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Threen House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 2 and 3 February 2015. After that inspection we received concerns in relation to the care and treatment of people using the service. As a result we undertook a focused inspection to look into those concerns on 21 July 2015. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Threen House Nursing Home on our website at www.cqc.org.uk.

Threen House Nursing Home is a registered care home for people who require nursing or personal care. The home can accommodate up to 26 older people. At the time of this inspection, 18 people were living in the home. Some people using the service had general nursing needs, others were living with dementia and some were receiving end of life care.

The home had a registered manager who was a qualified nurse and had worked at the home for 20 years. 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.

Summary of findings

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

The registered person failed to report allegations of abuse to the local authority or the Care Quality Commission (CQC).

The registered person failed to operate effective recruitment procedures.

Staff did not receive the training necessary to enable them to carry out the duties they were employed to perform.

The registered person failed to accept, record and respond to complaints made about the care and treatment of people using the service.

The registered person had failed to ensure care and treatment was provided in a safe way for people using the service.

The registered person failed to notify the CQC about significant events affecting people using the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The registered person had failed to respond appropriately to allegations of poor care and treatment of people using the service.

The registered person had failed to follow their recruitment procedures to ensure people employed were suitable to work with people using the service.

This meant people using the service may have been at risk of unsafe care.

Is the service responsive?

Inadequate

The service was not effective.

The registered person failed to accept and act on complaints from the relative of a person using the service.

The registered person failed to ensure they provided the appropriate care and treatment to one person following an accident.

This meant people using the service may have been at risk of inappropriate care or treatment.

Is the service well-led?

Inadequate

The service was not well led.

The registered person failed to identify and respond to poor care and treatment of people using the service.

This meant the people using the service were at risk of unsafe care.

The registered person failed to notify the CQC of significant events affecting people using the service.

Threen House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an announced focused inspection of Threen House Nursing Home on 21 July 2015. This inspection was done to follow up allegations of poor care and treatment of people using the service. We gave the provider 24 hours notice of our visit to ensure they were available to help with the inspection.

The inspection was undertaken by two inspectors. The team inspected the service against three of the five questions we ask about services: is the safe; is the service responsive and is the service well led?

During our inspection we spoke with six people using the service, six staff, the provider and registered manager.

Inadequate

Is the service safe?

Our findings

When we inspected the service in February 2015 we found one breach of the regulations as the provider had not looked into gaps in employment histories provided by staff applying to work in the service. The provider sent us an action plan following the inspection and told us, "The provider has completed checks on all staff files and found omissions in 2 employees for not completing the history of their previous employment for the past 10 years. The 2 employees have been alerted of their non-compliance and are happy to provide the missing dates of previous employment."

During this inspection we looked at one staff file and saw the applicant had provided two personal references. The provider's recruitment policy and procedures require a reference from the applicant's last employer, but they had not obtained this. This meant the provider could not be sure people they employed were suitable to work with people using the service.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In June 2015 we received allegations of poor care and treatment in the home, including theft of money from people using the service and the failure of the provider and registered manager to respond to allegations of abuse. We passed these concerns to the local authority safeguarding adults team and they opened two investigations into the allegations. The provider and registered manager told us they were aware of the allegation of theft, but not the allegations of poor care and abuse. They were unable to explain why they had failed to notify the local authority or the Care Quality Commission (CQC) at the time the allegation of theft was made.

In July 2015 we received information from the local authority's safeguarding adults team that they had received further allegations of poor care and treatment of people using the service. During this inspection, we discussed with the provider and registered manager why they had failed to report the allegations to the local authority and the CQC. They told us they were aware of the allegations and had met with the agency responsible for placing the people in the home who had made them. They were unable to explain why they had failed to notify the local authority or the CQC of these allegations.

Although staff told us training was provided, there was evidence that induction procedures had not been followed. When we asked one member of staff about induction training they said they had received training in moving and handling and that they had been given some DVDs to watch, but hadn't done so yet. They said they had received on the job training by watching the registered manager and other staff but no other official induction training, even though this was their first job in a care home. When we asked this member of staff about safeguarding, they were unable to provide any meaningful definitions or describe the procedure to be followed if they were concerned about the safety of a resident.

These were breaches of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People told us they felt safe in the service. One person said, I couldn't ask for better, they are looking after me very well." A second person told us, "There was a problem with one [staff member] but they've gone. Everything else is alright, the staff are very good."

One member of staff told us regular training was provided, including safeguarding and they were able to provide definitions of different types of abuse. They said they would tell the manager if they witnessed any incident of abuse. but that his had not happened so far. They told us, "People are looked after safely as far as I know."

