MD Homes

Frithwood Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 23 October 2014 and was unannounced.

Frithwood Nursing Home is a care home providing accommodation, care and nursing for up to 26 older people who may be living with the experience of dementia. At the time of our inspection there were 22 people living at the service.

The service is required to have a registered manager. 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 and associated Regulations about how the service is run. At the time of our inspection there was a manager in post but had not made the appropriate registered manager application to the CQC. Since our inspection the manager had informed us they are starting the registration process.

We last inspected the service on the 6 June 2014 and a pharmacy inspector visited on 1 September 2014. We found the provider was not meeting the legal

Summary of findings

requirements in relation to respecting and involving people who use the service, consent to care and treatment, care and welfare, management of medicines, supporting workers and assessing and monitoring the quality of service provision. Following those inspections we asked the provider to send us an action plan telling us the improvements they were going to make. During this inspection we looked to see if the actions had been implemented and we saw that some improvements had been made.

A range of risk assessment tools were completed to identify any possible risks associated with people's care needs, but guidance on how to reduce these risks was not provided for staff. This prevented staff from taking the appropriate actions required to reduce these risks when care was provided. We have made a recommendation about the identification of risks and developing guidance for staff.

We found there had been improvements in the recording and administration of medicines. The policies and procedures did not give enough information about the administering of covert (hidden) medicines and the use of topical creams. We have made a recommendation about the administration of medicines.

The policies and procedures used by the provider had not been reviewed for more than six years so did not reflect any changes in legislation or best practice that may have occurred. We have made a recommendation about the policies and procedures.

People using the service, their relatives, staff and other people who were involved in providing care for people were sent a questionnaire relating to the service. An action plan was developed from the comments received but we saw that dates were not identified on the plan for when actions should be completed by and it was not recorded if they had been completed to ensure any changes had been made. We have made a recommendation about monitoring the completions of actions taken to improve the quality of the service.

People told us they felt safe in the home and were able to raise any concerns with the manager. There had been improvements in the recording and investigation of incidents and accidents. The staffing levels during the day and at night had been increased to meet the support needs of the people using the service.

We saw detailed assessments had been carried out and care plans developed identifying the care and support needs of each person. The care plans we saw had been recently reviewed and described the tasks required to provide care but did not give any information about the person's likes, dislikes and how they wanted their care to be provided.

A review of staff induction and training records had been carried out and a plan had been developed for staff to attend a range of training courses during 2015. Staff also had supervision sessions with their manager during September and October with appraisals planned for the end of 2014.

People were very positive about the food provided at the home. We saw staff encouraged people to drink by providing access to a range of hot and cold drinks throughout the day to reduce the risk of dehydration.

We saw staff looked after people in a respectful, kind and caring way. The provider supported people to maintain relationships with those who were important to them. People using the service said that family and friends could visit at any time and we saw during our visit that this happened.

Improvements had been made to the way provider assessed and monitored the quality of the service to reduce the risk to the safety and welfare of people using the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to protecting people from being deprived of their liberty in an unsafe manner. You can see what action we told the provider to take at the back of the full version of the report.

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?

Some aspects of this service were not safe. Comprehensive risk assessments had been carried out but staff had not received guidance on how to reduce any risks identified.

Improvements had been made to the recording and investigation of incidents and accidents. People felt the care they received was safe.

Some improvements had been made in the recording and administration of medicines.

Staffing levels had been increased to meet the care and support needs of people using the service.

Requires Improvement

Is the service effective?

Some aspects of this service were not effective. Procedures were not in place in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure the service only deprived a person of their liberty in a safe and correct way.

A review of staff induction, training supervision and appraisal had been carried out and processes were in place to ensure staff received appropriate training and support to provide safe and effective care.

People were supported by staff to choose what they wanted to eat and drink. Staff ensured people received additional care and support from other healthcare professional promptly which was recorded.

Requires Improvement

Is the service caring?

Some aspects of the service were caring. Information relating to an individual's personal history was not always provided for staff.

Staff respected people's dignity and spoke to them in a kindly and respectful manner.

People had been supporting in identifying their wishes in relation to end of life care.

Good

Is the service responsive?

Some aspects of the service were responsive. People's care needs had been assessed and care plans were developed identifying how these should be met by staff. The care plans did not reflect people's likes, dislikes and how they wanted their care provided.

