Silverdale Care Homes Limited

Silverdale Nursing Home

Inspection report

Newcastle Street
Silverdale
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Tel: 01782717204

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 24 February 2016 and was unannounced. At our last inspection in April 2014 we found that the service was meeting the required standards in the areas we looked at.

Silverdale Nursing Home provides support and care for up to 27 people, some of whom may be living with dementia. At the time of this inspection 27 people used the service.

The service had a registered manager. However, the person currently named on our register was not the same person who was now managing the service. 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 not always protected from the risk of abuse as some staff were unaware of the actions they should take. Some unexplained injuries had not been identified as potential abuse; they were not reported or investigated.

Staff did not always receive the training they needed to be able to support people in a safe or effective way.

The provider did not have effective systems in place to assess, monitor and improve the quality of care.

Some leisure and social activities were provided, but not all people got the support they needed to engage in any meaningful activity. People were not always treated with dignity and compassion and their privacy was not always promoted.

People generally told us they enjoyed the food and had enough to eat and drink. The mealtime experience could be improved to ensure it was an enjoyable experience for all people.

People's medicines were managed safely, and people received their medicines in a timely way.

The Mental Capacity Act 2005 (MCA) is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The Deprivation of Liberty Safeguards (DoLS) are part of the MCA. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The provider followed the principles of the MCA by ensuring that people consented to their care or were supported by representatives to make decisions.

People were supported to access a range of health care services. When people became unwell staff responded and sought the appropriate support.

The provider had a complaints procedure and people knew how and who to complain to.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe. People were not always safeguarded from abuse as staff were unsure of what to do if they suspected someone had been abused. Risk of harm were assessed and action taken to minimise the identified risk. There were sufficient staff, employed using safe recruitment procedures to meet people's needs. People received their medicines in a timely way.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff had not been provided with appropriate training to fully meet people's needs and promote people's safety, health and wellbeing. People's nutritional and healthcare needs were met. The principles of the MCA and DoLS were followed to ensure that people's rights were respected.

Is the service caring?

Requires Improvement

The service was not consistently caring as we saw some staff working practices were not as caring as they should have been. People's dignity, privacy and modesty was not always upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Some people were being supported to participate in leisure and social based activities, but improvements were needed to ensure these met everyone's needs. People knew how to complain if they needed to. Care plans were reflective of people's current care and support needs.

Is the service well-led?

Inadequate

The service was not consistently well led. Some systems were in place to assess and monitor the quality of care provided but these were not as effective as they should be.

Silverdale 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 24 February 2016 and was unannounced. At the last inspection in April 2014 we found the service was meeting the required standards.

The inspection team consisted of two inspectors 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.

Prior to the inspection we looked at the information we held about the service. This included notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We spoke with three people who used the service; they were able to tell us their experiences with the service. We spoke with other people but due to their communication needs they were unable to provide us with detailed information about their care. We therefore spoke with the eight relatives of people who used the service to gain feedback about the quality of care. We spoke with the manager, a nurse, four care staff and the activities coordinator. We looked at four people's care records, staff rosters, two staff recruitment files and the quality monitoring audits. We did this to gain people's views about the care and to check that standards of care were being met.

Inadequate

Is the service safe?

Our findings

Not all staff we spoke with had knowledge of safeguarding people from abuse and harm. Not all were able to explain how they would identify abuse or what they would do about it. One member of staff told us they would report any concerns to the manager even if the manager was unavailable and not at the service. We saw one person had sustained bruising to their arms, this was recorded in their daily notes but no investigation had been made as to how the bruising occurred and this was not referred to the safeguarding team. We saw some other people with bruising to their hands and arms, staff were unable to offer an explanation of how the bruising had occurred. These unexplained injuries had not been referred to the local authority safeguarding for further investigation. This meant that people were at risk because actions had not been taken to safeguard people from further harm.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were assessed and plans were put in place when risks were identified. For example people at risk of developing sore skin had a plan of the care and support they required to help reduce the risk for them. The nurse told us that one person had developed a pressure ulcer and the wound area required regular treatment and dressing. We saw records that indicated the person received regular support from the nurse and the care staff and the nurse told us the wound had improved. Staff told us they regularly supported people with repositioning, to prevent them developing sore skin, throughout the day when they were unable to do this independently. We saw records were completed when staff supported people with this.

