Danaz Healthcare Limited

Pax Hill Nursing Home

Inspection report

Pax Hill
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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 well-led?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 24 February 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to care and welfare and records.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pax Hill Nursing Home on our website at www.cqc.org.uk.

Pax Hill Nursing Home is a 98 bed nursing home registered to provide care for older people and younger adults. The service is registered to provide care for people who experience physical health or mental health conditions including dementia. At the time of the inspection there were 82 people using the service.

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.

Summary of findings

Staff had followed the provider's guidance in relation to people's care following a fall. Records showed people had been assessed when they fell to identify if immediate medical assistance was required. People were then monitored for a period of time following the fall to enable staff to assess if their condition had deteriorated and their falls care plan had been updated where required. Risks to people following a fall were managed safely and clearly documented.

Changes had been made to the lunchtime service on Montgomery unit which accommodated people who experienced dementia. Staff had received additional dementia awareness training to enable them to increase their understanding of the needs of people who experience dementia. The changes to the lunch service supported people to be more actively involved in making choices about their lunch. People had a positive lunchtime experience as consideration had been given to their needs and staff understood how to meet them.

Staff now completed a comprehensive record of the care provided to people at night in order to demonstrate at what time people had been checked and by whom. Appropriate information was recorded in relation to people's care at night. This protected people in the event any potential investigation was required in relation to the care they had received at night.

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?

Requires improvement

We found that action had been taken to improve safety.

The provider had taken action to ensure staff followed the post-falls protocol when people experienced a fall. Records demonstrated that people had been assessed following a fall, monitored and their care plans reviewed to ensure their safety.

This meant that the provider was now meeting this legal requirement.

We could not improve the rating for is the service safe? from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Requires improvement

We found that action had been taken to improve effectiveness.

The needs of people who experienced dementia were met effectively at lunchtime as staff understood how people communicated and changes had been made to the lunch service to meet their needs and enhance their experience.

This meant that the provider was now meeting this legal requirement.

We could not improve the rating for is the service effective? from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires improvement

We found that action had been taken to improve well-led.

People's night care records contained a sufficient amount of information to protect them against the risks of unsafe or inappropriate care.

This meant that the provider was now meeting this legal requirement.

We could not improve the rating for is the service well-led? from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Pax Hill 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.

We undertook an unannounced focused inspection of Pax Hill Nursing Home on 2 June 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 24 February 2015 inspection had been made. We inspected the service against three of the five questions we ask about services: Is the service safe? Is the service effective? Is the service well-led? This is because the service was not meeting some legal requirements.

The inspection was undertaken by an inspector. During our inspection we spoke with three people. We also spoke with two nurses, three care staff and the chef in addition to the registered manager and the provider. We reviewed records relating to seven people's care and support, night care records and other records relating to the management of the service. We observed the lunch service on two of the units.

Requires improvement

Is the service safe?

Our findings

At our inspection of 24 February 2015 we found people had not been adequately protected from potential post-fall complications.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 Care and welfare.

At our focused inspection on 2 June 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 9 described above.

Staff used the systems in place to ensure risks to people following a fall were managed safely. We spoke with two people about actions taken following their recent fall. One told us "Staff monitored me after my fall" and another commented "Staff keep an eye on you after a fall". Records demonstrated where people had experienced a fall, staff had followed the provider's post-falls protocol. This ensured they monitored people's health and managed any potential risks to them. Staff knew about the falls protocol and said they used it when people fell. People were assessed following a fall, in relation to any potential injury they might have experienced and to determine whether immediate medical intervention was required. Staff had completed a body map to document the site of any injury sustained by the person. Nursing staff monitored the person's pulse and blood pressure for up to 48 hours after they had fallen in order to identify if their condition was deteriorating. People's falls were also documented on their falls record so staff could readily identify if people were at risk from frequent falls. Where required staff had reviewed and updated people's falls care plan, to ensure their records reflected their current needs. The registered manager audited the incident records on a monthly basis in order to check that staff were completing the post-falls record for people as required. The audit also enabled them to identify any trends in relation to falls and people who were at increased risk of falling.

Requires improvement

Is the service effective?

Our findings

At our inspection of 24 February 2015 we found people living with dementia did not experience effective care at lunchtime to meet their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 Care and welfare.

At our focused inspection on 2 June 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 9 described above.

People who experienced dementia lived on Montgomery unit. The registered manager told us since the previous inspection changes had been made to the lunch service on this unit to enhance people's experience. The chef now served people's lunch and people were shown the meal choices available at the point of service. Staff working with people with dementia had undergone further dementia care training to equip them with the necessary skills to support people effectively at lunchtime. Staff we spoke with said they had undertaken this training and this was confirmed by records. The chef said "We go up and show them the choices" and a staff member told us "People are enjoying lunch more now."

One person told us "The food is good." We observed the lunch service on Montgomery unit. The sight of the chef on the unit helped to reinforce that it was lunchtime and staff were heard to remind people that it was time for lunch. Staff showed people the two main meal options and explained to them what was on each plate. This supported people to make choices about their lunch as they could see and smell the available options. They could also see the size of the potion and decide if they wanted a bigger or smaller portion. Some people were able to vocalise their choice and others used a hand gesture to indicate what they wanted for lunch. When people struggled to choose staff were seen to be patient and spoke with people to encourage and support them. Staff were observant and looked for signs that the person might prefer one meal such as, their eyes lingering on the plate longer. When staff served people their meal they reminded them again what the meal was and checked if they required support. Staff respected people's choices to be independent whilst eating. There was a pleasant atmosphere in the dining room, staff chatted to people whilst they ate. People were supported appropriately with their lunch by staff who understood their needs and helped them to enjoy their meal.

Requires improvement

Is the service well-led?

Our findings

At our inspection of 24 February 2015 we found people were not protected against the risks of unsafe or inappropriate care as their night care records did not contain sufficient appropriate information.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010 Records.

At our focused inspection on 2 June 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 20 described above.

The registered manager told us they had introduced a new night care record, to ensure the checks staff made upon people's welfare during the night were fully documented. This ensured that if a person experienced an accident at night which required further investigation to confirm what checks staff had completed upon the person and at what time, there was a full and complete record of events. The new record sheet included the date of the check, the time the person was checked and by which staff member. It was also documented if the person was awake, sleeping or moving around. Night care records on each unit had been fully completed. People were now protected against the risks associated with inadequate night care records. This ensured complete records were available to enable the investigation of any potential accidents people experienced at night.