Greenacres Nursing Home Limited

Wavertree Nursing and Care Home

Inspection report

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20 February 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Wavertree Nursing and Care Home on 15 February and 20 February 2017. Wavertree Nursing and Care Home provides accommodation for older people who require nursing care. The service is registered to provide care and accommodation for 46 adults. At the time of our inspection there were 38 people living in the home of which there were 15 people requiring nursing care .The service is located in the Wavertree area of Liverpool and is close to local public transport routes. Accommodation is provided on the first floor and this floor can be accessed via a stair case or passenger lift.

The home is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. There had been no registered manager in post since March 2015. There was a 'home supervisor' and a clinical lead in post.

We spoke with the provider and the home supervisor and they were very transparent and told us that they recognised that the home needed to improve and that they were committed to the work required.

People we spoke with told us they felt safe at the home. They had no worries or concerns. People's relatives and friends also told us they felt people were safe. During our visit, however we identified concerns with the service.

We found breaches in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The service had not submitted statutory notifications to the Care Quality Commission regarding incidents that had happened at the service.

Quality assurance systems were in place but did not operate effectively and had not embedded into the culture of the service enough to ensure people received a safe, effective, caring, responsive and well led service.

We reviewed people's care plans and risk assessments as well as monitoring information. Not all of these were clear or legible regarding people's needs. Some monitoring information and risk assessments were also misleading and gave little guidance to staff on how to meet people's needs. We also identified concerns regarding the monitoring of equipment for pressure area care with inappropriate settings of air flow mattresses. There were no infection control procedures for mattresses, beds, pumps for the air mattresses and cushions as no one was allocated to clean or check them.

Staff were recruited safely, however there was not sufficient evidence that staff had received a proper

induction at the start of their employment. We saw that staff had received suitable training to do their job role effectively. The majority of staff had been supervised and appraised. The registered nurses had appropriate checks of their registration with the Nursing and Midwifery Council.

People had access to sufficient quantities of nutritious food and drink throughout the day, however we observed that people were not always supported with accessing food at mealtimes and some monitoring information was incomplete or misleading. We received a mixed response regarding the food provided with both negative and positive comments from the people living in the home.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had been followed by the home. The home supervisor told us about people in the home who lacked capacity and that the appropriate number of Deprivation of Liberty Safeguard (DoLS) applications had been submitted to the Local Authority.

We saw there were policies and procedures in place to guide staff in relation to safeguarding adults and staff were able to tell us who they would access both internally and externally if they were concerned about a person living in the home. There was information regarding safeguarding procedures in the entrance to the home as well on a communal notice board on a main corridor.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

In some care files the risk assessments were misleading, incomplete and duplicated.

Some monitoring information for some people living in the home was either conflicting, unclear or had not been completed at all.

Pressure area equipment had not been monitored for appropriateness of use or infection control.

Staff had been recruited safely. Appropriate recruitment, disciplinary and other employment policies were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Some staff files held induction documentation that was either incomplete or misleading.

There were mixed responses about the food that was supplied by the home and people had not had input into the planned menus.

The service had policies and procedures in place in relation to the Mental Capacity Act 2005 and staff had received basic training.

Is the service caring?

Requires Improvement

The service was not always caring.

Confidentiality of information was not always maintained.

There was little interaction between staff and people living in the home unless they were assisting them with a task.

When staff did interact with people they were upbeat in their communication and seemed patient and caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care files were illegible with large blocks of text and some were out of date with vague instructions.

Accurate information about how to raise a complaint was available within the home.

We saw people had prompt access to other healthcare professionals when needs were identified.

Is the service well-led?

Inadequate

The service was not well-led.

There had not been a registered manager in place since March 2015.

The required statutory notifications had not been made to the Care Quality Commission.

Documentation was not always good, readable and current.

Quality assurance systems for identifying risks to people's health and safety and to inform the service about improvements needed were not yet embedded into the culture of the home.

Wavertree Nursing and Care 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 was 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 15 and 20 February 2017 and was unannounced. The inspection was carried out by one adult social care inspector, one specialist advisor who was experienced in medication and pressure area care 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, their area of expertise was dementia care.

