Mr Charles Otter

Cranhill Nursing Home

Inspection report

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Date of inspection visit:
05 July 2016

Date of publication:
08 August 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 5 July 2016 and was unannounced. The care home was last inspected on 21 August 2013 and met the legal requirements at that time. Cranhill Nursing Home is registered to provide nursing and personal care for up to 31 people. There were 25 people living in the home on the day of our visit.

There was a registered manager in post. 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 were assessed before they moved into the home to ensure their needs could be met. Initial care plans were devised with input from people and their relatives. Follow up reviews did not always include people and their relatives.

Most risks to people were assessed, however, actions were not always taken to reduce the risks and keep people safe.

People did not always receive personalised care that was responsive to their needs. Care plans did not always reflect that people's individual needs, preferences and choices had been considered.

Governance systems were not in place to monitor and mitigate the risks relating to the health, safety and welfare of people.

People were supported to have their nutritional needs met.

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. Where people were deprived of their liberty this was done lawfully.

People who were supported by the service felt safe. Staff understood how to safeguard people, and knew the actions they would take if they suspected abuse.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some risk assessments were not completed and detailed risk management plans were not always in place to provide support to people in the event of an emergency.

People did not always receive their medicines safely and in accordance with their individual prescription.

Staff had been trained and recognised their role in safeguarding people from harm and abuse.

Accidents and falls were recorded. Appropriate actions were not always taken and recorded.

Staffing levels were sufficient for the needs of the people living in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

People's health care needs were assessed. However, the records did not always evidence the actions taken to meet people's needs.

Pressure relieving equipment was supplied and in use, but was not always used correctly to provide the level of protection people required.

The rights of people who did not have the capacity to consent to care and treatment were upheld because staff acted in accordance with the Mental Capacity Act 2005.

People had access to community healthcare professionals.

Is the service caring?

Requires Improvement

People were not always spoken to in a respectful manner.

People were cared for by staff in a kind and caring manner. People's privacy was respected.

People and their relatives were actively consulted and involved before and when they initially moved into the care home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care records did not provide evidence that people were involved when their care plans were reviewed.

The care records were not always written in a person centred way.

A complaints procedure was in place and this was easily accessible

Is the service well-led?

Requires Improvement

The service was not always well-led.

Routine quality assurance and monitoring systems were not in place.

People who used the service and their relatives were given the opportunity to provide feedback at meetings and in surveys. However, there were no records to confirm actions were taken in response to issues identified.

Staff meetings were held occasionally. Written records of the meetings were not completed.

Staff felt well supported by the registered manager and the senior staff in the care home.

Cranhill 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, 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 5 July 2016 and was unannounced. This meant the provider and the staff did not know we would be visiting. The inspection was carried out by one 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.

Before the inspection we reviewed the information we held about the service. We looked at notifications we had received for this service. Notifications are information about specific events the service is required to send us by law.

We contacted a health professional to obtain their views on the quality of the service provided to people and how the home was managed.

We spoke with eight people who lived at the home and five visitors. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people. We spoke with the registered manager, one senior staff member, and five care and catering staff. We observed medicines being given to people. We observed how equipment, such as pressure relieving mattresses and hoists, was being used in the home.

We looked at four people's care records. We looked at 10 medicine records, staff recruitment files, a quality assurance audit, a service user feedback survey, complaints records and other records relating to the management of the home. Following the inspection we received further information relating to staff training.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. Medicines received into the home were checked by senior staff and recorded on people's individual Medicine Administration Record charts (MARs). Medicines that were left over from the previous month were not recorded. We also saw that one person had a new supply of their medicines supplied in a blister pack. Their medicine had previously been supplied in a bottle. The amount remaining in the bottle was not recorded. This meant some people's medicines could not be accurately accounted for.

Some bottles of liquid medicines and tubes of topical creams had not been dated when opened. These were medicines that needed to be used within specific timescales after opening. This meant some medicines were being used when they may no longer be effective.

We noted two medicines were not given to people as they were prescribed. For example, one person had pain relieving medicine prescribed to be given four times each day. They had not been given the day before or on the morning of our visit. Another person also had pain relieving medicines prescribed four times each day. For the month prior to our visit they had been given these medicines on average, three times each day, and the day before our visit they had been given once during the day. The records did not provide reasons for these medicines not being given as prescribed. This meant people may not always receive pain relieving medicines when they needed them.

