Dibcan Limited

Witnesham Nursing Home

Inspection report

The Street
Witnesham
Ipswich
Suffolk
IP6 9HG

Tel: 01473785828

Date of inspection visit:
13 March 2017

Date of publication:
28 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The service had a registered manager. 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.

People told us they felt safe living at Witnesham Nursing home and we saw staff worked as a team to help keep people safe. Staff demonstrated they understood how to keep people safe and risks to people's safety and wellbeing were assessed and kept under regular review. People's medicines were managed safely, by staff who had received training. Improvements were needed in the protocols for the administration of medicines prescribed to be given 'as required' (PRN).

People's care plans and risk assessment had been revised since our last inspection. People and their relatives, where appropriate, had been involved in the writing of the new care plans. The new care plans still required further improvement as some did not always identify how people's needs and preferences were met.

The service provided a variety of activities but these were not always targeted at people's expressed interests.

People had their needs met in a timely way and we observed there were sufficient numbers of staff who had the right skills and experience to support people safely. There were recruitment process in place, records demonstrated that the appropriate pre-employment checks had been completed. Staff were supported by the management team and received regular one to one supervision. Staff told us they felt supported by the registered manager and provider.

People received the assistance they needed to eat and drink sufficient amounts to help keep them healthy. They told us that the food was good and we observed people being offered a choice of food for their lunch. People were supported to maintain their overall health and staff made referrals to healthcare professionals when required.

We observed staff to be kind and caring. They staff knew people's individual requirements in relation to their care and support needs and preferences. People and or their relatives had been involved in the planning of their care where they were able to and where this was appropriate.

People and their relatives were positive about the staff and management at the service. There were systems and processes in place to regularly monitor the quality of the care and support provided for people who used the service. However, these now needed to be embedded into the service and had not been in place long enough for us to assess if they were effective.

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 not consistently safe.

Medicines were managed safely but protocols for medicines to be administered 'as required' required more detail.

Risk assessments identified actions to be put in place to mitigate any identified risks.

There were sufficient numbers of staff on duty to meet people's needs in a timely way.

Staff had a good understanding of safeguarding processes and how to raise any concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The environment did not always meet people's needs.

Staff had received training in the Mental Capacity Act but people were not always offered choices in all aspects of daily life.

People enjoyed the food and were offered choice in what they ate.

People were supported to maintain good health and access healthcare services.

Is the service caring?

Good

The service was caring.

Staff treated people with compassion and respect taking steps to maintain people's dignity when required.

Care plans demonstrated that people had been involved with writing them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans recorded people's preference but did not always detail how these would be met.

The service provided a variety of activities but these were not always directed towards people's preferences.

The service had a complaints procedure and people were aware how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider carried out audits to check the quality of the service provided however these had not been in place long enough for us to confirm they were effective.

There was an open and honest culture within the service.

The provider was aware of the importance of forward planning to ensure the quality of the service provided.

Witnesham 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 checked 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 13 March 2017 and was unannounced.

The inspection team consisted of an inspector and an 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. Our expert at this inspection had experience of caring for a person who used this type of service.

Before our inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with six people who used the service and five relatives. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection. We spoke with the provider's representative, a consultant employed by the provider to support improvement, the registered manager and three members of care staff.

To help us assess how people's care and support needs were being met we reviewed four people's care records and other information, for example risk assessments and medicine administration records. We looked at four staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Good

Is the service safe?

Our findings

Our inspection of 26 July and 16 August 2016 found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because protocols for the administration of medicines prescribed to be administered as required (PRN) were not sufficiently detailed to ensure consistent administration. Our inspection also found that the assessment of risk was inadequate and that risk assessments were difficult for staff to follow and did not always put actions in place to mitigate risks. At this inspection we found that improvements had been made.

Protocols for the administration of PRN medicines had been updated and contained improved guidance to staff as to when this medicine should be administered. However, in some cases these still did not provide staff with sufficient guidance to ensure the medicine was administered when it was needed. For example the protocol for the administration of pain relief for one person with arthritis read 'Needs to be given when arthritis gets worse.' We asked staff on duty when they would administer this medicine and they explained that the person expressed pain via their facial expression or would not let staff support with personal care when they were in pain with their arthritis. However, they did not know if this information had been communicated to staff on different shifts. The lack of written guidance on when the person required their analgesia could result in them not being given it when required as some staff may not be aware of the behaviours they would exhibit.