Before our inspection, we looked at information the Care Quality Commission (CQC) had received about the service including notifications received from the service. We also looked at safeguarding referrals, complaints and any other information from members of the public. We talked with the local authority quality assurance team and the local Healthwatch organisation to see if they had any concerns or information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We spoke to seven people who used the service, two visitors, two health professionals and six members of staff. We also spoke with the provider.

We reviewed a range of documentation including care plans, risk assessments, medication records, records for six staff, staff training records, policies and procedures, auditing records, health and safety records and other records relating to how the home is managed.

Inadequate

Is the service safe?

Our findings

We spoke with seven people who lived at the home and asked if they felt safe. Each person told us that they did. One person said "I know the doors are secure." and another person told us "I feel safe enough with the door shut." There were mixed comments when we asked about staffing levels and the people who lived in the home said that staff didn't always have time to sit and talk to them. One person commented that they thought the night shift was short staffed.

We looked at risk assessments in care files of people who lived in the home. We saw that they varied considerably with conflicting information. For example we saw one person who had two malnutrition universal screening tools (MUST assessments) completed on the same day with different outcomes. This meant that it was not clear if this person was at risk of malnutrition. Another example was that we saw documentation that stated a person was at risk of displaying aggressive behaviour, however there was no assessment in place to identify risk or to guide staff on how to de-escalate behaviour.

In some cases the information for people who had to have their weight regularly monitored was unclear, with duplicated dates with different weights and in some cases it was unclear if people were meant to be weighed weekly or monthly or why people had changed from one to the other. This meant the staff could not effectively monitor a person's weight and so be able to act if a person lost or gained weight. We were unable to see what actions had been taken for those who had had significant weight loss. We also saw a weight chart inappropriately dated 01.17 and 02.17, there was no specific date with a weight loss of nearly half a stone and there was no indication of actions taken. The documentation had a section for actions however these had not been used. This meant we were unable to say that a person had received appropriate care and referrals to other professionals as a result of their weight loss.

We saw that monitoring information for some people living in the home was either conflicting, unclear or had not been completed at all. Examples of this being one person's fluid balance charts did not match their food and drink charts as it stated on their fluid balance chart that the person had drunk 800 millilitres throughout the day, however it was stated on their food and drink record chart that the person had refused all food and drink. We saw that some people had significant gaps in their monitoring information, including food and drink charts. This meant that we could not be certain that people living in the home were having their nutritional needs monitored and assessed appropriately and as a result having adequate fluids and nutrition throughout the day.

We saw that some repositioning charts for people with pressure area risks were unclear or had not been completed fully. The charts did not specify how often the person should be repositioned. Care staff did not record the condition of the person's skin. A section was available on the repositioning charts for this but not always used. On some repositioning charts it was recorded that the person would only lie on their back and that they were 'rolled', but did not record for how long pressure was relieved when they were rolled.

One person had a pressure ulcer. We were unable to find any information documented about the condition of the person's skin leading up to the wound. There was some confusion about the cause of the wound

when we asked staff. We were unable to find a repositioning chart for the day of inspection and the person was lying on their back. The documentation that was in place was difficult to follow and inadequate. This meant that we could not be certain that people living in the home were receiving appropriate care for their pressure areas and could be at risk of developing pressure sores,

We also identified concerns regarding the monitoring of equipment for pressure area care. We saw that air flow mattresses for three people were not being used appropriately. Examples of this was that two mattresses were found on comfort settings that were too high for the weight of the person and the air mattress of a person admitted the night before the inspection was completely deflated and not working. We did not see evidence of regular checking of beds, mattresses and cushions that were in place for pressure area care. This meant that we could not be certain that the equipment was fit for purpose with regard to the prevention of pressure sores. Before we completed the inspection, the home supervisor showed us a checklist for the mattresses that they had designed and was to be implemented immediately.

We saw that there were no infection control procedures for mattresses, beds, pumps for the air mattresses and cushions as no one was allocated to clean or check them.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because we could not be sure that all risks in the home were being assessed appropriately and in a timely manner in accordance with people's needs..

We reviewed medication administration records (MAR) and found concerns.

Cream charts were in place which showed the prescription, a body map and an evaluation section. There was inconsistency in signing the charts to confirm that the prescribed cream had been applied. There were no explanations of gaps on the MAR sheet for several people.