People using the service, their relatives and visitors were encouraged to take part in a range of activities organised by staff.

Good

Summary of findings

People using the service and relatives provided feedback on the quality of care provided through relatives meeting and completing questionnaires. Action plans were developed in response to any areas identified as requiring improvement.

Is the service well-led?

Some aspects of the service were not well-led. The provider did not have regularly reviewed policies and procedures in place to ensure care was being provided in line with current best practice and legislation.

The manager of the home was not registered with the CQC at the time of the inspection but since the inspection she has informed us an application for registration was being made.

Improvements had been made to the system in place to regularly assess and monitor the quality of the service.

Staff had clearly identified roles and responsibilities which they understood. Regular staff meetings and a nurse's forum had been introduced to discuss best practice and improving care.

Requires Improvement

Frithwood 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.

Two inspectors carried out an unannounced inspection on 23 October 2014. A pharmacy inspector carried out an unannounced inspection on 27 October 2014.

Before the inspection we reviewed information we had about the service including notifications we had received relating to safeguarding concerns about people.

During our inspection we spoke with nine people using the service and five staff members. We also spoke with the manager and the director of operations. We spent time observing how people received care and how the staff interacted with them. We looked at a range of records including four care plans, monitoring charts for five people, four staff recruitment folders, audits, incident and accident reports and medicine administration record (MAR) charts.

Requires Improvement

Is the service safe?

Our findings

When we visited on 6 June 2014 we saw that the provider did not have an effective system in place to regularly review and monitor incidents and accidents. The provider sent us an action plan identifying how they would make improvements. During this inspection we saw that since the end of August 2014 improvements had been made. We looked at records of five incidents and accidents. These had been completed in full and we saw investigations had been carried out.

When we inspected the management of medicines on 1 September 2014, we found that people were not protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place to ensure that all medicines were safely and correctly administered, and that accurate and up to date medicines records were kept. We asked the provider to send us an action plan identifying how they would ensure that medicines were managed safely. They sent this to us informing us that the required improvements had been made by 10 October 2014.

At this inspection we found that improvements had been made and they now complied with the regulations. These included regular medicines audits, updating medicines policies in line with current medicines guidance, staff had received medicines refresher training, a medicines competency assessment was in use, protocols had been produced for medicines prescribed to be given when required and a record was made of when staff applied creams.

Records were kept of medicines received, administered and disposed. When we checked medicines stocks against medicines records, we found no discrepancies, providing assurance that people were receiving their medicines safely. Medicines were stored securely and at the correct temperatures. We saw evidence that people's medicines were reviewed regularly by the GP. A medicines competency assessment had been carried out for one nurse who had been recently recruited. Weekly medicines audits were carried out and these detected instances of staff not following medicines management procedures.

Further improvements were needed to some medicines records. One person with limited capacity was having essential medicines administered covertly, and although appropriate authorisations were in place for their safety, no information was available for staff on exactly how to administer this person's medicines covertly, for example, whether to crush or add whole to food or drink. This meant that medicines could be administered incorrectly or in a way that reduced their effectiveness. A covert administration record of decision was available to record this information, and this was completed following our inspection.

When people were prescribed medicines to be given only when needed, such as pain relieving medicines, protocols had been put in place giving staff information on how to administer these correctly. Some of these protocols were lacking in detail, for example, how to tell if someone was in pain. Care staff applied prescribed creams and recorded this on a topical medicines application record. We saw that some of these records did not have sufficiently detailed instructions on how often and where to apply these creams. This could result in the creams being applied incorrectly. People we spoke with said they received their medicines when they needed them. We saw that some people applied their own topical creams, but they told us that they always told staff they had done so.

During our previous inspection on 6 June 2014 we saw the provider could not always ensure the safety of people using the service and meet their personal needs with staffing levels at night. We asked the provider to send us an action plan identifying how they would make improvements which we received. During our visit on 23 October 2014 the manager told us they had increased the staffing levels at night to one nurse and two care staff. The staffing levels had also been increased during the day with one nurse and six care staff in the morning and one nurse with five care workers in the afternoon. We saw the staff rotas confirmed the additional staffing levels and staff told us that there has been an increase in staff numbers. People using the service that we spoke with said they felt there was enough staff at the home. One person told us, 'Someone comes very quickly when I pull the call bell.'

