Mr & Mrs N Nauth

Credenhill Court Rest Home

Inspection report

Credenhill Court, Credenhill, Hereford, Herefordshire
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Website

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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

Overall summary

This inspection took place on 10 November 2014 and was unannounced. The Credenhill Court Rest Home provides nursing care for up to 35 people. There were 32 people living at the home when we visited and there was no registered manager in post. The previous registered manager left on 9 May 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People told us they felt safe. Staff knew what to do if they had a suspicion of abuse.

Staff had the information to keep people safe. However, not all plans were reviewed regularly. People told us that staff were kind and compassionate towards them. We saw that the staff talked to people respectfully although some of the phrases used could have been less directive.

We saw that there were enough care staff available to meet people's needs. Training for staff was ongoing so that they would be aware of the latest ways for meeting people's needs.

We saw that people's medicines were managed so that they received them safely.

Summary of findings

The deputy managers were clear about the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguarding's (DoLS). However, reviews as to whether or not people needed to be subject to a DoLS had not taken place. This meant that the provider could not be sure that all steps had been taken to protect the rights of those people.

People had access to medical professionals should they need to. People's records showed when and why visits happened. However not all records were maintained fully. This meant the provider could not be sure that appropriate had taken place to ensure that the person's needs were met.

We talked with the deputy managers who told us that the provider did not regularly visit the service. There were no records of any visits that would have showed that the provider assessed whether the service was meeting people's needs.

There were no effective means of identifying trends in accidents and incidents. This meant that risks to people may not have been identified and ways to reduce those risks put into place.

There was no evidence that the provider had sought people's views of the way the service supported them. Records of visits by the provider or analysis of surveys could not be found.

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 safe.

Staff did not always know how to keep people safe and reduce the risk of harm as they did not always have a good understanding of their needs.

There were enough staff available to support people and help meet their needs in a safe and timely way.

People's medicines were managed so that they received them safely.

Requires Improvement

Is the service effective?
The service was not effective.

People were supported by care staff who had received appropriate training.

The manager and staff understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). However, the provide had not made DoLS referrals when needed.

People were provided with a choice of meals and drinks that met their dietary needs. People were referred to appropriate health care professionals to ensure their health and wellbeing was maintained.

Staff did not always follow advice and guidance so people's health needs were not always supported effectively.

Requires Improvement

Is the service caring?
The service was not caring.

While people were treated with respect most of the time the way staff addressed them could be very directive.

People and their relatives were encouraged to express their views on the care they received and staff were knowledgeable about their needs.

People were generally treated in a dignified and respectful way but a number of people were seen to be unkempt in appearance.

Requires Improvement

Is the service responsive?
The service was responsive.

People had their needs and requests met by staff who responded appropriately.

People's wishes and preferences, the opinions of relatives and other health professionals were usually listened to. This ensured people received the care and treatment that met their needs.

People were supported to raise concerns and complaints.

Good

Summary of findings

Is the service well-led?

The service was not well led.

People and their relatives were confident that their concerns would be listened to and acted upon.

The provider had not taken steps to assess and monitor the home to take account of people's preferences and the views of relatives and other professionals.

Staff were not supported by a registered manager but someone had been recruited to that post and was to commence their employment in the near future.

Requires Improvement

Credenhill Court Rest 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 was 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 10 November and was unannounced.

The inspection team consisted of two inspectors.

We looked at information sent to us by the provider and other bodies such as local authorities who fund the placing of people in this service and the local Healthwatch.

We talked with seven people who used this service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing how people interact with others to help us understand the experience of people who could not talk with us. We talked with relatives and staff. We looked at four records about people's care, staff duty rotas, complaint files and records that showed how the home was monitored by the provider.

Requires Improvement

Is the service safe?

Our findings

We saw care plans that were designed to ensure that staff had information to keep people safe. However, we saw that in one person's care record they had been assessed as being at low risk of falling three months before our inspection. Two weeks after the completion of that assessment they had suffered a fall. We talked with the deputy managers on duty and they told us that a review of the persons falls assessment had not been carried out since then. This meant that they could not be sure that measures were in place to reduce the risk of the person falling again. Where risks to other people had been identified assessments detailed how to minimise or manage them.

We talked with people and they told us they felt safe and the staff treated them well. One person said, "I feel very safe". All of the people we talked with told us they felt they could talk about concerns with any of the staff if necessary.