One person administered their own insulin and checked their own blood sugar levels (BMs) and adjusted the insulin dose accordingly. A chart that monitored the person's blood sugar levels was in the MAR file but no BMs had been recorded for a number of weeks. We were told that the district nurses were overseeing this, but no records were available.

Another person's blood sugar levels were recorded until the end of January but had not been recorded since then, with no reason given for stopping. Again, the district nurses oversaw this but the service did not have any monitoring information.

Some of those people who had their blood sugar levels monitored by the home did not have a record of the times when the BMs had been carried out. This meant that the readings were of little value because they might have been before or after meals.

We checked all the nursing service users' MAR charts. There were some records that people had refused medication but nothing had been recorded to say why the person had refused or what was done about it.

We saw that an inhaler prescribed to be used twice daily was only being given once daily. We were told that the person did not administer it correctly so was probably not getting the full dose. We saw no evidence that any action had been taken to address this.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medication was not monitored and reviewed appropriately and in a timely manner in

accordance with people's needs..

We looked at the records relating to safeguarding incidents and we saw that the home had not made the required notifications to CQC. Records showed that the majority of staff had attended safeguarding training in 2016. We asked staff members if they knew safeguarding processes and asked if they felt confident to know how to be able to report any type of potential abuse. All the staff we spoke with were able to show an understanding of the different types of abuse and how to report abuse.

We saw the premises were safe. We looked at a variety of safety certificates that demonstrated that utilities and services such as gas, electric and water systems for legionella had been tested and maintained. We saw that the fire alarm system had been checked regularly and there was a fire evacuation plan that had been reviewed and updated. Personal emergency evacuation plans (PEEPS) had been completed for all of the people who lived in the home and were readily available in a file in case they were required. These also matched the information in people's care plans and risk assessments.

We viewed six staff recruitment files and found that all the appropriate recruitment processes and checks had been made. All files contained two references, proof of identification and had appropriate criminal records checks on each person. The registered nurses had appropriate checks of their registration with the Nursing and Midwifery Council.

We also looked at the records for accidents and incidents, we saw that actions had been taken following each event, for example the use of body maps and referrals to health professionals.

Requires Improvement

Is the service effective?

Our findings

We asked everyone if they thought that the staff had the right skills and knowledge to deliver an effective service and all said yes.

We looked at six staff files and training records. We saw that some of the induction documentation was either incomplete or misleading. in some files there were no induction records. One carer's induction record was actually for an administrator's induction. Records to show that new staff had shadowed an experienced member of staff had not always been completed. This meant that we could not be certain that staff had been appropriately inducted into the home following recruitment.

We look at the environment and saw that it had been generally maintained but we did note some concerns. There was a 'bubble' in the flooring in the dining room which was a trip hazard. This didn't have a warning sign near it and people who lived at the home were walking independently in this area. We were told that the provider was in the process of actioning this however throughout our inspection we did not see and warning signs for the benefit of people walking through the door.

The lounge had an adjacent kitchen area and a dumbwaiter that was used to transport food from the kitchen. We asked about the cleaning of the refrigerator in the kitchen area and we were told that no one had responsibility for this. The home supervisor actioned this at the time of inspection by adapting cleaning documents and delegating the responsibility to specific staff.

We asked people about the food and we received a mixed response. We had some positive responses with comments that included "It's very good, there's a choice, and plenty to eat. You get a sweet as well" and "It's been very good, my favourite meal is dinner". However we also received negative responses with comments that included "I'm not keen on the food, it's sloppy" and "It's dreadful, I drink milk instead. I never go for breakfast I had pudding and a glass of milk for lunch, for tea I'll have a plate of chips and a dessert". We also asked relatives about the food. One person said about their relative "[Person] has always been very, very fussy. The home was given a list but that's gone out the window".

We observed breakfast and lunchtime. At breakfast one person was given a plate with toast, egg, bacon, sausage and beans on, however the person only had the use of one arm and the carer didn't offer to cut it up for her. The food was served on a small plate and there was no plate guard to assist the person to eat independently. At lunch we observed that some people who left a lot of food were asked if they had finished before the plate was taken away. However we only saw one person being encouraged to eat more. There wasn't a daily menu displayed for the people who lived in the home and the four week menu didn't correspond to what the people were given to eat. We asked the cook if the people in the home were involved in planning the menus and we were told "No, I don't have time to ask the residents about the menus".

