Five Acres Nursing Home Limited

Five Acres Nursing Home

Inspection report

Hamner Road
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Milton Keynes
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Date of inspection visit: 02 July 2015
Date of publication: 17/09/2015

Ratings

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

Overall summary

Five Acres Nursing Home is registered with the Care Quality Commission (CQC) to provide care for up to 32 older people, who may be living with dementia. At the time of our inspection there were 28 people living in the home.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection on 19-21 May 2015, we found that there were ineffective systems in place to manage and monitor the prevention, and control of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We also found that the provider hadn't always sent the CQC statutory notifications when a Deprivation of Liberty Safeguard (DoLS) application had been approved. A notification is information about important events which the service is required to send us by law in a timely way. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

As a result of further concerns that we received, we undertook a focused inspection on 2 July 2015. These concerns stated that some people had not been provided

Summary of findings

with effective pressure care management, and were not cared for using appropriate preventative equipment. Staff did not have an awareness of pressure care and the requirement to monitor and report marks to skin, or the implications of marks to people's skin integrity. The failure to refer pressure ulcers to the relevant professionals meant that appropriate treatment and equipment was not available.

Concerns were also raised in respect of poor infection control systems, which meant that people were exposed to an increased risk of cross infection.

We also received information of concern stating that people were not always adequately hydrated.

Prior to our inspection it was evident that pressure care and wound care had not been well managed within the service, to the detriment of people. Referrals had not been made in a timely manner and advice given by professionals in respect of wound dressings, preventative intervention and required equipment had not been followed. Staff did not have a robust awareness of the correct way in which to monitor people's skin integrity and pressure areas, and when to react to changes. Records did not provide an accurate record of the care given.

We found that some improvements had recently been made to strengthen the care records and the wound care management given to people. This meant that people were now receiving the care they needed, in respect of wound management. There was still further improvements to be made in respect of ensuring staff had effective knowledge of wound care and when to react to changes within people's skin integrity.

People were receiving adequate hydration and this was recorded on food and fluid charts so that it could be determined whether they had achieved their required fluid balance.

We had not been notified of all legally required notifications.

We found that some improvements had been made to the systems in place within the service, to ensure that appropriate standards of cleanliness and hygiene had been maintained. New cleaning schedules had been implemented to ensure that cleaning regimes were effective. Staff had reviewed their practice in respect of cleaning, and had worked to ensure this was now more thorough.

We identified that the provider was not meeting regulatory requirements and was in breach of some of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of 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?
The service was not always safe.

We identified that improvements had been made to the infection control systems and processes. The service was cleaner although staff acknowledged that there were still improvements to be made.

Inadequate

Is the service responsive?
The service was not always responsive.

It was evident that the past provision of care in respect of pressure care and wound care management had not been effective and had significantly impacted upon people's wellbeing.

Care plans in place to support staff to meet people's assessed care needs, required further improvement to ensure they were reflective of people's required needs. We did however see that these had been updated in respect of recent safeguarding outcomes and that the care detailed within them was being carried out.

Requires improvement

Is the service well-led?
The service was not always well- led.

Statutory notifications were not always submitted in accordance with legal requirements.

Inadequate

Five Acres 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 the 2 July 2015, and was unannounced. The inspection was undertaken by a team of two inspectors.

Prior to this inspection we received information of concern. We therefore reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We spoke with the local authority and Clinical Commissioning Group (CCG) to gain their feedback as to the care that people received.

During our inspection, we observed how the staff interacted with the people who used the service, how people were supported during meal times and also during individual tasks and activities. Some people communicated with us by gestures and facial expressions or spoke a few words, rather than by fluent speech. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people as well as the registered manager and new clinical manager, three care staff, and two healthcare professionals.

We looked at 12 people's care records to see if their records were up to date and reflected their care needs. We also looked at other records relating to the management of the service, including accident and incident forms, safeguarding records and quality audit records.

Inadequate

Is the service safe?

Our findings

During our last inspection on 19 and 21 May 2015, we identified issues in respect of poor hygiene and cleanliness. Many areas of the home had not been well cleaned and there were not effective

systems in place to reduce the risk and spread of infection. This was in breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Prior to this inspection we received information of concern regarding the cleanliness of the service and the infection prevention and control procedures which were in place at the service.

Our observations during this inspection confirmed that people's bedrooms had been cleaned to a higher standard. They were cleaner and smelt fresh. We found that all through the service, improvements had been made to the cleaning systems since our last inspection. Communal toilets and bathrooms had been cleaned more effectively, although there were still some areas that required a deeper clean. We found that there was on-going cleaning in operation and that housekeeping staff had been given increased hours to ensure that a more stringent cleaning schedule could be implemented.