People's care plans contained guidance to staff as to how people liked to receive their medicine. For example one person's care plan recorded that they liked their medicine with a glass of orange. Medicines were stored and managed safely. A medicine policy was available to guide staff and records showed that staff had completed training in relation to safe medicine administration and had their competency assessed. Medicines were stored in trolleys in a locked clinical room and the temperature of storage area was monitored and recorded daily.

Following our July and August 2016 inspection risks to people from receiving care and support had been re-assessed and their risk assessments had been re-written. Care plans demonstrated that people and their relatives had been involved in the revised assessments. Risk assessments contained detailed information on how identified risks were managed. For example, one person required support with their mobility. Their care plan contained a risk assessment for falls and their moving and handling. These detailed how the risks were mitigated with actions such as keeping their room clutter free. Their care plan contained full details of how staff should support the person when they were transferring from their bed to a chair.

The service also used nationally recognised risk assessments such as the Malnutrition Universal Screening Tool (MUST) to assess and monitor people's nutritional state and Waterlow scoring to monitor people's skin condition. These were regularly updated and actions to address any identified risk had been put in place. For example one person's care plan contained details of how a person should be re-positioned every two hours to maintain their skin integrity.

The consultant showed us a computer tool they had recently begun to use to monitor the incidents of falls.

They explained this could be used to monitor numbers and trends. For example when information about any falls had been input into the system it could be used to analyse the time and location of any falls.

People told us they felt safe living in the service. One person said, "No doubt about it, I'm safe." A relative said, "No concerns about [person's] safety, [person] really can't walk on [their] own and [they] has a carer with [them] all the time, that's one thing I don't have to worry about, [person's] safe."

Staff we spoke with were knowledgeable about adult safeguarding and how to report concerns. They were able to explain how they would report any concerns they may have. A policy was in place to guide staff on action to take in the event of any safeguarding concerns and details of the local safeguarding team were available. This enabled referrals to be made to the relevant organisations. Since our last inspection the registered manager had made one safeguarding referral. Records demonstrated that they had worked with the local authority to investigate and resolve the issue.

People told us there were enough staff to provide the care and support they required. One relative said, "There is always someone about." The provider explained to us that they managed staffing levels using a dependency tool based on each person's assessed needs. Care plans demonstrated that people's dependency level was assessed regularly. The provider also told us that if somebody needed more support for a short period they brought in more staff and gave us an example of when this had occurred recently.

Staff recruitment files demonstrated the provider had a safe and effective system in place for employing new staff. They all contained pre-employment checks which had been obtained prior to new staff commencing employment. These included two references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Our inspection of 26 July and 16 August 2016 found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service could not demonstrate that staff training was up to date. Following that inspection the provider sent to us an action plan with clear timescales of when training would take place. At this inspection records demonstrated that the action plan had been adhered to and that staff training was up to date. Staff we spoke with confirmed that their training was up to date and met their needs. One member of care staff said, "Training is very good."

Staff told us and records confirmed, that they received an induction when they commenced in post. One member of staff who had recently begun work at the service told us that there was a set induction but that it was adapted to the needs of the individual member of staff. They told us that they had completed a variety of training, read care plans and shadowed other staff before working alone. This ensured that they were familiar with, and were able to meet, the needs of the people they would be supporting. One person told us, "They look after you well, creature comforts and the most basic needs. I would object if I thought staff didn't know what they were doing." Staff we spoke with told us they felt supported in their role and that they could raise any issues with the registered manager. One member of staff said, "The matron is very supportive." Staff received regular supervision sessions to provide support, discuss their role, training and development needs and set performance objectives for the upcoming year.

Our previous inspection had also found that people's needs were not met by the design and decoration of the service. This was because it was cluttered with a lack of storage for equipment. At this inspection we found that many areas within the service had been re-organised with identified storage areas for equipment such as hoists. This made the environment safer with no trip hazards which we had found previously, it also gave staff space to use equipment such as hoists. However, we noted that the two lounges were very noisy with three televisions on. Chairs were arranged around the edge all facing the three televisions. This gave the rooms an institutional feel. One person said, "I always sit in the same chair, it's just where they put me, I don't mind. I think it's so they know where you are. What I would like to do is turn my chair round so I could look out of the window, see the birds." There was nowhere quiet for people to sit. The date which was displayed in one of the lounges had not been changed for three days, this could cause confusion. Although improvements had been made these had not always taken into account people's individual needs and preferences.

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 Act 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that DoLS applications had been made appropriately.

Staff told us that they had received training in the MCA and records confirmed this. However, people were not always given choice and freedom in their daily lives which meant some people felt their options were restricted. One person said, "I'm a bit tottery. My Zimmer is over there behind the plant, it's to stop you getting about on your own I guess. Sometimes I get a choice about what to watch, I saw Songs of Praise yesterday". Another person said, "It's a bit of a change really, one doesn't get enough independence. You more or less go where you are told. They arrange the times you go to bed at night time but you can wangle it, sometimes you get away with it, sometimes not."