Staff were not given guidance on how to safely and appropriately reduce the identified risks. We saw comprehensive risk assessments had been conducted including mobility, personal care, falls, behaviour, skin integrity and nutrition. However, there was no record to state the way in which these identified risks should be managed. Staff did not receive the appropriate guidance

Requires Improvement

Is the service safe?

on how to reduce the possible risks associated with the care they were providing which meant that people could be receiving inappropriate care and support. Assessments had been conducted, signed and actioned for the use of bed rails, when people using the service share a room and people's preference for having their bedroom door open or closed.

People said they felt safe in the home and they felt able to raise any concerns with the manager who they said was often visible around the home. There was a safeguarding policy and procedure in place. Staff had not completed safeguarding adults training within the previous year and we saw the manager had identified that staff needed an update on safeguarding with staff being scheduled to complete the training during 2015. The manager explained she worked closely with the local authority and reported any concerns. We saw from records that safeguarding concerns identified by staff or the local authority were investigated and actions had been taken to address issues.

Staff were able to explain the whistleblowing policy, the procedure for reporting an incident and who to speak to if they were unhappy with the initial response to their concerns.

People using the service had plans in place in case of an emergency. We saw that there was an emergency evacuation plan in place for each person including a specific risk assessment and identifying any equipment the person required for example wheelchair or nebuliser. Each person had a named staff member identified as being responsible for ensuing they were evacuated in case of fire. All of the evacuation plans and risk assessments had been recently reviewed.

We recommend that the provider explores relevant guidance in relation to the information provided to staff on the administration of medicines.

We recommend that the provider identifies how guidance for staff could be developed from risk assessments.

Requires Improvement

Is the service effective?

Our findings

People were not protected from being deprived of their liberty in an unsafe or inappropriate way in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS). There were no policies and procedures in place and staff had not received training in relation to the MCA and DoLS. These safeguards ensure a person is only deprived of their liberty in a safe and managed way that is the least restrictive option at all times. In the care folders we looked at we saw people had mental capacity assessment forms completed by one of the nurses working at the home. These forms stated if the person had capacity to make decisions but did not identify what evidence was used to make this assessment. We asked the director of operations if the nurses had received any training to carry out these assessments and he confirmed they had not. The director of operations told us that if a person had a power of attorney in place he would not apply for DoLS as family members would make the decisions on their behalf. We asked to see copies of any power or attorney in place for people using the service but the director of operations was unable to provide any.

The above paragraphs demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection on 6 June 2014 we made a judgment that people were cared for by staff that were not supported to deliver care and treatment safely and to an appropriate standard as they did not receive the necessary training and annual appraisals. We asked the provider to send us an action plan identifying how they would make improvements and we received this.

The provider had taken steps to ensure staff delivered care that was safe and to an appropriate standard. We saw that induction and training records had been reviewed since the end of August 2014. Records confirming that the manager had arranged for ten care staff to complete a three day course at a local university during October and November 2014. This course included sessions on dementia, falls, safeguarding and delirium. The rest of the care staff had been booked on the course in March 2015. The manager had arranged for external training providers to deliver training on a different topic each month during 2015. Additional training had been identified for the nurses including tissue viability which was provided by the NHS.

The manager had repeated the induction programme with all the current staff to ensure they had received a general overview of the training identified as mandatory by the provider. Staff told us that the amount of training they were receiving had increased and more was planned, although they did say that some of the training was through watching a DVD.

We saw the records of supervision sessions with the manager for four staff members that were detailed and identified their training and support needs. The manager confirmed she had started the new supervision process and all staff had a supervision session during October. Supervisions were to take place monthly. The manager planned to carry out appraisals at the end of the year once she had completed two supervision sessions with each staff member and observed them in their roles. Staff told us they had a supervision session and that notes were taken of these meetings.

On our visit on 6 June 2014 we saw people's decisions in relation to end of life care and resuscitation had not been reviewed regularly to ensure that the provider acted in accordance with their wishes. We saw that end of life plans and Do Not Attempt Resuscitation (DNAR) forms had not always been drawn up with person where they had capacity to give consent and with their General Practitioner (GP). The provider was unable to demonstrate that these decisions had been made in the best interests of the person. We asked the provider to send us an action plan identifying how they would make improvements and we received the plan on 18th August 2014.

