Waverley Care Homes Limited

Autumn House Nursing Home

Inspection report

37 Stafford Road
Stone
Staffordshire
ST15 0HG

Tel: 01785812885

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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 19 April 2017 and was unannounced. At our previous three inspections we had found that care was not always safe, effective, caring, responsive or well led. At our last two inspections we had rated the service as Inadequate, placed it into special measures and begun enforcement action against the provider. At this inspection we found some improvements had been made however we remain concerned about the overall management of the service and the lack of continuous improvement. We found that the provider was still in breach of three Regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is inadequate and it will remain special measures.

Services in special measures will be kept under review and 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.

Autumn House Nursing home is a home providing accommodation, personal and nursing care for up to 67 people. At the time of the inspection 45 people were using the service. The service was in administration.

There was a manager in post who was in the process of registering with us. 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.'

The systems the provider had in place to monitor and improve the service had not been fully effective in making the required improvements. Lessons had not been learned following incidents with the deployment of agency staff. People's medicines were still not being managed safely. People did not always receive their medicines at the required times.

There were insufficient numbers of suitably trained effective staff to safely meet the needs of people who used the service. Risks of harm to people were not always minimised. Action was not always taken following incidents that put people at risk and staff did not always know or follow people's risk assessments.

People were supported to eat and drink sufficient amounts to remain healthy, however people complained about the quality of food available.

People were supported to seek advice from health care professionals when they became unwell or their needs changed. However the appropriate health care support was not always sought in a timely manner.

People were not always treated with dignity and respect and their right to privacy was not always upheld. People did not always receive care that met their individual needs and preferences due to a lack of available, effective staff.

People were kept informed and involved in the running of the service through regular meetings. However people expressed concern about the frequent change of management and the use of agency staff.

People and their relatives knew how to complain however action was not always taken to satisfy people's complaints in relation to the use of agency staff.

There was a range of hobbies and interests available to people if they chose to join in. People's choices were respected.

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 safe.

There were insufficient suitably trained staff deployed safely to meet the needs of people.

People's medicines were not managed safely and people were at risk of harm due to not having their medicines as prescribed.

Risks of harm were assessed however action was not always taken to minimise the risks and keep people safe.

Incidents of suspected abuse were reported to the local authority for further investigation.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always receiving care from staff who were effective in their role due to an increased use of agency staff who were not aware of peoples individual care and support needs.

Most people received health care support when they became unwell and attended appointments when required.

People were supported to eat and drink sufficient amounts to remain healthy. However people complained about the quality of the food they were offered.

The principles of the Mental Capacity Act 2005 were being followed to ensure that people were consenting or being supported to consent to their care when they lacked mental capacity.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

People's right to privacy was not always upheld.

People were able to be as independent as they were able to be and were involved in meetings concerning the running of the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that met their individual needs.

People and their relatives knew how to complain, however action was not always taken to satisfy people's complaints.

There was a range of hobbies and entertainment for people to participate in if they chose to.

Is the service well-led?

Inadequate

The service was not well led.

The systems the provider had in place had not been effective in ensuring that improvements in the quality of the service were made and to ensure that the Regulations were being met.

Action was not always taken to reduce the risk of incidents and accidents occurring again.

People who used the service and their relatives expressed concerns over the frequent change of manager and the use of agency staff.

Autumn House 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 19 April 2017 and was unannounced. It was undertaken by 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.

We looked at a range of information we held about the service which included the action plan the provider had sent us following our last inspection. We also looked at notifications the manager had sent us about significant incidents. Statutory notifications include information about important events which the provider is required to send us by law. We had discussions with the local authority to gain their views on the quality of service. We used this information to help us plan the inspection.

We spoke with 11 people who used the service and four relatives. We spoke with the manager, area manager, the clinical lead, three care staff, two agency staff and a visiting health professional.

We looked at seven people's care records, staff rotas, training records, the systems in place to monitor and improve the service. We did this to check the standards of care being delivered.

Inadequate

Is the service safe?

Our findings

At our previous three inspections we found a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that although some improvements had been made the provider was still in breach of this regulation as care being delivered was not consistently safe for everyone using the service. We remain concerned that insufficient improvements had been made in a timely manner to keep people safe.

We saw that one person had recently attempted to hurt themselves using equipment that was available within their room. The person had attempted to self-harm before and we saw a risk assessment informing staff that they were at risk and how to minimise the risk. However we found the person was still at risk on the day of the inspection and precautions had not been taken to prevent the person from self-harming. We saw numerous pieces of equipment were in reach of the person which they would have been able to use to hurt themselves. We discussed this with the clinical lead who told us that they had implemented 15 minute checks of the person; however records showed and the clinical lead confirmed that these checks were not being completed regularly. This meant that this person was at continued risk of harm as necessary precautions were not being taken to minimise the risk of them harming themselves.

