Allenbrook Nursing Home Limited

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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?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Allenbrook Nursing Home is registered to provide accommodation, personal care and nursing for up to 36 people, who are mainly older people with dementia. At the time of our inspection 30 people were using the service. Our inspection was unannounced and took place on 13 April 2016. The service was last inspected on the 19 May 2015 where we found that the provider was not meeting all of the regulations we assessed associated with the Health and Social Care Act 2008 and the service needed to improve. In particular it was deemed to require improvement in the areas of effective and well led.

The manager was new in post and had not yet submitted an application to register with us as is required by law. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Medicines were given, but this was not always done appropriately and people were not always checked to ensure that they had taken their medication. Medicines were kept and disposed of as they should be. People were supported to take sufficient food and their health needs were met, however people did not always receive enough drinks.

Systems for updating and reviewing risk assessments and care plans to reflect people's level of support needs and any potential related risks were not always effective. Quality assurance audits were undertaken regularly, but were undergoing scrutiny to assess how they could be improved.

People told us that they felt safe, however some relatives felt that their loved ones had not been given the time and attention that they would have expected. Although some relatives felt that staff were too busy to care for people appropriately, we found that there was a suitable amount of staff on duty with the skills, experience and training in order to meet people's needs.

People were able to raise any concerns they had and believed that they would be acted upon. They understood the complaints procedure that had been given to them. The complaints procedure was effective and complainants received appropriate feedback. People's ability to make important decisions was considered in line with the requirements of the Mental Capacity Act 2005 and people's consent was sought. Staff interacted with people in a positive manner and aided communication by understanding the person's needs.

Staff maintained people's privacy and dignity whilst encouraging them to remain as independent as possible. Visitors were also encouraged to come into the home and they were welcomed. People took part in activities and staff interacted positively with them, spending time to stop and talk wherever possible. Religious and cultural needs were observed and people felt that staff understood their needs. People, their relatives and staff spoke positively about the availability of the manager. Structures for supervision, allowing

staff to understand their roles, and responsibilities were in place.

The managing director gave the manager on-going support. Notifications were sent to us as required, so that we could be aware of how any incidents had been responded to.

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.

Medicines were not always administered correctly.

Risk assessments were in place.

Suitable numbers of staff were on duty.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive enough fluids.

Staff had a good understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards and how these impacted upon people.

Staff ensured that people had been asked their consent wherever they were able to and they understood people's non-verbal communication.

Is the service caring?

Requires Improvement

The service was not always caring.

People's needs were not always recognised and acted upon.

Staff knew people well and interacted with them in a kind and compassionate manner.

People were encouraged to be independent and their privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in the planning of care.

Staff were aware of people's likes, dislikes and abilities and friendships were maintained.

People knew how to make a complaint and felt confident that the registered manager would deal with any issues raised.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager had not always acted on concerns immediately.

The manager carried out quality assurance checks regularly in order to develop and improve the service.

People and staff spoke positively about the availability of the manager and that they were open and inclusive.

Allenbrook Nursing Home Limited

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 13 April 2016 and was unannounced. The inspection was carried out by one Inspector.

We reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are details that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury. We liaised with the Local Authority Commissioning team to identify areas we may wish to focus upon in the planning of this inspection.

We spoke with four people who used the service, five relatives, four staff members, the deputy manager, the manager and a senior manager at provider level. We reviewed a range of records about people's care and how the service was managed. This included looking closely at the care provided to six people by reviewing their care records. We reviewed three staff recruitment and/or disciplinary records, the staff training matrix, three medication records and a variety of quality assurance audits.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care, to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

One person told us "I receive my medicine when I should". Other people and their relatives told us of their concerns that people were not being supervised effectively whilst taking medication and tablets had been found discarded in people's rooms when staff assumed that they had been swallowed. One relative told us, "I have found spat out tablets and painkilling patches around the room when I have been putting things away". Another relative told us, "I really worry, as nobody is checking these tablets have been swallowed". We did not see specific risk assessments to address these incidents. Our own observations were that staff remained with people whilst they took their medicine and asked if they had taken it. We spoke with the manager about people's concerns and he agreed that this had happened and that he would be speaking with staff and retraining them on this issue. We found that medicines were signed for appropriately, they were stored at the correct temperature and were disposed of correctly. The nursing staff had received training and told us that they felt confident to give medicines out.