Where people had pain relieving medicines to be given when they needed them, referred to as PRN, the records did not always comment on the effectiveness of the medicines. This meant people's pain may not always be sufficiently controlled.

The above were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were safely stored. There were systems for storing medicines, including medicines that required cool storage and medicines that required additional security. We checked the medicines that required additional security and these were accurately recorded and accounted for.

We observed medicines being given to people. The Medicine Administration Records (MARs) were signed by staff after they checked the person had taken their medicines. Where people were able to self-administer their medicines, systems were in place to enable this to happen. Lockable storage was provided in the person's bedroom, so they could keep their medicines safe.

There was a system and protocol in place for the use of 'homely remedies'. These are medicines such as laxatives that can be given for a limited time, with the written agreement of the GP, without an individual prescription. These medicines were recorded when they were given to people.

Medicines that were no longer required were disposed of safely and records were maintained.

Most risks to people's safety had been assessed and plans were in place to minimise the risks. These included risks associated with nutrition, mobility, falls and skin condition. Risk assessments and risk management plans were reviewed and updated on a regular basis. However, some risks associated with the environment were not fully assessed and plans were not in place to reduce the risks of harm or injury. For example, the registered manager told us they assessed, as part of the pre-admission process, the risks to people who needed to negotiate a step up or down into their bedroom. They told us they had discussed these risks with people and their relatives. This was not always recorded.

The registered manager told us all of the baths and showers had thermostatic valve controls and the hot water temperature was controlled to avoid the risk of scalding. The temperatures were checked regularly and recorded by the handyperson employed in the home. People had wash hand basins either in their bedrooms or en-suite facilities. We noted some of the water temperatures recorded were over 60 degrees centigrade. Current Health and Safety Executive guidance about health and safety in care homes states that engineering controls should be provided to ensure that water hotter than 44 degrees centigrade is not discharged from outlets that may be accessible to vulnerable people and where there is the potential for whole-body immersion. Similar controls may be needed at other outlets where people are especially vulnerable (e.g. basins where people have skin sensitivity impairment). Risk assessments had not been completed. This meant some people were at risk of scalding.

Accidents and falls were reported and recorded. We found some accident forms were incomplete and did not provide sufficient detail of the accident or the actions taken by staff. For example, one person was noted to have been found on the floor, 45 minutes after they were last seen by staff. The report from the registered nurse stated the person was, "Found on floor..lying on right side, helped back to bed…no injury noted." There was no description of the checks completed by the registered nurse who had made the entry on the accident form. The fall was not recorded in the care plan, it was not referred to again. A section for the registered manager to review as a follow up had not been completed. This meant people were at risk of not receiving sufficient and safe care. People were at risk of sustaining injuries that may not be promptly identified or acted upon.

People had call bells in their bedrooms. The care records stated that some people were not able to use the call bells. Their care records stated, "Check hourly day and night". This was also written for people who needed to be checked to make sure they were safe when they were in their rooms. The checks were not recorded. The registered manager told us they were confident checks were completed. However, the registered manager did not have any monitoring systems in place and did not work during the night. This meant people were at risk of not receiving the care and support they needed.

Emergency planning had been considered and contact details were recorded for services that may be required to provide support. The records were incomplete. The registered manager could not provide us with people's emergency evacuation plans (PEEPs). These are plans that confirm the help and support people require if they need to be moved in an emergency situation. This meant people may not be fully and safely supported in the event of an emergency.

The above were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed application forms prior to their employment and provided information about their employment history. Interview notes were not always fully completed. The provider's recruitment policy stated, "Assessments made at interviews must be recorded on an interview assessment form." The reason for a gap in one staff member's employment history was not recorded although the registered manager told

us it had been discussed and they were able to explain the reason for the gap. Previous employment or character references had been obtained. Disclosure and Barring Service (DBS) checks were completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified.

People living in the home told us they felt safe. One person commented, "I do feel safe and the care staff are nice." Another person told us, "I feel safe because people [staff] are always around."