The same person had been assessed as being at high risk of falls due to poor mobility and a visual impairment. The person's risk assessment stated that they should be in an uncluttered environment. We saw that their environment was cluttered with a table, chair, wheelchair, walking frame, commode and mobile radiator. This put the person at risk of falling as their risk assessment was not being followed to keep them safe.

We saw that one person had been assessed by the speech and language therapist (SALT) as requiring their drinks to be thickened to prevent them from choking. We saw their care plan stated that there should be one scoop of thickener to 100mls' of fluid, however we saw a member of staff give the person a 200ml drink with one scoop of thickener. This put the person at risk of choking as the fluid would not be thickened sufficiently to maintain the person's safety whilst drinking.

Previously we had concerns about the management of people's medicines. At this inspection we found that there were still concerns as people did not always have their medicine when they needed it as it had ran out of stock or not been received from the pharmacy. One person told us that they had been without their pain relief for 9 days and this was confirmed by the manager. On the day of the inspection they had their pain relief but had been waiting for over a week for some cream which the GP had prescribed. We saw records of other people where there were gaps in the recordings of when external creams had been applied. This meant that people were not always having their prescribed medicines when they needed it.

These issues constitute a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous three inspections we found the provider in breach of Regulation 18 of The Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider was still in breach of this regulation as there was still insufficient suitable trained staff available to safely meet people's needs.

People and their relatives told us they were unhappy with the amount of agency staff the provider they were using. We were informed by the area manager that there was on-going recruitment for permanent staff to fill the current vacancies however there was still a need for agency staff to ensure safe staffing levels until the permanent posts were filled. One person told us: "I wouldn't say that the staff are stretched it's just the use of agency staff as there is such as lot of them and I mean a lot". Another person told us: "There is usually enough staff, unless they're busy elsewhere, mainly its pretty good. The only thing I don't like is agency staff, they're not very good".

Two people told us of incidents where two agency staff members had been deployed to support them and their relative with their mobility. These people required the use of hoist and specific moving and handling skills to be able to support them. On both occasions help had to be called for as both people were left in the hoist in a position that put them at risk. A relative of one person who was obviously upset told us: "I had to stop them from moving my relative the other night as she was very distressed and I had to call for permanent staff". Another person told us: "Two agency staff came to me at night and didn't know how to move me up the bed, I had to send them away and ask for other permanent staff". The deployment of agency staff failed to ensure that people received support from staff who could meet their known care and support needs.

This was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff who were being recruited by the provider were employed through safe recruitment procedures to ensure they were fit and of good character to work with people who used the service. Pre- employment checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.

People were safeguarded from the risk of abuse. Staff we spoke with and the manager knew what to do if they suspected abuse. We had been made aware of potential safeguarding incidents having been referred to the local authority for further investigation. These included unexplained bruising and one person who used the service assaulting another person who used the service. This showed the provider was using appropriate processes to safeguard people from harm and abuse.

Requires Improvement

Is the service effective?

Our findings

People who used the service and their relatives told us they were happy with the care being delivered by the permanent staff however they expressed continued concern about the effectiveness of the agency staff deployed within the service. A relative told us: "There is so many agency staff and half of them don't seem to know what they are doing". A person who used the service told us: "I don't see why I should show them what to do. I ask them can you change a colostomy bag and they say no". Another relative told us: "When you pay for a service, it's a lot of money sometimes for what you actually get!"

Permanent staff we spoke with told us they received regular support, supervision and training to be effective in their roles. We saw records that confirmed that the manager and area manger were in the process of conducting one to one supervision sessions with staff. However, we saw that following avoidable incidents, agency staff members were still being deployed to work alone and without permanent staff members support. This meant that not all staff employed by the provider were being supported to be effective in their roles.

Most people received health care when they became unwell or their needs changed. However, we saw one person's mental health needs had deteriorated and this was putting them at risk of harm. Although the person had been referred to the memory clinic this had been two months prior to this inspection and there had been a marked change in their behaviour and a serious self-harming incident since the referral had been made. No action had been taken to alert the appropriate health care professionals when the health of a person had deteriorated. This put this person at risk of a further deterioration in their mental health as their needs were not being addressed in a timely manner. Other people we spoke with told us they received health care when they needed it. One person told us: "We have access to a doctor, a dentist, a chiropodist and an optician; they all come on special days". We spoke to a visiting health professional on the day of the inspection. They told us that the staff contacted them when needed and made appropriate referrals.