All staff we talked with knew what to do if they suspected abuse had taken place and said that they would report this to the manager. They told us they were aware of external agencies that they could report to if they suspected abuse or had concerns about people. One staff member said, "I'd report it to one of the managers and check to make sure they had done something about it". They told us that they felt able to report any suspicions they might have about possible abuse of people who lived at the home. One issue had been referred to the local authority safeguarding team. We talked with the local authority and they told us that the service had cooperated with their investigation and implemented their recommendations.

We saw that care staff were supported by the three deputy managers, catering, administration and housekeeping staff. People told us that staff were available to support them when they needed assistance. One person said, "There's usually someone around to help". What we saw, such as people being assisted to move around the building confirmed this. The deputy managers told us that the staffing levels had been established according to the needs of the people using the service and these were reviewed when people's needs changed.

People we spoke with told us that staff managed their medicines for them and they felt they received their medicines at the same time every day. One person told us, "We get our tablets when we should have them".

We saw that people's medicines were managed so that they received them safely. Staff told us that their ability to give medicines was regularly assessed by the senior staff.

The type and quantity of each person's medicines was clearly recorded. The times each dose should be given was also clearly shown in the medicines administration records. There were clear guidelines that had been written for the staff to follow to make sure that medicines were given correctly.

We saw the medicines were stored and handled in a way which ensured that only the correct person could be given them. When unattended storage was kept locked and only one person's medicines was handled at a time to avoid confusion.

Requires Improvement

Is the service effective?

Our findings

The managers were clear about the requirements of the Mental Capacity Act 2005 and DoLS. However, reviews as to whether or not a number of the people that we saw needed to be subject to a DoLS had not taken place. Many of the people we saw and spoke with were unable to fully communicate. We saw that most records referred to this in their mental health care records. Only one DoLS application had been completed for people who lacked capacity and may have been deprived of their liberty. The deputy managers told us that they had been prompted to do so by a visiting professional. This meant that the provider could not be sure that all steps had been taken to protect the rights of those people. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We talked with staff and they told us that they had received training in the Mental Capacity Act 2005. However not all could explain how they would meet their responsibilities within it. This meant that people's right to choose may not always be respected. An example of this was the lack of choice of drinks at lunch time. We saw that everyone was given the same drink and nobody was asked if they would like an alternative.

People told us that they had access to medical professionals should they need to. People's care records showed when and why consultations happened although they did not always show the outcome. The records showed how people's health was monitored, however not all records were maintained fully. An example of this was that a medical professional had advised that one person should be encouraged to drink more and that their GP should be contacted the following day. We asked the staff and they could find no information about the outcome of the call. Talking with the two deputy managers established that neither had been aware of the increased need to encourage the person to drink more fluids. This meant that appropriate systems were not in place which ensure that the person's needs were met.

We saw many examples of staff providing support to people in an appropriate way. Staff told us that they had received training and individual support from the management team that helped them to meet people's needs. The deputy managers told us and the training plan showed that training for staff was ongoing so that they would be aware of the latest ways for meeting people's needs.

People told us the staff helped them in the ways that they preferred. They also told us that they were involved in planning their care. One person said, "They asked about me and seem to remember what I said". We looked people's care plans. We saw that the care plans described the care people had either described or we had observed.

We saw that each person was offered a choice of meals each day. We were told "It's all right – plenty of it". We looked at the menus and saw that people were offered a varied and nutritious diet. We also saw that if people did not want either of the choices being offered they could ask for something different. At lunch time we saw that the meal was presented in a way that people's records said they found easy to manage being mashed or pureed if necessary. Where people needed assistance the staff were available. We saw people being helped in and out of chairs, assisted to go from one area of the building to another and helped with their meals.

We saw that if a person required a special diet for medical reasons then one was provided. We talked with the staff and they were aware of people's dietary requirements.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and compassionate towards them. One person told us, “Care staff look after me very well”. Another person told us, “They’re good staff’”. We saw that the staff talked to people with respect including friendly banter although some of the phrases used could have been less directive. We heard some conversations where staff were telling people what they must do rather than giving them choices. For example “Go to the toilet”, “Eat your breakfast” and “Go and sit in the lounge”.

Some people were unable to express their views about their care. Staff told us that they asked family members about people’s preferences so that they had information from people who knew them well. We saw that staff involved them when they were supported giving them choices and options. People told us staff asked what they wanted and how they wanted things done. One person told us, “You can ask them anything”. One person told us how they had talked with the staff about their care. They said, “I can have a bath every night.” The person told us that they preferred to have a bath in the evenings. This showed that this person was involved in choices about their own care.