We saw that risk assessments covered health, mobility and transfers, hygiene, appetite, continence and skin viability. There was also a bed rail assessment and mental capacity was assessed. A new computerised system for storing and recording care plans and risk assessments only yet allowed senior staff access, but the deputy manager told us that this was being rolled out to all staff in the near future and that senior staff could assist other staff members to view the reports whenever they needed to in the period prior to their own access. Staff told us that should they need to view such records they were able to easily. Staff were able to discuss with us risks posed to individual people, such as who needed assistance with mobility.

People we spoke with told us that they felt safe. One person shared with us, "I like it here it suits me, I think I am safe". A second person told us, "It's not so bad and I am safe, nobody gets in who shouldn't". A relative said, "They keep [person's name] safe, she is always satisfied with how they support her". Another person shared, "They [staff] keep her [person] safe. I have a lot of confidence in how safe they keep her. She is never left alone for long periods". A staff member told us, "We [staff] definitely keep people safe here, it is a big improvement on my last place of work". Another member of staff said, "I think that people will be safer here now as the new manager is being realistic about who we can or cannot accept. Previously people have been admitted when their needs were too great for what we were able to provide and it could be a struggle at times".

A staff member told us, "I am aware of the process to inform the local authority of a safeguarding concern". Staff that we spoke with demonstrated a good knowledge on safeguarding and were able to give us examples of how they had worked with the manager to provide information to the external agencies dealing with safeguarding concerns. We saw a recent example of how information had been shared.

Staff told us that they would be able to spot any symptoms of abuse and one staff member said, "I would recognise signs of abuse and an indicator for me would be people with bruises, scratches and bite marks. I would always inform management whether I thought the abuser was staff, family or another resident". We found that accident and injury forms were completed when needed.

We saw that a personal evacuation plan had been completed for each person living in the home. Staff were aware of this and understood how some people would need to be moved in line with what was deemed best for them. A member of staff told us, "It is about balancing it out, getting them out, but not doing any damage to their health whilst moving them in a rush". Staff told us that in the event of an emergency they would call 999 and if a person had been taken ill they would remain with them until professionals arrived.

People told us that there were sufficient numbers of staff on duty and available for them. One person said, "There are enough staff and they come to people when their alarm is pressed". A relative told us, "There has just been lots of new staff taken on, I hope that they will stay". A second relative told us, "There are enough members of staff, some have been here years and years". A staff member told us, "I never feel that we are short of staff members and everyone always chips in to help each other". We observed staff being able to support people efficiently and coming to assist them within a reasonable timeframe when called.

Staff told us that prior to commencing in their role they had been requested to provide references, identification and to undertake a Disclosure and Barring Service (DBS) check. The DBS check would show if a prospective staff member had a criminal record or had been barred from working with adults due to abuse or other concerns. We looked at four recruitment files and saw that all the appropriate checks had been completed correctly. We saw that pin numbers to show that nurses were registered had been recorded and we found that were there had been any disciplinary action against staff, this had been carried out appropriately, with written warnings put in place and a plan to improve on practice was put in place if required.

Requires Improvement

Is the service effective?

Our findings

A number of relatives we spoke with told us that they were concerned about the intake of fluids received by their loved ones. A staff member told us, "We try to push fluids as far as people will accept them, with lots of tea rounds to encourage people to drink". We found that four people we spoke with and two people that relatives told us about had experienced recurrent urinary tract infections and we did not see evidence of drinks on people's side tables to take when they wanted to. We saw referral letters to doctors in some people's files to evidence that they were under a physician due to experiencing recurrent infections. Although there were basic risk assessments around fluids, people and their relatives told us that they didn't feel that this was focussed upon enough and that recordings of fluids needed to correlate better to drinks that were actually taken. We saw that fluid charts were not always completed consistently.