Staff told us they had been trained in the safe use of the hoist however we saw two staff used an unsafe technique. The person in the hoist was unaffected by this and we spoke with the manager regarding our observations. They told us they would arrange for all staff to receive refresher training in the safe use of the hoist. Some people had problems with mobility and were at risk of falling. We saw that their walking frames were close by them so that they were easily accessible when needed. Some people needed the mechanical hoist to support them with safely transferring from area to area.

People who used the service told us they felt safe. One person said: "I suppose it's because staff are available if needed. I was falling all the time at home but here I have not fallen once in eight weeks, because they [the staff] remind me all the time to take my frame with me when I move about". A visitor said: "There is always someone in the lounge and if my relative is in his room they pop in regularly to see he is okay". We saw that there was nearly always a member of the staff in the lounge area to provide support to people when they needed help.

We looked at the way the service managed people's medication. Medicines were administered to people by the nursing staff. One person who used the service told us: "I am diabetic and get my medicines dead on time all the time. I am also asked at the same time whether or not I need any pain relief or if I need it in between I only have to ask and if it's safe they give it to me". We observed the nurse supported people with

their medicines in a kind and professional way. They took time to ensure the person knew that it was time to have their medication and waited with them until they had safely taken it. We did see one occasion where the nurse moved away from the medicines trolley and left it unsecured. We spoke with the nurse and the manager about our observations and the risk of this practice.

People told us that the staffing levels were sufficient to meet the needs of people. A person who used the service told us: "Staff always seem to be available if I need them and they often ask me if I am alright or need anything else". Visitors at the service offered their views on the staffing levels and said: "I visit at all different times and it's always the same, there are plenty of staff around. Sometimes they seem a bit rushed if people are off sick but I think there is usually enough". We saw staff were very busy attending to the care and support needs of people and there were times during the morning that people were left alone. People had call bells in easy reach when they were in their bedrooms and staff responded quickly when these were activated.

We looked at the way in which staff had been recruited to check that robust systems were in place for the recruitment of staff. We saw the manager had followed safe recruitment procedures, checks to ensure that people were suitable and fit to work had been carried out prior to them being offered a position. Staff confirmed that checks had taken place prior to starting work at the service. These procedures ensured staff were suitable to work with people who used the service.

Requires Improvement

Is the service effective?

Our findings

We saw several people who used the service experienced periods of unease and anxiety. They became quite agitated and shouted out. We asked the nurse about one person who was particularly agitated; the nurse said the person 'would calm down later'. We saw a care plan for one person who regularly became anxious and stressed, the action needed to reduce the anxieties were recorded as 'divert her mind'. Staff told us they had not had any training in how to support people who experienced and presented behaviour that may challenge. Staff went on to say they received some training, this included fire safety, infection control, moving and handling and food hygiene. The manager told us they had recently arranged training and updates for staff but was unable to show us the plan for the roll out of the training.

Staff told us they had not had a recent one to one supervision session with their line manager and could not recall any annual appraisals of their work performance. The manager confirmed that supervision and appraisals for staff were outstanding and had recently sent a memo to get it put in place. However staff had not had the opportunity to discuss their performance and identify any further training they may have required.

These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us the food was good and they enjoyed it. One person who used the service told us: "The food is smashing, it's lovely. In the evening I have choice and it's up to me if I have an alternative". Another person said: "The food is very good. If I want special food I will get it". A visitor told us the food had recently improved and that people were provided with 'a lot more fresh food'. The manager told us of the recent changes to the meal times and now the main cooked meal of the day was served in the evening. We saw most people were provided with a light lunch although one person because of their medical condition had their main meal at lunch time.

We observed the lunchtime meal and saw most people remained in the lounge to eat, no one was asked where they wanted to sit or if they would like to use the dining facilities. However there would be insufficient dining tables and chairs if many people chose to go to the dining room. The mealtime was disorganised. People were not offered a choice of drinks, all were offered blackcurrant juice. We saw staff placed meals in front of people, they offered a brief explanation of what was on offer and then went on to serve other people. Some people looked bewildered as though they were not sure what to do, staff attempted to encourage people to have their meal, with little success, people were disinterested in the food and had little to eat during this mealtime. We noted that after 20 minutes at least six people had barely touched their food which meant that the soup offered would not be a suitable temperature for people to enjoy.

