Indigo Care Services Limited

# Eckington Court Nursing Home

## Inspection report

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Eckington
Derbyshire
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Tel: 01246430066

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22 November 2016

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## Ratings

| Overall rating for this service | Requires Improvement |
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| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Good** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

This inspection took place on 22 November 2016 and was unannounced.

There is a requirement for Eckington Court Nursing Home to have a registered manager and a registered manager was in place at the time of this inspection. 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 service is registered to provide nursing and residential care for up to 50 people, including some people living with dementia. At the time of our inspection 41 people were using the service.

Medicines were not always well managed and administered. This was because not all people received their medicines as prescribed. In addition, records did not always accurately reflect what medicine people had received, or required.

Staff were not always available to provide care as required on the day of the inspection. The cover arrangements for when staff were unable to work due to illness, meant there was not always enough staff deployed to meet people's needs.

Risks to people were identified and actions to reduce some risks were clearly recorded. However, other monitoring of risks to people's health were not always clearly recorded.

Although checks on the quality and safety of services provided to people using the service were completed, they did not always result in consistent improvements.

The provider had taken steps to reduce the risks of abuse to people. Pre-employment checks were in place to help the provider make judgements as to whether staff applying to work at the service would be safe to do so.

Staff training was up to date and covered areas relevant to the care needs of people. However, staff were also being asked to complete checks on equipment that they had not been trained in, nor were competent to do so.

Most staff checked with people that they consented to their care and support. Policies and procedures were in place to ensure the principles of the Mental Capacity Act (MCA) 2005 were followed. Applications for assessments using the Deprivation of Liberty Safeguards (DoLS) had been made when required.

People were supported to enjoy mealtimes and received sufficient food and drink that met their nutritional

needs. Staff were supported through supervision and training and demonstrated knowledge of people's needs. People were supported to access other health care services as required.

Most of the time care and support respected people's privacy and dignity. However we saw one occasion when this did not happen. People were supported by staff who were kind and caring. People's choices and decisions were respected. People's independence was supported.

People received personalised care from staff who understood them and their interests and hobbies. People were supported to engage in interests and activities that they enjoyed. People were asked for their views and people knew how to raise concerns or make suggestions.

The registered manager was viewed as being open and approachable and involved in the day to day management of the service. The registered manager was supported in their leadership by a supportive staff team.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

**Requires Improvement**

The service was not consistently safe.

Medicines were not always managed and administered in line with guidelines to reduce risks to people. Staff sickness was not always covered in a way to ensure people's needs were met by the deployment of sufficient numbers of staff. Although risks were identified, monitoring of some risks had not always been clearly recorded. Recruitment processes checked staff were safe to work at the service and staff had been trained in safeguarding people.

### Is the service effective?

**Good**

The service was not consistently effective.

Staff received training and support in areas relevant to people's needs, however had not been trained to competently complete some tasks they had been given. People enjoyed their meals and received sufficient nutrition. People received support from external health professionals when required. Policies and procedures were in place to support the principles of the Mental Capacity Act 2005.

### Is the service caring?

**Good**

The service was caring.

People were supported by kind and caring staff. Most care and support was provided in a way that respected people's privacy and promoted their dignity. People's views and opinions were respected and people were involved in their own care.

### Is the service responsive?

**Good**

The service was responsive.

People received personalised care and support and their preferences were understood and respected by staff. People were supported to participate in hobbies and interests they enjoyed. People were asked for their views and understood how to make a complaint or offer feedback.

## Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager led with an open and inclusive style. Improvements and developments to the service were identified by quality assurance audits; however these were not consistently achieved. Staff were motivated in their role.

# Eckington Court 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 was unannounced and took place on 22 November 2016. The inspection was completed by one inspector, one inspection manager, a member of the CQC medicines team, a specialist professional nursing advisor 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 reviewed the information we held about the service, including notifications. Notifications are changes, events or incidents that providers must tell us about. We spoke with the local authority and health commissioning teams and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

As some people were living with dementia, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with 15 people who used the service and seven relatives. We spoke with eleven members of staff, including the registered manager, deputy manager, nurses, care staff, maintenance, domestic and kitchen staff. We looked at five people's care plans and we reviewed other records relating to the care people received and how the home was managed. This included some of the provider's checks of the quality and safety of people's care, staff training and recruitment records.

Requires Improvement

# Is the service safe?

## Our findings

A member of the CQC medicines team reviewed the management of medicines, including the medicine administration record (MAR) charts for seven people. We saw that people did not always receive their medicine as prescribed. For example, one person had been prescribed an antibiotic that was to be given for 5 days (15 doses). The records kept were not clear but showed that the person received 17 or 18 doses of the antibiotic. Another person was prescribed another antibiotic and the number of capsules left in the trolley did not match the number of doses recorded as administered. The MAR chart had been signed to say the person had received their medicine when they hadn't.