People told us that staff were knowledgeable, with one person saying, "I think they know what they are doing, they help us as we need them to". A relative told us, "Staff have a good level of knowledge and they seem to understand people's needs. For a while [person's name] didn't get enough to drink and we had to raise this with them, but they understood and its ok now". We saw a person hoisted from wheelchair to dining chair, with two staff assisting. The move was effective and safe and staff maintained the person's dignity by quickly repositioning their clothing that had moved during the lift.

Staff told us that their induction prepared them to carry out their role and one staff member told us, "My induction involved three days of shadowing other staff. Seeing the resident's needs and routines. I also did two days of training and more recently I have done manual handling training. I am always learning, the training is on-going and there is lots of support and encouragement available". A second staff member said, "During my induction I got to know the residents before carrying out their personal care, so it wasn't a stranger caring for them and I got to know the ropes".

Staff told us that they received supervision on average every eight weeks. They also said they felt able to go to the manager or the deputy manager at any time if they wanted to discuss any concerns and that they were open and ready to listen. We found that staff received an annual appraisal where their progress was measured and they were able to talk about issues that mattered to them.

Training was carried out regularly and one staff member told us, "We have regular training and I learn a lot from it. I have done safeguarding training and it has helped me understand how to keep people safe". A second member of staff told us, "I really enjoy the training we do, it's very useful". We saw evidence of the training staff had undertaken.

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.

Staff we spoke with had a good understanding of the MCA and DoLS and they were able to give examples. One staff member told us, "Mental capacity is about not being able to make your own decisions. A person may say that they do not want to go to the toilet but they may really need to go and DoLS would be about legally taking them for their own benefit". Another staff member told us, "If you wanted to keep somebody contained by the use of bedrails, then you would need to apply for deprivation of liberty, as you are stopping their movement". We found that mental capacity assessments were carried out at the point of entry into the home and that the questions posed and judgements were recorded on people's care files. We saw that 16 DoLS applications had been submitted, with two applications being approved by the external agency processing them.

People told us that staff asked their consent before carrying out actions, with one person telling us, "They ask my permission, but I usually do things for myself". A relative shared with us, "They always ask [person's name] consent and they explain why they are doing it too". A staff member told us, "We always ask, but if people can't reply, it will have already been agreed with family in a best interests meeting and the consent agreements are signed and are in care plans". We found that these agreements were in place. We saw an example of consent being requested at lunchtime when staff asked people if they would like to wear a napkin and they explained why they were asking.

People told us that they enjoyed the food provided and one person said, "I have cooked meals and I like the breakfast. I have a cup of tea when I want one". A second person told us, "The food is lovely and it is all home cooked". A relative told us, "I have eaten here, its good healthy cooked meals and good portion sizes". There was a daily menu written on a white board in the dining area, however this was not easily understandable and some of the words were unclear. We saw that the meals were enjoyed and that most people's plates were emptied. People were offered a choice of meal and it was explained to them what was on the different plates. There were also alternatives on offer such as, soup, sandwiches or salads.

Some people chose not to eat in the dining area and this was accommodated by staff. We observed that people eating in their rooms had their food delivered at the same time as other people received theirs at the table. We saw that dietary preference sheets were kept in the kitchen area and staff told us that changes in people's diets were also discussed at each handover. When asked staff were able to explain to us, specific people's needs.

We found that important documents related to people's health, such as doctor's appointments, letters relating to tests and any emergency calls were available in people's care records. People told us that they attended hospital appointments related to their various ailments and that staff had arranged appointments for them. A staff member told us, "We arrange lots of appointments for people and make sure they attend on-going appointments for things like physio or therapy".

Requires Improvement

Is the service caring?

Our findings

A relative told us, "[Person's name] worries too much to drink, as they are not always taken to the toilet when they ask, so they would rather go without a drink than be desperate for the toilet". We raised this with the manager who told us that he would speak with staff members to ensure that they understood the importance of people being assisted to the bathroom if they required help.

At lunchtime we observed a person who appeared distressed. They had been trying to eat their meal but were unable to lift their fork to their mouth. The deputy manager approached and asked if the person would like a yoghurt instead, completely unaware that they wanted to eat the meal. The yoghurt was left untouched. We asked a member of staff to assist before the meal went cold, she did so and the person started to eat. Only a few mouthfuls were consumed, but the person readily ate these, until they decided they did not want anymore. We informed the manager about this and he said that he would speak with staff about ensuring that people received assistance if required at mealtimes.