We saw that the people using the service had their end of life wishes identified as part of their care plan. The manager had also arranged for the GP to complete DNAR forms with people who had requested them and we saw these forms on the files we looked at.

There were regular visits from district nurses, the General Practitioner and nurses from the palliative care and tissue viability services. We saw information from the visits was recorded in the person's care folder and changes were made to the person's care plan and risk assessment. There was a system in place for staff to identify when people needed to see the chiropodist and record when they had been visited.

People spoke very positively about the food, one person told us they had recently asked for a specific meal and this

Requires Improvement

Is the service effective?

had been served and they had really enjoyed it. One person said, “There is plenty of variety in the food.” Another person told us about the new chef that had recently joined the staff team. They were not working on the day of our visit so we were not able to speak to them.

We saw that comprehensive notes were kept of what a person had eaten and drunk during the day. Each bedroom we visited had fresh water available and we observed staff encouraging people to drink.

People in the lounge were asked by staff if they wanted something to eat or drink. One of the staff had recently been given the role of nutrition co-ordinator. They weighed people monthly and monitored any unexpected weight loss or gain and took appropriate action when necessary. This staff member also checked people’s food charts to ensure they had been completed correctly. They told us that they encouraged people to do as much for themselves as possible. We saw people had their nutritional needs assessed and care plans included information and guidance for any specific dietary or support needs.

Good

Is the service caring?

Our findings

When we visited the service on 6 June 2014 we saw that people's views and experiences were not taken into account in the way the service was provided as staff did not engage or communicate with them. We asked the provider to send us an action plan identifying what improvements they would make and we received this.

The provider was meeting the Regulation as improvements had been made. People knew the names of staff and who would be supporting them. People told us that staff respected their dignity when helping them with personal care. One person said. "Staff are very nice, always polite and kind" and another said "Staff like a joke" and "The staff make this place good." We saw staff talking to people in the main lounge and asking them if they would like the television or music on.

Staff responded quickly to a person who said they felt unwell. Care staff stayed with the person while the nurse was called. The staff spoke quietly and reassured the person that help would be given.

We observed that staff spoke to people in a kindly manner, gave people time to answer and treated them with respect, promoting their independence and choice. People were encouraged and supported to make choices throughout the day relating to food, drinks, activities and their care. When staff moved people using a hoist we saw they explained what was going to happen before they started and ensured the person's dignity was maintained throughout the process.

The provider supported people to maintain relationships with those who were important to them. People using the service said that family and friends could visit at any time and we saw during our visit that this happened.

We saw pre admission forms had been completed when a person first came to the home and some of these included a short life history of the person. Some of these life histories had not been completed in full or updated since the person had moved in, which meant that staff did not have access to detailed information about a person's previous life.

Three of the care plans we looked at contained a section identifying the person's wishes in relation to their end of life care. These had been developed by staff following discussions with the person and their relatives. Staff told us that everyone had an end of life plan that was agreed and signed by the GP. The manager told us several plans were still with the GP for signing.

Good

Is the service responsive?

Our findings

During our visit on 6 June 2014 we saw that people using the service were not engaging in meaningful activities. The activities co-ordinator visited the home once a week even though there was an activities schedule displayed on the wall there was no evidence that the activities took place. We asked the provider to send us an action plan identifying how they would make improvements and we received the plan.

We saw activities were arranged each day in the main lounge. The manager explained the activities co-ordinator had left since the previous visit and she had allocated the role of co-ordinator to a member of the care staff. The co-ordinator told us that visiting families and friends often joined in the quizzes and sing-a-long sessions. Other members of staff were also involved in the activities and we saw care staff dancing with people in the lounge. Items people had made during craft activities were displayed in the lounge. The co-ordinator also spent time with people who had chosen to stay in their rooms. Staff told us that the local church visited the home but the days and times are not always consistent.

When we visited the service on 6 June 2014 we saw that people's views and experiences were not taken into account in the way the service was provided as people using the service or their relatives were not involved in the development and review of care plans. We asked the provider to send us an action plan identifying what improvements they would make.

We saw the provider was meeting the Regulation as improvements had been made. The care plans we looked at had all been recently updated and some were signed by the person using the service or their families.