Staff had received training and were able to explain their roles and responsibilities for keeping people safe from harm and abuse. All the staff we spoke with told us they would report concerns. They told us they also had access to contact details for the local authority safeguarding team. One member of staff told us, "I would report to Matron straight away if I was worried about someone."

On the day of our visit, there were sufficient staff on duty to provide the support people needed and to meet their needs. People told us staff responded to their calls for support and assistance when needed. One person told us, "The waiting time for the call bell to be answered is ok." We did hear the call bell sounding regularly throughout the day. The registered manager told us they monitored call bell response times informally. This was not recorded. Another person commented they thought the home had been short of staff and that, "It is not unusual to see agency staff around." The staff rota's confirmed that most of the time, staffing numbers were maintained at the levels the registered manager told us were needed for the people currently living in the home. Agency staff were being used on a regular basis because of a staff vacancy. The registered manager told us they provided additional support to the nursing and care staff when it was needed.

Personal protective equipment was provided in sufficient quantities. For example, we saw gloves and aprons used appropriately by staff.

Other health and safety checks on the premises, such as checks on equipment and standard of electrical, gas and water safety had been completed.

Requires Improvement

Is the service effective?

Our findings

Some people in the home used pressure relieving mattresses because they were at risk of developing pressure ulcers. The mattresses settings, for the mattresses in use, required adjusting according to the person's weight. We checked two mattresses at random and found they were set incorrectly. For example, one person weighed 56.6kgs in June 2016. The mattress was set for a person with a weight of 20-30kgs. We brought this to the attention of the registered manager who told us there was no system or records in place to check the pressure settings of these mattresses. This meant people were not always receiving the health care support they needed.

Daily care charts were used to confirm the personal care people had been supported with each day. The charts were completed with codes used to confirm the person had been supported, for example, with bathing, showering or assisted washing. We noted these charts were not always completed. For example, for one person, the care chart was not completed for seven days in May 2016, four days in June 2016 and four days in July 2016. We brought this to the attention of the registered manager. They told us they were confident that people had received the care and told us the shortfall was in the record keeping. This meant people's health care needs may not be met because the records were not always complete, accurate or up to date.

The above examples of failures to accurately record care and treatment are breaches of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an induction process. This did not encompass the Care Certificate. This was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The Care Certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. At the time of our inspection there were staff who had been employed recently. They were not completing the Care Certificate. One member of staff told us they had received training when they started in post. They did not know what the Care Certificate was. They told us they had completed training such as fire safety, moving and handling and caring for people who were living with dementia. They had then worked alongside other staff until they felt confident to work unsupervised.

On-going and refresher training was provided. We received further details about the training after the inspection. These records confirmed that some of the refresher training, such as first aid and moving and handling had not been completed by all staff in the required timescales.

The failure to provide adequate induction and update training for staff is a breach of Regulation 18 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

The registered manager had a system to support staff through regular performance supervision. Staff received supervision approximately every three months. Staff told us they felt supported and the supervision meetings gave them the opportunity to discuss their progress and agree areas where they may need further

support and direction.

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 applications 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 had been met.

At the time our inspection there were people living at the home who had a DoLS authorisation in place. No one had a condition applied to the DoLS authorisations. They had all been granted for those people were unable to make the decision themselves, to move into the care home. The staff we spoke with were not aware of the people who had DoLS authorisations in place and they had a limited understanding of what DoLS authorisations meant for people.

Staff had received some basic training about the MCA as part of their induction. They told us they understood they needed to obtain consent from people before they provided care and support. One member of staff told us, "I always ask ..would you like me to? I never tell people, I always ask." Another member of staff said, "We always check, some people don't want us to help them, so we go away and call back later."

Best interest meetings are held when a person lacks the capacity to make a particular decision about their care and treatment. These are held with relevant people for example, family, staff from the home and health and social care professionals. The records showed where best interest meetings had been held for some people.

Some people had special dietary needs and preferences. For example, some people needed softened food where they had been assessed as at risk from choking. People received the type of food and drink they needed according to their individual assessment and care plan. Where people were at risk or had lost weight, actions were taken. For one person, the care records stated they needed, 'Small and frequent snacks." We saw the person was also given nutritional supplement drinks when they did not want to eat snacks or meals.