People told us that the attitude of staff towards them was a caring one. One person told us, "They are kind to me and help if I need it". Another person said, "The staff are good company for me". A relative told us, "I think that they care about mom and they try their best". A second relative told us, "From what I have seen they are kind and compassionate". A staff member told us, "We do all that we can to help people, we try our best, sometimes people want more than our best, but we try". We saw examples of staff working to support people this included a person worrying they couldn't find their glasses that they were already wearing. A staff member gently guided their hand to their face and showed them where they were. Another example displayed was staff delivering morning newspapers to people and then sitting and reading the headlines to them and engaging them in a chat.

People said that they felt that most of the time they were listened to by staff. One person shared with us, "Staff try and listen to us, but they have lots to do." A second person told us, "They have taken new staff on recently and they seem to want to listen". A relative told us, "Lots of times staff just don't seem to have a lot of time to sit and listen, but some of them will stop and sit with people". A staff member told us, "We would listen if someone wanted something, we try and help them". We found that staff were sensitive to people where their communication was limited and we found that they relied on gestures, body language and short phrases to assist communication.

We were told by people that they were encouraged to make their own choices and decisions. One person said, "I can choose my own clothes and meals". Another person told us, "I chose my own cardigan today, with some help". We found that people were assisted to be as independent as possible and a relative told us, "They [staff] encourage independence and find out what people can do". A staff member shared with us, "Some people get into the habit of not doing anything, but we try to get them to help themselves with a bit of help from us". Staff were not aware of advocacy services to refer people onto when we spoke with them, but one staff member told us, "They [people] have professionals visiting all the time and they have social workers to help". We saw that advocacy service details were on the notice board for the benefit of people who live at the home.

People shared with us that their privacy and dignity was respected with one person saying, "They [staff] help me to have a wash, but they always keep me covered". A relative told us, "I am satisfied that they [staff] keep people's privacy and dignity". A staff member said, "It is a very personal thing to have to assist with personal care, we do our best to not make it awkward and I think everyone understands that it is something we do, but we don't make a fuss about it so nobody is embarrassed".

We saw that visitors were made very welcome and that they knew staff well. A person told us, "When my family come in to visit they are made welcome". One relative told us, "I am very welcomed and I can bring my relatives much loved pet in to see her". A staff member said, "We love to see relatives and know them all, we just ask that they respect meal times, but they are always welcome".

Good

Is the service responsive?

Our findings

People told us that where possible they had been involved in compiling their care plan. One person said, "They [staff] asked me about what I needed them to do for me". A relative told us, "We are involved in care plans and informed of any proposed changes". A staff member told us, "There is a lot of input from people and their relative put into the care plans". We found that care plans were updated regularly and this included likes and dislikes, routine and any prompts needed alongside physical and medical needs. We saw in people's care plans that they and their relatives had signed to say that they had been involved. Staff were also able to discuss with us their knowledge on specific people's needs. Pre-admission assessment documentation also formed part of how risk was assessed with previous needs and requirements noted from the point of admission and staff were able to speak with knowledge on people's needs and the possible risks posed to them.

People told us about activities that they participated in. One person said, "I like to complete jigsaws or go for a walk with staff". Another person shared, "I like to go into the garden area and they [staff] get me the newspaper that I like". A relative told us, "We come all of the time and see them [people] doing things. We see the exercise man, Monday music, throwing and catching a ball and doing puzzles and painting. [Person's name] loves it". Another relative told us, "[Person's name] reads a lot and has a lot of books, they prefer that to getting involved in activities". A staff member shared with us, "When we organise activities we listen to what people want to do". A second staff member said, "It might be possible to put on more things for people to do, but a lot of people only want really gentle activities, their faces light up when we interact with them, but they are happy to sit and talk". We saw people completing individual puzzles and flower arranging with staff on a one to one basis.

One person told us, "I have a friend here". We saw people sitting together and chatting and that people could choose wherever they wanted to sit and with whomever they chose to. Staff were aware of who got along with who and we saw that they supported and encouraged friendships to develop.

