lift on the lower ground floor. We noted that the bathroom on the lower ground floor had damaged flooring around the base of the toilet and looked stained and soiled and poorly fitted.

Between the inspection on 5 November 2015 and this inspection two bathrooms had been renovated, and carpets were no longer stained. The flooring on the basement level remained in a poor condition but was due to be replaced by the end of April 2016.

At the last inspection it was noted staff members had on two occasions turned off call bells remotely without first checking that the person who had made the call had been responded to by a staff member. We had spoken to the registered manager and nurse manager about this and they said they would enquire if they can have the system adapted so it can only be answered inside the room where the call has been made.

At this inspection we did not see any call bells being answered remotely. The registered manager told us she plans to introduce a new call bell system in the summer of 2016. We could see from records that at the staff meeting on 18 November 2015 best practice in relation to call bells was discussed and it was made clear that answering bells remotely was not acceptable. The registered manager told us she also monitored the practice herself as well as asking service users their experience of being responded to. We checked two residents' rooms and noted that there call bells were within their reach. In a third person's room we noted a person's bell was behind the raised bed head out of reach. When the bell was passed to the person they rang it and staff came promptly but they kept on ringing it even after the staff had called on them twice. There did not appear to be a strategy for dealing with this behaviour apart from removing the bell. We discussed this with the registered manager who told us they ensure they regularly go into the room to check this person was fine. When the person kept ringing the bell they did leave it out of reach until this time passed.

At this inspection we spoke with the registered manager regarding staffing levels. The shift patterns for working were 8am to 8pm with two nurses on duty and four carer staff and 8pm to 8am with one nurse and two carer staff on duty. Whilst we did not identify any specific instances where there appeared to be insufficient staff, we did query how peoples' needs were met at night given the number of people living at the service who required two people to transfer. The registered manager told us she was not aware of any issues with meeting peoples' needs at night but was continually reviewing staffing levels. She also told us that where people needed to attend appointments in the day she placed more staff on the rota to meet these requirements.

Requires Improvement

Is the service caring?

Our findings

At the inspection in November 2015 people using the service told us the staff were kind and caring in their interactions. At this inspection one person told us "It is quite good living here. [The carer staff] are friendly." Another person told us "They look after me extremely well. When I arrived they were all standing around my bed smiling and saying "Welcome". I just relaxed. You can have a joke with the staff, nothing is too much trouble."

At the last inspection we heard a member of staff approaching a person and asking loudly and in a manner that could be heard by the whole room, "Do you want to go to the toilet?" We observed that when using the hoist to raise a person in their chair, staff members left the persons stomach exposed throughout. No effort was made to cover them up until the procedure had been finished. We also noted that a staff member, when using the hoist was efficient but that people were given little reassurance or encouragement. People were not requested to make movements but instructed in a tone that though polite, was delivered as a command. They were given no opportunity to have any control or say over what was going on. This was observed on three occasions.

At this inspection we noted staff talking with people in a quiet manner and with the exception of one member of staff, all were interacting positively with the people they were supporting to eat lunch. We spoke with the registered manager regarding this and she undertook to speak with the member of staff. People were not rushed with eating, and there was a relaxed and calm atmosphere in the sitting room. People told us "We always get a choice of food. It's good." One person who was staying at the home for a short term respite placement told us "[The caring] is excellent plus from every point of view; material, social, psychological. A practical lesson in how to care for your fellow humans. I can't see anything that's lacking here."

We noted many positive interactions between staff members and people living at the service throughout the day but noted there remained the odd occasion when a staff member acted without speaking with a person. For example, such as putting a straw into someone's mouth so they could drink without saying anything, or moving their wheelchair without saying anything. The registered manager undertook to discuss this issue with staff on an ongoing basis. We noted from records that there was evidence of residents refusing support and this was respected by staff. For example one person refused to have eye drops that were prescribed. This was recorded in their notes.