People told us that they had a choice of food, however most people we spoke with complained about the quality of the food on offer. One person told us: "It can be lukewarm and it leaves a lot to be desired". A relative told us: "I'm not overly impressed from what I've seen' and 'The meals I've seen are not appetising". People complained that the options on the menu repeated themselves regularly. We checked the menus which confirmed what people had told us. People complained that the food lacked seasoning and we were informed that the cooks had been trained not to add salt into the food as it was bad for people's health. However consideration to people's individual needs and preferences had not been made to ensure everyone enjoyed the food on offer.

People's nutritional needs were met and if people experienced difficulties in eating and drinking then the appropriate support had been sought. This included referrals to Speech And Language Therapists (SALT) when people had difficulty in swallowing and to their GP and dietician if there been unexplained weight loss. However, some staff did not always know and follow people's assessments and care plans in relation to eating and drinking. For example, some staff did not know how much thickener one person was assessed as requiring in their fluids. People were supported with supplements and with eating and drinking if they were

unable to eat and drink themselves. People were supported with special diets if they required one such as pureed meals or when people needed to receive liquid nutrition directly into their stomach via percutaneous endoscopic gastrostomy (PEG).

The Mental Capacity Act 2005 (MCA 2005) 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. We saw that where a person's capacity to consent was in doubt a mental capacity assessment had been completed. We saw that people's relatives and other agencies were involved in the decision making about their care and other specific decisions when they had been assessed as not having the mental capacity to be involved in the decision making process.

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 are called the Deprivation of Liberty Safeguards (DoLS). We found referrals for people who had been assessed as lacking the mental capacity to agree to being at the service and other restrictions had been made. We saw one person had a DoLS authorisation in place with a condition attached to it. We saw that the condition had been met by the provider. The meant that the provider was following the principles of MCA 2005 by supporting people who lacked mental capacity to agree to their care at the service and to ensure they were not being unlawfully restricted.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found that people were not always treated with dignity and respect. At this inspection we found that the provider still required improvement in this area. People told us that staff treated them with kindness and respect. One person told us: "The staff are very kind to me". A relative told us: "The staff really care about the person". We observed staff spoke with people in a kind and caring manner. We saw staff engage in conversation with people whilst supporting them in tasks such as eating and drinking in a kind and patient manner whilst encouraging their independence. For example, we observed one member of staff supporting a person with a drink and they said: "Do you want to drink? You hold it and I'll help".

However, we saw one person who was visually impaired and unable to make their own bed. We observed that staff had made this person's bed for them and it was full of crumbs where the person had been eating when in bed. We also saw that the person had dropped some sweets on their bedroom floor and their room was untidy. The staff supporting this person had not considered that they could not see to do this themselves and this did not demonstrate that they cared about this person's overall wellbeing. Another person told us that on occasions when two agency staff worked together they spoke to each other in their own language and the person being supported had not understood them. This did not demonstrate a caring and respectful manner towards people who used the service.

We observed that staff did not always knock when entering people's bedrooms or wait for a reply when knocking. For example, we were talking to one person in their bedroom when a member of staff knocked on the door and walked in without waiting for a reply and then proceeded to clean the person's bathroom. The person hadn't noticed and when they did they asked the staff member to leave the room as they were 'having a private conversation'. Most people had their bedroom doors open; we could not see evidence that this was by their individual choice. We saw that because the bedroom doors were open staff walked into people's room without checking if this was convenient first. This meant that people's right to privacy was not always upheld.

Most people were offered choices and their choices were respected. Some people chose to spend time in their room, whilst others spent time in the communal areas. We saw that people were free to independently move around the home as they liked and people's relatives and friends were free to visit. People and their relatives were encouraged to have a say in how the service was run through regular meetings and they told us that they were kept fully informed of the changes and progress towards the sale of the service. One person told us: "We met the potential new owners last week, they seem really nice".

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found that people did not always receive care that met their individual needs and preferences. At this inspection we found that the provider still required improvement in this area.

We saw that people did not always receive a consistent approach to their care as the agency staff being employed did not have a good understanding of people's individual needs. A person who used the service told us: "We need more full time carers without a doubt, who know who you are, what you need and give you what you're paying for". A relative told us: "There is different agency staff member each time I visit". People gave us examples of when agency staff had not known their needs, for example, not knowing how to support one person to move in bed and they were unable to assist them. A relative told us: "The care is just not consistent, like cream not applied every day, the call bell not always in reach. I've given up speaking to staff about it now".