We found that equality and diversity issues were part of the care plan and that people were asked about their beliefs, culture and religion and what support they required to meet their needs. Some people that we spoke with told us that they enjoyed attending a church service, put on once a month and that is was a comfort to them. Staff informed us that they would be able to arrange religious or cultural services from any denomination requested.

People told us that they understood the complaints procedure. One person told us, "I have never had to make a complaint, but I think they [staff] would listen if I did". A relative told us, "I have complained about [relatives] care and we are now having a meeting. Having lots of changes in managers has been really negative, so I am hoping this one stays and does something". We found that complaints had been recorded and that the action taken was shown as part of an audit trail.

People we spoke with told us that they hadn't received any questionnaires seeking their feedback on the service. The deputy manager informed us that they were unable to provide us with details of any previous

questionnaires that had been sent out, as they were unable to be located within the home. The deputy manager informed us that surveys would be sent out to people and relatives as part of the new manager's plan for the home.

Requires Improvement

Is the service well-led?

Our findings

Both the manager and deputy manager had only been in post for a matter of weeks at the time of our inspection. We found that despite them acknowledging that there were concerns around issues related to people not swallowing medicines, lack of fluids and poor recording of fluid intake and support from staff not always being available to people, no positive action had been taken to address these issues. The manager was now in a period of time where they could use their input to improve practices within the home and sustain them and they told us that they were enthusiastic for this challenge, but suggested that it would take some time.

The manager told us that as part of their plan for running the home quality assurance would form a large part of their role. We found that they had started to put things in place to scrutinise practice within the home and that it was as the manager stated, "a work in progress". We saw that audits carried out included those around skin viability, health and safety, nutrition, mental capacity, complaints procedure, the use of bed rails and medicines. Although audits were carried out around fluid intake, the regularity of recording was not consistent. The manager informed us that people would be looked at to see if they were at risk of dehydration and where required they would have a specific plan to monitor and record fluids taken.

People told us that they knew the new manager and one person said, "The new manager has introduced himself to me". Another person told us, "The manager is always out and about around the home". A relative told us, "[Manager's name] is a very nice person". A second relative told us, "It is run ok, [manager] seems to be doing a good job". A staff member told us, "It is a new start having the new manager here, he seems to be enthusiastic and full of new ideas". We saw the manager talking to people at lunchtime and they were familiar with him and happy to chat.

We were informed that a new managing director had been appointed and he would be taking over the daily running of the home alongside the manager. The managing director made himself available to us during the inspection and shared with us his plans for the future of the home. The manager told us that he felt supported by the managing director and that alongside new initiatives such as expanding the garden and updating people's files, he had plans for adopting a computerised system to record medicines, which would be of benefit to the home.

We spoke with the managing director who showed us how the garden had recently been extended and that it had been designed to ensure the optimum amount of space for people to enjoy. People we spoke with told us that they enjoyed the new garden facilities. We were also told by people how they enjoyed occasions when children from a local primary school would visit to sing for them.

One person told us, "I have no regrets coming here the building is great". We saw that the lounge area was very bright and sunny and that the atmosphere was vibrant and filled with chatter coming from many staff and visitors. However should people wish to sit in a quieter area, there was designated seating at both ends of the lounge for people to use.

Staff members shared with us their views on whistle-blowing, where they would make a declaration to the appropriate agencies should they witness negative practice by colleagues. One staff member told us, "Whistle-blowing is supported we know what it is and how to do it". Another member of staff said, "It is our job to care, so we have to do it if people are being treated badly, thankfully I haven't needed to".

Staff told us that they had attended team meetings and that they were able to raise issues and share ideas. One staff member said, "We could go to the manager and I am sure that they would listen". A second staff member said, "Although he hasn't been here very long the manager has told us about his plans for the service". We found that a residents meeting had been arranged for the end of the month and staff were aware of this. The manager told us that these would be held regularly with relatives invited.

We received notifications of incidents and accidents as we should and this allowed us to see how effectively staff responded to people's needs. We saw that the previous CQC rating was displayed appropriately and that the home's website had a link to the CQC report.