We observed lunch service to people in their rooms and to 12 people in the dining room. They told us they had chosen their lunch earlier that day. The lunch service started at 12.35pm and the final service to a person was at 1.45pm. This was not due a request for late lunch. The service was slow and all of the meals, which were fully plated, were served by one member of catering staff. Most people spoke positively about the meals. However, one person told us they did not feel comfortable asking for a different meal if they changed their mind at the time of service. The person commented they did not want to ask for a different meal because they, "Didn't want to interfere with the running of things."

People had access to healthcare professionals. The records showed that people had received support from chiropodists, opticians and GPs.

Requires Improvement

Is the service caring?

Our findings

We listened to the communication between staff and people during the meal service. For one person there was no conversation about what the meal was or what was being offered on the spoon. The member of staff told the person to, "Open your mouth" "Come on sweetheart" and "That's a good girl." The person, who was living with dementia, did not appear upset by being spoken to in this way. Although the words were not said in an unkind way, they sounded patronising and disrespectful.

People and relatives told us staff were kind and caring. Comments included, "The carers respect our privacy and always treat us with dignity and respect..the caring is really good here, they look after us well," "The carers treat me kindly and in a caring way" and "The carers are very attentive, they see to her needs properly."

One relative told us they thought staff treated people with respect and maintained their dignity. They also said, "Most are ok but my wife has a problem with a couple of carers although I think it is more of a personality issue than anything else." They did not give us any more information and told us they would speak with Matron if they were really concerned.

Staff ensured people received their care in private and were aware of the importance of this. A member of staff told us, "We are all really strict about privacy and respect and Matron would soon tell us if we weren't being respectful." Another member of staff said, "We always make sure people are covered up and other staff don't come into the room unless they're needed." In addition signage was provided on each bedroom door that indicated whether or not it was appropriate for someone to enter the bedroom. This meant people could be confident their privacy would be maintained.

The registered manager told us they received compliments from time to time. They told us these were usually received in the form of thank you cards and letters. This feedback was not collated in a file or folder and was not available for us to look at.

The registered manager told us how they supported people to express their views and how they were supported to be involved in decisions about their care. They told us about the pre admission assessment process they completed with people. They told us people and their families were actively consulted and involved before and when they moved into the care home.

There were no people receiving end of life care when we visited the home. The registered manager told us they consulted people about their end of life plans and wishes. They told us they also received support from the local hospice. Some people had Do Not attempt Resuscitation (DNAR) in their records and these had been signed by the person's GP.

Requires Improvement

Is the service responsive?

Our findings

The registered manager completed initial assessments and reviews with people and their relatives before and when people first moved into the home. People and their families were involved in their initial care plan. Monthly reviews of risk assessments and care plans were then completed. However, a senior member of staff told us the reviews did not usually involve people or their families. We brought this to the attention of the registered manager.

We read an entry in the care plan that was not written in an appropriate way. The record stated, "Pretending to take medication. Very bad behaviour to care staff. Matron to be informed." The record did provide any more detail or description of what had happened. This record was not written in a person centred way and was incomplete. The registered manager told us they had arranged to follow this up with the member of staff concerned.

The care plans were not always written in a person centred way. For example, one care plan recorded, "Agitated during personal care" "Pain on movement especially in her back" and "Try to reassure her." There were no further details about how to provide the reassurance needed or whether the noted agitation was linked to the person's pain. A pain assessment tool was not used. This meant the person's specific needs may not be met.

Staff told us they did not read the care plans on a regular basis. One member of staff told us, "I read them [the care plans] when there has been a change, but mostly we keep up to date at [staff] handovers." Another member of staff said, "I haven't read a care plan in the last six months." This meant people were at risk of not receiving care and support as they needed and in line with their individual preferences.

The above were breaches of Regulation 9 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2014.

An activities programme was available and a copy was given to people each week. The programme included musical afternoons, outings to the local park, reminiscence sessions and garden centre visits.