At the last inspection we noticed staff did not always wait for a response after knocking before entering people's rooms. At this inspection we observed staff knock and await a response before entering residents' rooms.

At the last inspection we observed two staff members having a whispered conversation while one of them was assisting a person with eating. The conversation was in the staff member's first language that was not English. We heard on several occasions throughout the day staff members whispering to each other in communal areas and corridors and then stopped when we approached or walked past. This may have made

people feel uncomfortable as staff were not being open about what they were communicating, both in the language they were using and in their whispering.

At this inspection we listened to conversations between staff and residents. Despite the multi-cultural nature of the staff and residents, the staff conversed in English between each other, but spoke in the first language of people living at the service where this was relevant. This was of benefit to people living there. We did not witness any whispering between staff.

The people who live at the service and the staff are from a wide range of cultural and ethnic backgrounds. This meant that people had staff caring for them who could speak their first language which was not always English. The majority of meat was Halal and staff were aware of people's religious requirements.

Following the inspection in November, a staff meeting had been used for training to discuss the importance of dignity. Elements of the training included understanding people's backgrounds, supporting their choices, likes and dislikes and religious and language needs. We found on each file a document relating to dignity for each person. For example, one document told us about the person's personal background, their current family and friends and the way they communicated with their next of kin. It also noted the person required a head scarf at all times, stated they were to always be offered a shower on Fridays for religious reasons and they wanted to observe all religious festivals.

Files contained Do Not Attempt to Resuscitate (DNAR) forms, as required. These were in the main appropriately completed by General Practitioner and some confirmed discussions with relatives and clinical team. One DNAR confirmed discussion and agreement with the resident, who was noted to have mental capacity.

On two care records, although the DNAR forms were completed by a GP, as lead clinician, there were some concerns about the appropriateness of the completion. For example, one form on a care record was signed and dated 22 February 2016 by the general practitioner but no other sections were completed. It was important for these sections to be completed prior to signature to ensure the proper process to have been completed. We spoke with the registered manager regarding this issue who undertook to do an audit of all the DNAR forms to ensure they had been completed appropriately.

Care records contained choices and information on post death arrangements or family members who had agreed to make decisions in this situation so people's wishes could be respected.

Good

Is the service responsive?

Our findings

At the last inspection we saw that care files were not person centred and did not always reflect the preference of people, they used several of the same phrases and sentences, with many general and nonspecific interventions such as "discuss with multidisciplinary team, "ensure privacy".

At this inspection we could see that records had been updated so they now had person centred information on them. We could see people's personal histories, likes and dislikes and wishes were recorded. We could read recommendations as to how to interact with someone. For example, for someone with hearing problems the file said "Make her aware of your presence by standing in front of her and touching her hand lightly."

The care plans showed routine use of risk assessment and clear guidance for staff in respect of mitigating the risk. For example, Waterlow skin assessments and pressure relief regimes and equipment were utilised. There was guidance on food intake in response to a choking risk and there were prescribed numbers of staff and use of specific equipment to mitigate moving and handling risk, for example sliding sheets, hoists and pressure relieving equipment. There was also evidence of appropriately responding to needs as they arose. For example, referral to GP, dietician, tissue viability nurse and speech and language therapists as appropriate.

We looked at the record of one person who had had leg ulcers. The nursing response was appropriate, skin risk assessments were implemented and regularly reviewed, pressure relieving equipment was provided, re-positioning regimes were in place and appropriate recordings made and body mapping was completed. The wound was photographed and dated, with care plans updated as required and involvement from the tissue viability nurse was provided.

We noted that one resident had been admitted to the service with pressure ulcers which had now healed and we were told no current resident had any pressure ulcers. This is evidence of effective nursing care taking place at the service. .

At the last inspection we spoke with people about when they went to bed and if this was their choice. Also a relative had told us they said to a member of staff that it seemed a bit early for their relative to go to bed, but the staff member said that was what the person had wanted. The person had reported to their relative that was not the case, and "they just moved me."