Our previous inspection had found that meals were not a sociable and enjoyable experience. Following that inspection the service had re-organised the dining area and the procedure for serving meals. We observed lunch during the inspection and found that people could choose where they wanted to eat their meal. There was a choice of meal and people were asked what they would like for lunch. People told us they enjoyed the food. One person said, "I choose more or less what I'm going to eat and how it's cooked. I don't like mashed potatoes so they cook them whole just for me." Another person said, "I'll tell you something, they have lovely food in here, today I had stew, the meat was chopped up like Oxo cubes."

We observed people who remained in their bed rooms being supported to eat their lunch. This was carried out in a calm and considerate manner with people being offered drinks in between mouthfuls of food. We also observed that people in the communal areas were offered a choice of drinks throughout the day which encouraged people to maintain a good level of hydration. However, we did note during visits to people in their bedrooms, that drinks were not placed within reach. This could cause frustration and mean people did not always get the fluid they wanted or needed.

Care plans contained a record of people's dietary preferences which meant staff were aware of what people liked and disliked. People's nutritional health was also monitored with a recognised tool, the Malnutrition Universal Screening Tool (MUST). This was reviewed monthly and appropriate action, such as the fortification of food or referral to another health care professional taken when needed. Where people had specific diagnosis which affected their nutrition, such as gastro oesophageal reflux, there were instructions in the care plan as to how these were managed.

People living in the service were supported by the staff and external health care professionals to maintain their health and wellbeing. The care plans we looked at showed that staff made timely referrals to other health professionals for advice, care and treatment for people when required. Records we viewed showed that people received input from a range of other professionals, including the GP, dietician and optician.

Relatives we spoke with told us that staff always kept them informed about any changes to their family member's health or wellbeing and that advice was sought quickly when needed. One relative describing the care and support their relative received for a specific condition said, "The nurses do everything they can. The doctor comes every Friday and monitors it."

Good

Is the service caring?

Our findings

People told us that staff treated them with kindness and compassion. One person said, "I'm happy as I can be, staff are nice, very polite, very helpful. To start with it was not very nice but you get used to it, they help with dignity by covering you up with a towel." A relative said, "My [relative] has to go to the clinic to have [relative] toes done. The carer will take [person] to my car, get [person] in the car, pack up the wheelchair and do the same in reverse. The care [person] has had made a lot of difference. They go out of their way to make sure my [relative] is okay."

We observed staff interactions with people throughout the day of or inspection. We saw that staff consistently showed kindness towards people both when they were providing support, and in day to day conversations and activities. Staff we spoke with told us that treating people with respect and dignity was important to them. One staff member said: "It's important to treat everybody as an individual." The atmosphere within the service was friendly and relaxed, and at times fun, and the approach adopted by staff contributed to this. Staff we spoke with knew people's needs very well, and could describe their individual preferences and the way they wished to be cared for. When staff were supporting people with care tasks, they did so in a calm and unhurried way, ensuring that tasks were carried out at the person's own pace.

Care plans demonstrated that people had been involved in writing them both with signatures and by the information contained within them. They were written in a person centred way and instructed staff in people's likes and preferences. For example one care plan stated where a person liked to sit in the lounge and another recorded how many pillows a person liked to sleep comfortably. A member of staff told us that they had enjoyed being involved in writing the new care plans which had been put in place since our last visit as it had helped them to get to know people better.

People and their relatives spoke about the staff having caring attitudes and the compassion that people and their relatives were shown by staff. Staff also understood the need to respect and maintain people's right to privacy and dignity. One visiting person said, "Alright living here, people are very nice, polite, friendly. I have got a lovely room." A relative said, "The girls, I can't praise them enough, they all know what they are doing, they have all had the training. [Person] can be quite awkward sometimes but they never get stressed with [person]. If there is anything untoward screens are brought in straight away. They always ask him if it is OK to do anything."

Staff, as much as possible, encouraged people to retain their independence and do as much as they could for themselves. A relative told us, "No concerns at all. [Person] will do things [person] thinks [person] still can but there is always someone's eyes on [person]. I don't worry, there is always someone about. I would come here if I needed a home." Care plans encouraged staff to support people with their independence, for example, one person's care plan stated 'Please allow me to do as much of my personal care as possible.' We saw staff speaking with people in a dignified way and bending down so that they could make eye contact with the person they were addressing.