We saw that staff, including ancillary staff, had all attended training required by the provider, which included safeguarding, moving and handling, food hygiene, fire safety and health and safety. We asked staff if they had had supervision and appraisal and we were told yes. One staff member said "We have it a couple of

times a year". We also asked if they found it helpful and we were told "Sometimes, yes" however another person told us no.

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 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 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. The home supervisor had accessed the local authority and peer support to ensure the appropriate procedures had been followed and showed a good understanding of the MCA and its application. We saw that the majority of the staff had received MCA training.

Everyone we spoke to told us that their consent was sought before carrying out care and we saw that some documentation in people's care files had been signed by people agreeing to their care. This was brought to the home supervisor's attention who told us that this would be completed.

Requires Improvement

Is the service caring?

Our findings

We asked the people if they thought the service was caring. We were told by one person "Well, they're caring. They always knock before they come in my room." Another person told us "They treat me very well, they're very good keeping my privacy". However we were also told "They treat me very well indeed apart from one night staff, I didn't like this girl, she was bossy and vindictive, I couldn't get away fast enough" and another person told us "OK, there's a couple that are a bit rough, and I shout at them".

We observed that confidential information was mostly kept either in cupboards in the nurse's' office or the main office on the corridor. However, we also saw charts in a pile in a corner in the corridor by the nurse office waiting to be archived, these were not locked up and could be accessed by the public and other people living in the home.

We saw little interaction between staff and people living in the home unless they were assisting them with a task. However staff appeared to be conscientious and upbeat when communicating with people. We asked people if the staff knew them well, for example their likes and dislikes and all said yes. One visitor told us "I think so. They're getting to know his moods". When we spoke with the staff they showed an awareness of the health needs of the people who lived in the home and were able to tell us of what care was needed and preferred.

We asked people if they had choices in the way they lived and if they were respected. One person told us "Yes, I always wake up early and I read" and another person said "Yes, I usually pick what I want to wear, but today a young man (carer) picked, but I'm happy with it". We also asked relatives if they thought the persons choices were respected one person commented "[Person] goes along with the flow, but she's happy" and another commented "[Person] is falling into the home's routine".

Everyone told us the staff encouraged them to be as independent as possible and one person told us that they were self-caring and went out regularly on their own.

We asked to look at a copy of the home's 'Service User Guide' that was available for people and families. This held information that included service user rights, privacy and health and personal care. A copy of the home's 'Statement of Purpose' was also included in the 'Service User Guide'. This meant that people who used the service and their families were provided with information about the home so that they would know what to expect.

We saw evidence in people's care plans of their end of life choices and we noted that there were eight staff members who had up to date end of life training, this meant that they had the care knowledge and skill to appropriately support people at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they knew who to go to if they wanted to make a complaint or if they knew who was in charge of the home at the moment. Three people living in the home were able to name the home supervisor whereas a fourth person thought the clinical lead nurse was the manager. Another person told us "No, the manager's left". We also asked visitors, one of whom did not know and the second was able to name the home supervisor.

We asked the people we spoke to if they had made a complaint. Two people told us that they had. The first person said "I complained about the food, but nothing changed." The second person said "Things like the call button, I can't reach it if it's left lying on the floor. I have to ask for it, it should be made available all the time". We saw that the complaints procedure was in the entrance area of the building and was also available in the 'Service User Guide'. We were able to see that complaints to the home had been investigated and outcomes had been documented.

The care files in the home were in the process of being updated and audited by the home supervisor. We reviewed eight care files and found some care plans were illegible with large blocks of text and some were out of date with vague instructions. Care plans included information about how to support a person with eating and drinking, mobility, end of life care and emotional needs. These had been reviewed on a monthly basis however some months had been missed. This meant that this person was at risk of receiving inappropriate care as staff did not have a clear plan to follow and this person could not say how they wished to be cared for.