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. Some people who used the service required support to make decisions and to consent to their care, treatment and support. We saw that several people had a lasting power of attorney (LPA) who were authorised to make specific decisions on their behalf and in their best interests. Staff told us that one person lacked capacity to retain information and to make decisions about their end of life care. We saw that a best interest decision had been made with the LPA, doctor and staff at the service.

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 found the service was working within the principles of the MCA. The manager told us and we saw that DoLS referrals had been sent to the local authority because some people were subject to continuous supervision and not free to leave the premises due to concerns with their personal safety. Some people had legally been deprived of their liberty and had authorisations in place.

People who were able to consented to their care and support. One person who used the service told us: "Mostly they will explain what they are going to do and ask if it is alright". Another person commented: "I do a lot of things for myself but yes they ask permission and will check that I have everything I need". Two visitors spoke with us about their observations and said: "They always tell my relative what they are going to do before they do it, so I suppose they are asking permission really". Another visitor said: "They always make sure that she can hear and say her name in one ear to get her attention and then tell her what they are going to do".

Staff supported people to access health care services should they become unwell or required specialist interventions. One person who used the service told us: "I have lots of health problems and have been in and out of hospital for over 30 years. If I have any problems that the nurses can't manage they get GP involved straight away". Another person said: "They ask me how I am and if I am not feeling too well the nurse will take a look and try and sort it out. The GP comes in every week and if the nurse thinks I need to see him, they arrange it for me". A visitor told us about their relative they said: "He has problems with his chest; staff are aware of this and get the GP in straight away. They always contact me and make sure I am aware of this". We saw that a person had been referred to the dementia services when their memory and health had deteriorated. This meant people's health care needs were met.

Requires Improvement

Is the service caring?

Our findings

There were times when we observed people's privacy and dignity was not upheld. We saw staff supported a person to transfer using the hoist, their dignity and modesty was compromised staff did not offer or provide covering for the person legs whilst they were in the sling.

There were times when there was no communication between people and some were people left to sit for lengthy periods with no stimulation. Some people became agitated and restless, staff did not respond in a timely way to offer support to reduce people's anxieties. After lunch one person sat in a wheelchair for a period of two hours, they were all alone in the dining area. When we spoke with the person they told us they were cold. We asked a member of care staff to help the person to move into more comfortable seating and to a warmer area.

We observed care staff sat with the people at times during the day but there was a variation in the way in which they interacted and some barely spoke to the person they sat with. We saw little communication between staff and people who used the service except when support was offered. There was no social aspect to the mealtime and for some people it was not an enjoyable experience.

We saw that the door locks had been removed from communal toilet doors. No vacant or engaged signs had been positioned on the doors to inform people the facilities were free to use. People's dignity maybe compromised because of this lack of signage. The manager told us the locks had been removed to prevent people from locking themselves in the toilets.

The above evidence shows that people's right to be treated with dignity, privacy and respect was not consistently promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were happy with the care they or their relatives received at Silverdale Nursing Home. There were many positive comments and people felt staff were very caring towards them and they were treated well. One person who used the service told us: "I am very happy with the care. Not been here long but I am treated like a lord. Nothing is too much trouble. If they tell me things they always make sure I have understood before they leave me. Sometimes they [the staff] have to repeat things twice because I don't always understand but they are always very patient and don't rush things". A visitor commented: "The staff are all very caring. I like the fact that they keep me well informed about anything. It gives me peace of mind".

We observed mixed interactions between staff and people, some were positive and we saw staff were kind, attentive and caring. For example we saw a person being provided with a pillow to ensure their comfort when they sat in a chair. A person in bed was supported throughout the day with comfort and wellbeing checks, staff made sure the person was comfortable and had everything they needed.

Relatives were free to visit at any time and we saw frequent visitors throughout the day. One visitor

commented: "I visit each week and have always been made to feel welcome. They [the staff] are like family and look after the relatives as well as residents". Another visitor said: "I visit very often and was involved in completing the care plan when my relative first came here. The staff keep me informed about any changes to my relative's care. For example last week they spoke to me two or three times to discuss his health and what they were doing or planned to do about it".

Requires Improvement

Is the service responsive?