The clinical manager told us that as a result of our last inspection, staff were now more vigilant to infection control and standards of cleanliness throughout the service. We observed that rather than one member of staff cleaning the service, there was three staff on duty undertaking cleaning. Staff had access to a good supply of protective equipment for the tasks they were carrying out, for example, disposable gloves and aprons when assisting with personal care. We found that there were good supplies of cleaning equipment, with colour-coded mops and cloths for use within different areas.

The registered manager and clinical manager acknowledged that further improvements could still be made and informed us that they were going to implement a 'walk around' check on a daily basis with the housekeeper to ensure that everywhere was kept clean. A new mattress audit had also been implemented to conduct regular checks of all mattresses in the service for signs of wear and tear, as well as to monitor their cleanliness and suitability for people to use. This would ensure the on-going maintenance of appropriate standards of cleanliness and hygiene within the service.

Risks to people's safety had been assessed and included those associated with malnutrition, pressure damage and falls. The clinical manager told us that risk assessments were in place to manage identifiable risks to individuals. We found that individual risk assessments had been completed for people and had been updated on a regular basis. Risk assessments were in place to manage identifiable risks to individuals in a way that did not restrict people's freedom, choice and control more than necessary. We found that specific risks to people such as moving and handling, pressure care, falls and weight loss had been assessed and reviewed. However, waterlow scores had not always been scored correctly. Neither did they dictate the frequency with which they should be reviewed, for example, there was nothing to determine if a person was deemed at high risk of pressure damage, how frequently they should be reviewed.

We observed staff on a number of occasions supporting people as they moved about the home. They demonstrated safe techniques, and provided people with clear explanations, so they understood what was happening to them.

Requires improvement

Is the service responsive?

Our findings

Prior to this inspection, we received information of concern regarding people's pressure care and the way in which staff provided appropriate care. Care plans were not always developed with reference to the guidance given by the tissue viability nurses and that action was not always taken when problems had been identified. Concerns also included that referrals had not been made in a timely manner, that pressure wounds had not been graded and that care plans did not contain sufficient information about the frequency of dressing changes required.

We found that pressure care and wound care had not been well managed within the service, to the detriment of people. We identified that referrals had not been made in a timely manner and advice given by professionals in respect of wound dressings, preventative intervention and required equipment had not been followed. This has resulted in people's skin integrity breaking down and pressure wounds developing as a result. Staff did not have a robust awareness of the correct way in which to monitor people's skin integrity and pressure areas, and when to react to changes. Records did not provide an accurate record of the care given.

Following professional input, including continued support from the tissue viability nurse, we saw that improvements had been made to people's pressure area care. Appropriate equipment, dressings and treatment were now available For example, we saw in people's records that they were regularly turned to relieve pressure areas.

The care plans we reviewed showed evidence of action being taken to make them more specific and to guide staff as to the care that was actually required. We did find some positive examples of care plans which contained robust information about people's care needs. In some records, there was no detail as to the size of sling required for manual handling or the setting that the pressure mattress needed to be set on to ensure that optimum pressure relief was given. We discussed this with the clinical manager and were advised that this would be addressed in conjunction with the other issues of concern that the local authority had identified.

This was a breach of Regulation 12 (1) (2)(a)(e)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The clinical manager spoke with us about the issues that the local authority had found and told us they were working hard to address these issues. The registered manager and clinical manager both acknowledged that they had some improvements to make in respect of the specific information required in some people's care plans and confirmed that this would be part of their overall action plan to make improvements. For example, the frequency of review required for people's risk assessment and screening assessments.

Inadequate

Is the service well-led?

Our findings

During our previous inspection on 19 and 21 May 2015, we found that we had not always received all required notifications from the provider. We found that we had not received statutory notifications when a Deprivation of Liberty Safeguard (DoLS) application had been approved. A notification is information about important events which the service is required to send us by law in a timely way. We discussed this with the registered manager who told us that he was not aware this was a requirement but that they would address this with any future approvals from the supervisory body.

This was a breach of Regulation 18 (4A) (a) & (4B) (a) (b) (c) (d) of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

Prior to this inspection, the information CQC held showed that we had not always received all required notifications. We found that the provider had not notified CQC of events that they were required to do so. During our inspection we found that a person's health had significantly deteriorated and the service had not raised a statutory notification. In addition we found that an incident had occurred within the service which resulted in potential harm or abuse, for which we also did not receive a statutory notification.

This was a breach of Regulation 18(1) (2) (a)(i)(ii) (b) (f) of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **There were no effective systems in place to manage and monitor the prevention and control of infection or ensure that the premises and equipment used was safe and cleaned to an appropriate standard.**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person had not sent statutory notifications to the Commission.**