We observed that some staff did not always follow people's risk assessments and care plans to maintain their safety and well-being, for example one person not being given the correct amount of thickener in their fluids. People's care records were in the process of being updated, however several care plans did not contain up to date and current information about their individual needs within them. Some people we spoke with told us that they were involved in the planning of their care and agreeing their care plans however other people told us they did not know if they had a care plan. This meant people who used the service were at risk of receiving care that did not meet their individual assessed needs, preferences and interests.

There was a complaints procedure and we saw records that showed that the manager and area manager had investigated formal complaints according to the procedure. However a relative told us: "I've complained about the agency staff, but like they say they try their best. They changed agencies and they said they're trying to get more staff". Other people told us of their concerns about the use of agency staff and we saw that people had complained at residents meetings and formally. However the provider had taken no action to ensure that the deployment of agency staff was managed effectively to lessen the disruption and the risk of inconsistent care people were receiving.

Permanent staff we spoke with knew people well and knew people's likes and dislikes. We observed that some people required specialist cutlery during lunchtime and staff ensured this was available to them. One member of staff told us how they supported one person with their medicines and how they made sure they had one tablet at a time as this was how they liked them administered.

There was a range of hobbies and activities available to people if they chose to join in. We saw that there was a timetable of events and staff supported people to attend if they needed support, whilst others independently joined in. One person who used the service told us: "Every week we get these activity sheets that tell you all about what's on. My relative likes things she can do with her hands". There was an allocated activity room and coordinator who planned and facilitated events based on people's likes and dislikes. We saw there were art and crafts, themed events, bingo and a wide range of activities available.

Inadequate

Is the service well-led?

Our findings

At our previous three inspections we found that the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the governance systems the provider had in place were not effective in driving improvement. At this inspection we found continuing breaches of The Health and Social Care Act 2008 following our previous three inspections and the enforcement action we have taken. We remain concerned that the provider had not made sufficient improvements to the quality of care for all people using the service in a timely manner.

Since the last inspection the manager had left and a new manager was in post and they were in the process of registering with us. They were being supported by an area manager to understand what is required in the management of a registered service. Most people we spoke with told us that they were happy with living at Autumn House, although they told us that the quality of care was not as good as it was and expressed on-going concerns in the frequent change of manager and the use of agency staff. One person told us: "Normally, I don't complain but I have had to complain a lot recently, the management is affecting it the home. Some of the managers are awful". Another person told us: "We've had three or four different managers in. When the administrators took over the place it just nose-dived". care being delivered to people by staff was not always being monitored to ensure it was safe and appropriate.

The systems the provider had in place to monitor and improve the quality of the service were not being used effectively to ensure the quality of the service improved. We saw that although regular audits were being undertaken the provider continued to be in breach of Regulations and had failed to identify and improve the quality of care in relation to the use of agency staff. This put people at continued risk of receiving care that did not meet their individual needs in a safe and consistent way.

Incidents and accidents were not always acted upon to ensure the risk of them occurring again was reduced. People told us and we saw reports that agency staff who did not know people who used the service had been deployed to work together without the support of permanent staff members. This had resulted in two recorded incidents that had put people at risk of harm and other incidents of people's basic care needs not being met. We had identified this as a concern at our previous inspection and despite this no action had been taken and there had been a further two more incidents. We discussed this with the manager and area manager and they agreed that the deployment of agency staff needed addressing, however this had not been identified and acted upon previously by the manager or nurses on duty on a shift by shift basis.

People were still not always receiving their prescribed medicines. There had been issues with the delivery of people's medicines from the pharmacy and this had not been addressed and rectified. Some people had been or were without their prescribed medication. This meant the system to monitor medication was not effective and prompt action had not been taken to ensure people had their medication when they needed it.

Agency staff employed to work at the service were still not receiving adequate support and supervision. There were issues with the performance and competency of these staff which continued to be of concern

following the last inspection. Staff did not always follow people's care plans or demonstrate respect for people by knocking on doors. These issues were not being addressed by the nurses or managers on duty on day to day basis. This meant the quality of care being delivered was not being monitored and improved effectively.

These issues constitute a continuing breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were regular meetings with people who used the service and the staff which informed them of the concerns raised at our previous inspections and the action plan they had to improve. The provider met regularly with the local authority and commissioners of the service to up date them with progress reports.

The provider is required to notify us of events that affect the delivery and quality of the service. We had received notifications as is required.

The provider displayed our previous inspection rating as they are required to do.