We asked people living at the service whether they thought they had choice in relation to routines. We heard quite divergent views. For example, one person told us "They come [to get me up] when it's convenient [to them] I suppose. I go to bed about seven-ish, some go much earlier. I've got used to it." Another person told us "They come immediately if I call them [using my bell]. I decide when I want my sheets changed. I more or less do what I like within reason. The manager said to me: "This is your home and we are here to serve you."

We asked the registered manager why so many people were taken to their rooms early in the evening. She

told us that for some people they had developed routines and when one person was taken from the lounge to go to their room others then also wanted to leave. The registered manager undertook to continually review people's schedules and routines to ensure they were person centred and not simply established to suit the needs of staffing schedules.

We noted at lunch that whilst some people were not able to communicate with each other, there was a physical distance between three people who could have spoken to each other. We asked the registered manager why these three people were not seated around a table rather than with individual tray tables in front of them. She told us that with the exception of the person in respite they had tried to seat people nearer to each other, but they had become distressed at the changed space they occupied so had asked to be moved back to their specific areas.

At the last inspection we noted that a number of people remained in their rooms for long periods of time and were at risk of social isolation. We saw from records and heard from talking with people during this inspection that some people chose to remain in their rooms. We saw from records one person was reported to be uncommunicative but was known to enjoy Nigerian films. A supply was noted to be within their room. We were also told by the registered manager that another person didn't speak much English and as she enjoyed watching Asian language dramas she spent much of her time in their room.

We noted the level of need of the majority of the people living at the service was very high. Most people needed the assistance of two staff to transfer and all had nursing needs. There were activities carried out both morning and afternoon by an activities co-ordinator, who also staffed the reception area, and the registered manager. Activities were limited but included quiz games, bingo, dominoes, reminiscence work and attendance by a musician.

We discussed whether people were taken out by staff to activities. Whilst the registered manager told us they did take people out on occasion, it was acknowledged no-one had been out with staff in the last month, or there was no evidence in records of outings. The registered manager undertook to look at more opportunities for people to go out even if only to be pushed in their wheelchair outside to get fresh air. There was a garden people could sit outside in when the weather was warmer.

Good

Is the service well-led?

Our findings

At the previous inspection we were told that the service was held in high esteem by people, relatives and staff. The feedback we had was that people were happy in the service and that relatives and other professionals felt the service offered good care and support. However, we found there was not a sufficient quality assurance process in place to ensure care records and risk assessments were up to date and safe. We also found the registered manager had not ensured that people living at the service were routinely treated with dignity and respect.

At this inspection we could see the registered manager was involved in the day to day activities of the service and knew staff and people living there well, so was in a good position to monitor staff's interactions with people living there. We could also see from records that following the inspection the registered manager had met with people living at the service, staff and some relatives regarding the inspection report and the issues raised. Staff meetings usually took place every three months, but there had been five meetings since November to discuss issues or provide training.

We could see that care records had been audited and updated in January 2016 and the registered manager had further audited eight care records in February. She had undertaken to routinely audit eight care records monthly. All now had current information. Information relating to people's dignity was embedded in the care plans but also documented on a separate sheet within people's care records so it was easy to find. We could see that whilst a limited medicines audit had taken place monthly prior to the last inspection, the new documentation for auditing medicines was more detailed. We could also see evidence of new audits being carried out in relation to pressure sores and hygiene and infection control. We also saw the records relating to Deprivation of Liberty Safeguards were up to date.

The registered manager could show us quality assurance questionnaires completed since the last inspection. Three had been completed by people living at the service, one by a reviewing officer, and one by a relative. All were complimentary regarding the service.

The registered manager told us that she had received helpful support with quality issues from local authority staff and would continue to do so until the new quality assurance processes were fully embedded and took place on a regular basis.

Areas of the home that had been identified as needing modernisation had either been completed or were in the process of being completed by the end of April 2016.