We saw that detailed assessments had been carried out before each person had moved into the home identifying the person's individual support needs including mobility, social and health.

Each person had a care plan folder which was kept securely in a cupboard in the dining room. The folder contained their care plan, risk assessments and any other information relating to the person's daily support needs. The care plans were comprehensive including information on nutrition, mobility and continence. There were separate night care plans and a registered nurse's communication sheet.

We saw that charts used to record when a person was turned in bed, any activities offered or participated in, topical medicines used and food consumed were kept in people's rooms. Staff completed daily records relating to wellbeing and care which detailed what support and personal care had been provided. These records provided up to date information about the care and support provided by other staff during the day.

We saw that two relatives' meetings had been organised since August 2014 and the manager explained that invitation letters were sent out so relatives that did not regularly visit were aware that a meeting was being held. Relatives were also sent a copy of the notes from the meetings. .

There was a complaints policy and procedure in place with information on how to raise concerns or make a complaint displayed in the reception area. We saw information was also included in the resident's guide that was kept in each person's bedroom. There was a complaints folder which detailed the complaint, any actions taken and their outcomes. During our inspection we were unable to see any complaints records as none had been made since the end of August 2014.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we saw the results of a questionnaire that was sent out in May 2014. The questionnaire was sent to people using the service, their relatives, staff and other people who were involved in providing care for people. People were asked to comment on the cleanliness of the home, the friendliness of staff, the standard of care received and the quality of the food. We saw a relative commented that the home was clean and the care provided appeared to be excellent. They also identified concerns relating to staffing levels and the interaction between the staff and people using the service. We saw an action plan that had been developed from the results of the questionnaire. The action plan identified two areas of the service that needed to be addressed, the actions and who was responsible for them. We saw there were no dates identified on the plan for when these actions were to be completed by and no record if they had been completed to ensure any changes had been made.

Policies and procedures had not been regularly reviewed. We saw the policies used by the provider had not been reviewed for more than six years so did not reflect any changes in legislation or best practice that may have occurred.

During our previous inspection on 6 June 2014 we saw that the provider did not have an effective system in place to regularly assess and monitor the quality of service to reduce the risks to the safety and welfare of people using the service. The provider required weekly care plan and medication audits to be carried out by the manager as part of their quality assurance process but we saw that only three of each audit had been carried out during five months. We asked the provider to send us an action plan to identify how they would make improvements which we received this. We saw improvements had been made as the manager had started to complete weekly care plan and medication audits during September and October. Other regular audits that had been started since August 2014, which included wound care and falls audits. We looked at a range of the completed audits and saw they were detailed and if any issues were identified the manager took action.

At the time of the inspection the home had a manager in post for two months but they had not been registered with the CQC. Since our inspection the manager had informed us they are starting the registration process. 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.

Staff told us there had been a lot of changes at the home since the new manager had started and all the changes were for the better. One staff member said "We work as a team now, everyone pulls together and we help one another", another said "Staff are more confident now, we needed this stability."

We saw the manager interacted with people using the service, visitors and staff in a positive and supportive manner. The people were happy to see her and the manager could describe the support needs of the people using the service and the specific role of each staff member.

The provider had clear aims and objectives which were included in the resident's guide with a copy in each person's bedroom. The provider also had a 'Resident's Charter' on their website detailing the rights of the people using the service including the right to be consulted about their care, be free from discrimination and retain their personal dignity.

Staff had clearly identified roles and responsibilities at the home and staff confirmed they understood their responsibilities. Staff had also been identified as keyworkers for the people using the service. Each nurse was responsible for eight people and they carried out the monthly assessments of each person's care plan. Each care worker was allocated as the keyworker for a number of people and they would provide feedback to the nurse as part of the care plan review process. This ensured people's care needs were monitored and assessed by staff working closely with the person and could identify any changes in need.

We saw the manager had introduced regular team meetings and a forum for the nurses to discuss best practice, training and any changes to the way care was provided. This supported staff in providing care based upon best practice. We saw the notes from these meetings during our inspection.

Requires Improvement

Is the service well-led?

We recommend that the service seeks advice and guidance on implementing effective systems to ensure timely and sustained actions are taken and reviewed following feedback from people using the service.

We recommend that the service seeks advice and guidance to ensure policies and procedures reflect current best practice and legislation.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.** Regulation 18