Inadequate

Is the service responsive?

Our findings

One person told us, "I've got no complaints, I get the help I need." A second person said, "The staff are very good, they do what they can to help."

When we inspected the service in February 2015 we saw the provider displayed their complaints procedure in the home and people using the service and staff told us they knew how to make and respond to complaints. The provider and registered manager told us there had been no complaints since our previous inspection in July 2014.

Following our inspection in February 2015, a relative of a person who used to live in the home contacted us and said that they had made numerous complaints in 2014 about the care their relative received and the provider had failed to accept and respond to these. The relative provided copies of emails and letters sent to the service and the provider that clearly detailed their concerns about the ways their relative's care was managed.

During this inspection, we discussed this with the provider and registered manager and they told us they believed the person's concerns were dealt with by a safeguarding investigation. They were unable to tell us why they had failed to provide the complainant with a copy of the service's formal complaints procedure when asked on two occasions. The provider was also unable to tell us why they had failed to record other complaints from the same person about their relative's care that were not covered by the safeguarding investigation.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff told us one person had recently had a fall and cut her head resulting in vomiting and a temperature. The member of staff told us the person did not attend accident and emergency, no other medical assistance was sought and the incident was not officially recorded.

During this inspection we checked the care records for two people using the service. In the daily care notes for one person we saw staff had recorded injuries caused by a fall. The fall occurred in the person's bedroom and staff did not observe what happened. The daily care notes described bleeding on the person's head and ear. There was no evidence the injury was reported to the person's GP and no evidence of regular monitoring of the person following the fall and head injury. We asked the registered manager if they thought this was an appropriate response to a head injury and they told us they were disappointed with the way the incident was dealt with.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager who held a relevant professional qualification. The Care Quality Commission registered the manager in February 2011.

During this inspection we found the registered person had failed to notify the Care Quality Commission (CQC) about significant incidents and events that affected people using the service. This included the failure to report allegations of abuse to the CQC or the local authority that we have detailed elsewhere in this report.

The provider and registered manager had also failed to identify examples of poor care, including the inappropriate management of a head injury and had not responded appropriately to concerns raised by the relative of a person using the service.

When we inspected the service in February 2015, we reported, " The registered manager and provider carried out a range of checks and audits to monitor the service. The registered manager told us she carried out regular audits that covered the physical environment, medicines management, people's care plans, complaints and risk management." However, the evidence we found during this inspection showed the provider's systems for auditing the day to day operation of the service were not effective. The provider and registered manager had failed to identify failures to follow robust recruitment procedures, ensure staff had adequate training for their role and effective care planning and risk management systems were in operation.

The culture in the home was not open and transparent as the provider and registered manager had failed to notify other agencies of significant events that affected people using the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We discussed staff training with the registered manager who told us there was an induction procedure for all new staff. This consisted of a series of training DVDs which were given to the staff member to watch. They were then asked to fill out a workbook which was checked by the registered manager, who then carried out an assessment of the person's knowledge. The registered manager told us the process was recorded in staff files. However when we checked one staff member's file there was no evidence of a workbook or assessment and they had told us they had not completed watching the DVDs, although they had been working at the home for five months.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person did not inform the Care Quality Commission of allegations of abuse.** Regulation 18 (2) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not** 1. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); 2. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 3. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive the training necessary to enable them to carry out the duties they were employed to perform.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not operate effectively systems and processes to prevent abuse of service users. Regulation 13 (2) The registered person did not operate effectively systems and processes to investigate, immediately upon becoming aware of, any allegation or evidence of abuse. Regulation 13 (3)

The enforcement action we took:
We have issued a Warning Notice and the provider must meet the Regulation by 30 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person did not operate effectively systems for identifying, receiving, recording, handling or responding to complaints by service users and other persons. Regulation 16 (2).

The enforcement action we took:
We have issued a Warning Notice and the provider must meet the Regulation by 30 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not operate effectively recruitment procedures to ensure that persons employed had the qualifications. competence, skills and experience to work with people using the service.

The enforcement action we took:
We have issued a Warning Notice and the provider must meet the Regulation by 30 September 2015.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had failed to ensure care and treatment was provided in a safe way for service users. Regulation 12 (1).

The enforcement action we took:

We have issued a Warning Notice and the provider must meet the Regulation by 30 September 2015. We have also issued a Notice of Proposal that the Registered Provider must not admit any service users to Threen House Nursing Home without the prior written agreement of the Commission.