All the people we spoke with told us and we saw that staff respected people’s privacy and dignity when they were supported with their care. One person told us, “They make sure I’m all right – very discreet about it”. We saw that staff were discreet when they assisted people with their personal needs and knocked on doors and waited for a reply before they entered. We saw people being helped to stand from the armchairs in the main lounge. This was done in a way that preserved people’s dignity.

All clothes worn by people were clean, smart and individualised in style. We saw that some attention was paid to people's appearance, including their hair and nails. However, a number of the men appeared to be unshaven. We asked them if they would have liked to have been shaved that morning and they said they would but they had not been. This did not help people to look their best and maintain their self-esteem.

Good

Is the service responsive?

Our findings

People told us they received care, support and treatment when they needed it. People told us staff listened to them and responded to their needs. For example, we saw a person wanted to find their jacket in their bedroom. We heard a staff member ask this person what they wanted and we saw them help the person look for it. The staff member chatted with this person and then helped them down the stairs. We later spoke with this person and they told us, "We are really enjoying it here".

We talked with two people who had recently started to use this service. They told us that senior staff had talked with them about what their needs, wishes and interests were. They said that the information about them appeared to have been given to the staff as they seemed to know their likes and dislikes.

People that we talked with said that they did not always have something to do. They commented, "It can be quite boring here" and "Can be a bit boring at times". We talked with the managers and the staff. They told us that they had talked with people to find out what they wanted to do and had arranged for extra activities to take place. Others said that they had had enough activities to take part in with one saying, "We're not bored, we've got plenty to do"'. We saw posters that showed a variety of activities that were offered each week. These included arts and crafts, bingo, quizzes, gardening and board games. This showed that there were a range of activities for people to take part in. Staff told us that group activities are organised by the activities coordinator. They told us that people were asked about their interests and hobbies so that these could be taken into account when activities were being arranged.

We saw staff used the time they were providing people with support to talk to them about what was important to them. Organised activities, the use of various communal areas and the one to one support from the staff gave people the opportunity to mix socially with others.

People that we talked with told us that they were confident to raise any concerns that they may have. One person said, "There was something and I went straight to the office". Another person told us, "If there was a problem I'd talk to the manager about it". We saw that there was a copy of the service's complaints procedure in the hallways where people could see it if they needed to refer to it.

Staff told us that they used the discussions that they had during general conversations to identify people's concerns. They then tried to address issues quickly to avoid unnecessary distress to the person concerned

Requires Improvement

Is the service well-led?

Our findings

People told us they knew who the deputy managers were and one person told us, "I see them around". Staff told us that the deputy managers were always accessible so that they could talk to them as issues arose. People were complimentary about the staff and the deputy managers. We observed that people spoke with the deputy managers and staff without hesitation at any time.

The provider sought the views of people about the quality of service provided by asking them to complete questionnaires. We saw that this had been done in January 2014. The completed forms had been kept together with a form that, when completed, was intended to analyse the overall results. This form had not been completed. Similar forms were seen for questionnaires completed by staff and visitors. These had not been completed indicating that the provider had not used the results of the surveys to assess how the service could be developed.

At the time of this inspection there was no registered manager for this service. Staff told us that someone had been identified and recruited for this role and they would be starting in the new year. Information we held told us that where necessary the service normally notified us of events that they are required to inform us about.

At times the day to day running appeared disorganised. An example of this was at lunch time. As there were not enough places for everyone to have lunch together two sittings were required. However, people were brought to the dining area to find that there were not seats available. A number of the people that this affected had mobility issues which was why they were amongst the late comers. They then had to return to the lounge which was difficult for them. Forward planning could have made lunch time a much more pleasant experience for those people.

The deputy managers told us there was no effective means of identifying trends in accidents and incidents. This meant that risks to people may not have been identified and ways to reduce those risks put into place. We talked with the deputy managers who told us that the provider did not regularly visit the service. There were no records of any visits that would have showed that the provider assessed whether the service was meeting people's needs.

We saw records that showed that a range of the equipment used in the home were checked regularly. These showed that such things as wheelchairs and defibulators would have been in safe working order if they had been needed.

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	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People had not been protected against the risk of control or restraint. Regulation 11 (2) (a) and (b).**