The home employed an activities co-ordinator who was able to show us their activities assessments and their weekly plans which were currently under review. We asked how people spent their time during the day and we were told "I read and watch TV, I've been out a few times. I don't like the activities". Another person told us "Colouring, reading, there's lots of activities it's never boring. I get my hair and nails done. If I feel I need someone, I go and talk to the nurse and another nurse comes in from outside". There were activities in both the morning and the afternoon. In the morning, some people decorated cakes and then went on to colouring. In the afternoon there was a singer in the lounge which people appeared to enjoy.

The television in the lounge was on all day apart from when the singer was there. In the afternoon some of the people living in the home watched a film. The activities co-ordinator showed us that they had a log of activities that recorded what each person had attended. We were told that she had no problems with accessing resources for activities and we were told that one of the lounges was in the process of being adapted into an activities room for the benefit of the people living in the home.

We saw that people had prompt access to medical and other healthcare support as and when needed and this was documented in people's care plans. We were able to speak to other healthcare professionals who had visited the home. We were told by a district nurse that the nurse in charge was helpful but there had been far too many changes of staff which made it hard to build a good rapport. We were also told that there had been problems in the past regarding pressure area care and use of special cushions. Another visiting

professional told us that they were always welcomed, staff listened to them and the people appear happy, however staff need to be prompted regarding mobilising people.

Inadequate

Is the service well-led?

Our findings

The home had not had a registered manager in post since March 2015. This meant the home did not have 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.

There was a 'home supervisor' who had been in post for six weeks and a clinical lead who was not available at the time of inspection. The home supervisor told us that they recognised that the home needed to improve and that they were committed to the work required. The home supervisor reacted promptly to address issues we found during the inspection. The home supervisor was implementing new systems and was aware that these systems would need to be embedded within the organisation's culture.

We looked at the records relating to safeguarding incidents and we saw that the home had not made the required notifications to CQC. The local authority had contacted the CQC regarding the outcome of a safeguarding investigation following an incident in January 2017. The Commission had not received a statutory notification as required by regulation. The inspector checked with the home supervisor and no notifications had been submitted.

We observed that confidential information was easily accessible for people who used the service and visitors due to lack of security. We saw that each care file had a 'name and signature sheet' for staff to say they'd read the care file. All were unsigned apart from home supervisor's signature. One file was last signed over a year ago.

We raised concerns about records in the home and the inconsistent recording of issues relating to care records. We also noted that some entries in care records were illegible and that this could impact on the care being given.

Induction records were not appropriate. One staff member's induction documentation was for administrative staff but had been signed by a new care staff. We also saw that nurses' inductions were inconsistent, some showing shadowing practice some didn't.

Systems and processes did not operate effectively to enable the registered person to assess, monitor and improve the quality and safety of the services provided.
These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people if they thought the home was well run. One person said "I suppose there could be changes made" and another person told us "I think so and they're always cleaning". Other comments included "As far as I can see" and "It's not bad, I've only ever been in this home. From people I've spoken to it's an average home". We also asked visitors their opinions and we were told "I think so, I've no problems, and I'm settled

with [person] here". Everyone else we spoke to said yes.

The home supervisor had implemented audits that included medication, care plans, complaints and accidents and had started to identify actions, however these had not been acted on at the point of inspection. We were able to see an action plan the home supervisor had devised. They were also aware that these systems would need to be embedded within the organisations culture.

We saw minutes of a staff meeting held with nursing staff by the home supervisor and provider when the staff had the opportunity to put forward suggestions for the service and air their views. The care supervisor was in the process of arranging meetings for other staff so we were unable to see any minutes relating to care or domestic staff.

We asked staff if they felt supported in their role. One staff member told us "[Home supervisor] is approachable" and another staff member said "I've found [home supervisor] to be ok". However a common theme throughout discussions with staff was the inconsistency of management.

We looked at the polices of the home including health and safety and we saw that the majority of them were dated 2015. This was confirmed in discussion with the management team.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to the health and safety of the service users were not always assessed appropriately, The service did not do all that was reasonably practicable to mitigate risks. The provider did not have the equipment used for providing care or treatment to service users was safe for use.

The enforcement action we took:

We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There was no registered manger in post. The required statutory notifications had not been made to the Care Quality Commission. The provider did not maintain secure records. Regulation 17(2) (d) (i) (ii).

The enforcement action we took:

We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.