Our findings

There were limited opportunities for people to engage in hobbies and activities of their choice. One person who used the service told us: "I tend to stay in my room mostly. I read a lot, well all the time. The home have just got me a TV for my room as well but I am not much for TV. I don't do other activities, I am not at all interested". During the morning there was very little structured activity provided for people to enjoy. The television was on but most people seemed disinterested in the morning programmes. During the afternoon some people were provided with some recreational activities. We saw one person painting and another playing darts. One person enjoyed and was engaged with the one to one support they received where the staff member was reading a book with them. Some people clearly did not wish to partake in activities, however sensory and recreational items suitable for people living with dementia were not available.

People had a plan of care which informed staff of their history, likes, dislikes and preferences. We saw one person was on bed rest; they were comfortable and had the radio on. It was recorded in their care plan that when in bed the person liked to listen to music. A visitor told us: "I see the way the staff deal with each resident individually. They know the individual needs of each resident; it's never a case of one size fits all". People's individual care plans were reviewed monthly. One visitor told us they were always included in the reviews and spoke on behalf of their relative who would be unable to discuss their care and support needs.

The provider had a complaints procedure. People we spoke with and their relatives told us they would speak with the manager if they had any concerns and they were sure they would be taken seriously. One visitor said: "I have not seen anything that concerns me here but know how to complain should the need ever arise". The manager told us no formal complaints had been raised with them since they had worked at the home.

Inadequate

Is the service well-led?

Our findings

The manager told us that audits and checks for the quality and safety of the service were completed at regular intervals throughout the year. They were unable to show us any record of the audits undertaken as they told us these had been completed by the previous manager and were unavailable at the service. We did see an infection control audit had recently been completed this identified no concerns with the cleanliness and hygiene of the premises. However we saw some infection control risks that had not been identified through the audit. We saw that refuse bins located in toileting and communal areas were broken or unsuitable to use. Some waste bins did not have a lid and some were overflowing with used paper goods. This meant there was a risk of the potential spread of infection or people could easily access the contents of the bin that contained no lid. People did not have their own slings when they needed the mechanical hoist to support them with moving. We saw the same sling being used for several different people. This again was an infection control risk and had not been identified on the recent audit.

The manager told us that staff had received relevant training in 2015 so that they were fully skilled to meet the needs of people who used the service. They told us that training for staff in 2016 had been planned. The manager was unable to show us any record of the training staff undertook in 2015 or that planned for this year. Staff told us they had received training in moving and handling people safely but we saw staff performed an unsafe manoeuvre when they used the mechanical hoist. Staff told us they had not received training in managing and supporting people who experienced episodes of challenging behaviour, although we saw incidences where people presented these behaviours. We could not be assured that staff had the training they needed for them to do the job they were expected to do.

The manager told us that satisfaction surveys were distributed at regular intervals throughout the year. They were unsure if any action had been taken to review the completed surveys and to consider any suggestions for improvement.

There were some areas around the service that could benefit from refurbishment or redecoration and some equipment replaced. We saw the decoration of some parts of the home looked in need of attention, paintwork and walls were scuffed and some carpets were worn. The one tumble dryer had been out of working action for a period of time. Staff told us and we saw that some wet washing was placed on handrails around the service to dry. Staff told us that sometimes they took the laundry to their own homes to dry or to the local launderette. The manager told us the machine was quite old and the parts needed to repair the machine were on order. The sensory room was being used as a store room so was unavailable for people to use. The enclosed garden area was over grown and unsafe for people to enjoy some outdoor space. The manager told us that an environmental audit had not recently been completed and there was no development plan to improve the quality and safety of the premises where people lived and worked.

The above evidence shows effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This constitutes a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection in April 2014 there had been a change to the management of the service. A new person had been recruited as manager of the service. Their application to register with us had been received. People told us the new manager was approachable. One person said: "If she is here she is always available and has time to listen. I think she wants to do things to improve the home. She's more than approachable, she is very friendly". Staff reported they felt listened to and that the manager was approachable. They told us there had been some staff meetings in the past but were unclear when the next one was planned. One staff member said: "We are a really good team".

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 10 HSCA RA Regulations 2014 Dignity and respect People's right to be treated with dignity, privacy and respect was not consistently promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure persons employed by the service received training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have systems and processes established and operating effectively to act, report or refer immediately upon becoming aware of, any allegation or evidence of abuse.

The enforcement action we took:

issued warning notice on provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor and improve the quality and safety of the service or systems to mitigate the risks relating to the health, safety and welfare of service users.

The enforcement action we took:

issued warning notice on provider