Requires Improvement

Is the service responsive?

Our findings

Our inspection of 26 July and 16 August 2016 found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the care plans did not provide a clear explanation of people's care and support needs. After that inspection the provider had sent us an action plan detailing actions they would take to improve. At this inspection we found that improvements had been made.

Care plans had been re-written with the involvement of people and, where appropriate their relatives. One relative told us, "Yes [person] has a care plan and I feel involved in the care [person] is given." Staff spoke enthusiastically about their involvement in writing the care plans, telling us it supported them to understand people's needs better.

Each person had a care plan which was tailored to meet their individual needs. Pre-admission assessments were completed with people and their families before they moved into the service to ensure their individual care needs and preferences could be met. Personalised care plans were developed which provided guidance to staff about how each person would like to receive their care and support. These included their medicines, personal care and any aids they used to help with, for example, their mobility. Care plans also included information about people's preferences, choices, and the people who were important to them. People's care plans were reviewed regularly or when their care and support needs changed.

However, we did find that while care plans contained information on people's preferences and the activities they enjoyed there were not always details of how these would be met. For example, one person's care plan stated that they loved cats and horses, cooking and reading the bible, but there was no information in the care plan as to how the service supported their interests. On the day of our inspection we observed one member of staff supporting people with crafts. One person said, "I do gardening, arts and crafts, cooking. Last time we made buns, it was a laugh, we all helped each other out." The registered manager told us that people would help to plant pots for the service patio area. However, activities were not planned and co-ordinated to meet people's interests recorded in their care plan. We discussed this with the provider's representative and their consultant who recognised it as an area for development and explained it would be addressed as part of the continual review of care planning.

On the day of our inspection we observed that three of the televisions in the inter-connected communal lounge were on for the whole of the morning. People were not watching the televisions with some people asleep and others trying to have a conversation. Apart from returning to their bed-room there was nowhere for people to sit away from the television. This did not encourage social interaction and may not have been everybody's choice.

People were encouraged to maintain relationships and with friends and family. On the day of our inspection we observed people receiving visits from friend's and relatives.

People felt able to approach staff if they had concerns or wished to make a complaint. One person said, "I

wanted to complain I would just tell them." A relative said, "I have never made a complaint but I have the information on how to here." The service complaints procedure was displayed in the reception area. This set out how the service would deal with complaints including a time scale for responses. The service had not received any formal complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

Our inspection of 26 July and 16 August 2016 found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have systems in place to monitor the quality and safety of the service. At this inspection we found that improvements had been made.

Following our previous inspection the provider had sent us an action plan as to how they planned to improve the service. This addressed all of the issues raised in our report and detailed how the shortcomings would be met with appropriate timescales. They have kept us updated with the progress on the action plan. Some improvements were put in place in keeping with timescales in the action plan but others were not. In these instances the provider was open and honest that their timescale had not been met. They gave reasons for this and then met the revised timescale.

The provider's representative had been regularly visiting the service to support improvement plans. A consultant had been employed to advise on best practice in the industry. This had resulted in a completely revised quality assurance process. The provider now carried out regular audits under the headings Safe, Effective, Caring, Responsive and Well-led. The provider sent us a copy of the audit forms. We saw that they addressed the quality of the service. However, they had not been fully implemented and we were not able to assess if they were effective in driving improvement in the service.

The provider was aware of the importance of forward planning to ensure the quality of the service they provided could continue to develop. For example the current registered manager was due to retire in the coming months. The provider had recruited a replacement manager and the new manager was engaging with the provider's representative and the consultant to ensure a smooth transition when the current registered manager retired.

The provider's representative also discussed with us planned improvements to the building. Our previous report had raised concerns regarding the accessibility of the service garden. Plans were in place to improve the accessibility of the garden and the quality of the communal areas in the service.

People told us that the management team was accessible and they felt able to approach them to discuss any issues. One person said, "There is always a manager, 24 hours a day, they are all proficient, can't fault them really." A relative said, "I normally speak to someone as soon as I come in, they keep us well informed of changes." Staff told us that the management team were open and approachable. On the day of our inspection we observed the provider's representative and care staff engaging in discussions about the running of the service.

However, minutes of meetings with residents and relatives did not demonstrate that people were asked their opinion and views on the development of the service. They were more a record of the changes that the service had made. There were no follow up actions from the meetings. For example, at an earlier meeting one person had said they would like to go out into the garden more but subsequent meetings did not contain any information as to whether this had been achieved. Minutes of meetings with staff did

demonstrate that staff had been involved in the improvement of the service and that the provider had been open and honest with staff, for example, sharing our previous report.