Most people in the home chose to spend most of the day in their bedrooms. We saw some people had books to read and some people told us they enjoyed listening to music or watching the television. An activities record was included in each person's care plan. However, we saw these were not completed on a regular basis. For example, for one person, their care records stated they preferred to spend most of the time in their bedroom. They spent time in the lounge 'very occasionally'. The activity record was completed on two occasions since January 2016. The registered manager told us the person did not enjoy joining in social activities. However, there was no evidence that they were offered or received any other social support or one to one time whilst they were their room. This meant there was a risk that people could be socially isolated.

People who lived at the home and their relatives were generally positive about the service and felt it was responsive to their needs. For example, one relative commented, "We were looking around for a care home,

we settled on this one and haven't regretted it."

The staff and people we spoke with told us that visitors were welcome to the home at any time. During the day of inspection, there were a number of visitors and we saw they were welcomed by staff. One visitor told us, "They support me well and I am just a visitor. I am invited to join in all the activities and they really treat me like one of the family."

The provider had a complaints procedure available for people and their relatives. The policy was displayed and available in the resident handbook. We reviewed the complaints files and saw that very few complaints had been received. There were three recorded complaints since 2012. The registered manager told us how they responded to complaints and this was in accordance with the details recorded in the resident handbook.

Requires Improvement

Is the service well-led?

Our findings

There were no regular internal governance systems in place to monitor the health, safety and welfare of people living in the home. The registered manager told us they did not complete regular auditing and monitoring, for example of care records, accidents and falls, response to call bells, medicine management and infection control practices. We found several shortfalls in record keeping and risk management including emergency planning. These issues had not been identified because there were no regular quality monitoring and assurance checks in place. This meant people did not benefit from living in a care home that could demonstrate its commitment to continuous learning and improvement.

Policies and procedures were available. These were general policies and not specific to the care home. They were developed by an external organisation and many had not been updated since 2007. They contained out of date information. This meant people may not be provided with up to date care because staff did not always have access to up to date information.

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An audit was completed by an accredited external organisation on annual basis. The care home received a certificate to confirm the audit had been completed. The registered manager did not complete an action plan in response to the audit. Information contained in the audit did not provide feedback about the quality of the information audited. For example, the audit stated that a number of care plans had been checked. The registered manager told us they did not receive feedback about whether the documents viewed were satisfactory or whether they needed to be improved.

People and their relatives were invited to meetings and we looked at the notes from the most recent meeting held during November 2015. The notes stated the results from questionnaires distributed to people and their relatives in October 2015 were discussed. The feedback included comments made, and many were positive. For example, "All staff encountered are excellent" and "They are so caring and always there whenever you need anything." However, the feedback had not resulted in an action plan to address the areas where issues were identified. For example, in response to comments such as, "Staff shortages mean they are sometimes unable to give you the time" and "Not enough knowledge about my illness and its symptoms."

People and their relatives spoke positively about the management of the home. One relative told us, "The matron is very accessible and communications are good. They call the doctor when necessary, the optician has visited and my wife has her hair done three times a week." Another person commented, "I see matron sometimes, and I see the deputy every morning as she does my medications and I talk to her if I need."

Staff were positive about the support and direction they received. One member of staff told us, "Matron is fair and good with us. We know we have to do things properly." Another member of staff commented, "We can give our opinions freely."

The registered manager told us they held meetings with staff and staff confirmed this. However the minutes from the meetings were not recorded. This meant staff unable to attend were not provided with written information about the meetings held in their absence. The registered manager told us that staff were reluctant to attend meetings and this was the reason they were not held on a regular basis. The last staff meeting took place in October 2015

The registered manager told us they were supported by the provider in that they could be contacted at any time. The provider was not involved in the day to day running of the care home. The registered manager told us they would inform the provider if there were serious issues or events within the home. The registered manager was not required to provide regular reports or updates. The registered manager told us they received sufficient financial support and if they requested, funding was made available for equipment and decorating.

The registered manager told us how they kept up to date with current and best practice. They told us they attended local care forums, they attended seminars at the local hospitals, and had 'link nurse' arrangements with the local hospice. They told us they had worked at the care home for many years. They explained the values of the care home and told us they were committed to providing a good quality of care for the people living in the home.

The manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not supported to be involved in reviews of their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety and welfare were not always identified or acted upon. Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and complete records were not always maintained. Quality assurance systems were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive sufficient induction and training.