One MAR that we looked at had the dose of pain medicine increased by hand, by a nurse at the home. When we asked to see evidence that this dose change had been recommended by the prescriber, the staff were unable to provide any evidence of this. In addition, the increased dose had been administered to the person before the handwritten change to the MAR chart.

Some people that take medicine only when required had clear protocols in place to provide staff with enough information to know when the medicine was to be given. However, we saw that this information was not accurate or was missing for a few people, which meant people might not always be given their medicine consistently, and at the times they needed them.

Carers applied prescribed creams to people's skin. Records of administration showed that people were not always getting their cream as prescribed. A person's skin may become dry and sore if creams are not applied as often as the doctor intended.

We saw evidence that the provider reported and investigated significant medicines events. However, there was no recent evidence of reporting, shared learning or meaningful action plans in response to near misses or less significant errors to help prevent similar errors occurring again.

Staff that were handling and administering oral medicines had received training and regular competency checks. However, staff that were applying creams did not have any training or competency checks. We saw evidence that the provider was in the process of arranging some training.

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

Medicine was stored safely in locked trolleys in a locked medicines room. Controlled drugs are medicines that require special storage and recording to ensure they meet the required standards. We found that controlled drugs were stored securely and recorded correctly. Medicine that had a short expiry date once opened was always dated to ensure that staff knew how long the medicine could be used for.

People's comments about staffing levels were mixed. One person who liked to stay in their own room told us, "[Staff are] always popping in and out. It's like a revolving door to my room." However, another person

told us, "[Staff] sometimes take ages coming if you need anything. When I need the toilet it can be awful having to wait." A relative also told us they felt staff did not attend to their relative very quickly; they told us their relative sometimes had to wait after being incontinent and this made them uncomfortable. Staff told us staffing levels had improved with the new registered manager, although staff commented they were sometimes short because of staff sickness.

The registered manager calculated the number of care staff required based on an assessment of people's needs. Staffing rotas showed the number of staff matched the guidelines provided by the staffing dependency tool. On the day of our inspection one member of care staff was not at work as planned and their role was covered by the deputy manager; however the deputy manager also completed some management tasks and so was not available to work as a member of care staff at all times throughout the day.

In addition, a member of the domestic cleaning team was also unavailable to work. Although cover arrangements were in place, one member of staff we spoke with told us they were struggling to complete all the domestic tasks. The registered manager told us they ensured any sickness was covered and other staff were available to help, for example some staff who worked in the kitchen were also qualified in care. Although cover arrangements were in place to cover staff absences, these were not always sufficient to ensure all expected checks were completed. For example, during our inspection we observed staff were not always available to check on people in communal areas. The registered manager had introduced a checklist to ensure staff regularly checked on people in communal lounges to ensure people were safe. However, we observed staff had not completed checks on a communal lounge for a period of time when a person had been seated there. This meant staff had not always been deployed to check on people in communal areas to ensure they were safe.

In addition, one person's care plan stated they could become anxious and distressed and express behaviours that challenged. It instructed staff to take time and sit and talk with them when they became upset; staff were also instructed to reassure any other people affected by the person's behaviour. It also stated their behaviour could put them at risk from other people. We observed this person became upset in a communal area and staff spoke with them and they calmed. However, for the next 15 minutes there were either no staff present in the communal area, or staff only passed through the area whilst completing other work. During this time the person became upset, and for some of the time they became agitated and expressed behaviours that impacted on other people in the communal area. There were no staff available to follow the instructions in the person's care plan to reassure the person and others affected. Staff were not always deployed effectively to meet people's needs.

We reviewed the care plan for one person who had received care for a pressure ulcer. The registered manager told us the person was admitted with a grade three pressure ulcer. Although we were told the person's pressure ulcer was healed at the time of our inspection, records for the progress of the person's wound, and any healing or deterioration were not clear. For example, only one wound assessment had been completed and so this did not record any changes from deterioration or from healing. One record reported deterioration in the person's skin and recorded this as a grade three pressure area. This deterioration developed whilst the person was receiving care and treatment at the service. CQC require a statutory notification to be submitted when a person is receiving care and treatment for a grade three pressure area as this is considered to be a serious injury. We brought this to the attention of the registered manager who submitted a notification shortly after our inspection.

Also, at the time of the person developing the pressure ulcer, records showed they had experienced a significant weight loss. Although the person was reviewed by the doctor for their weight loss, the person was

still only weighed on a monthly basis. We discussed their care with the nurse responsible. They agreed the risks from their weight loss could have been more closely monitored if they had monitored their weight weekly instead of once a month.

Other risks to people's health and wellbeing were identified and steps taken to reduce risks where possible. For example, people had risk assessments that identified if they were at risk of falls or malnutrition. One family member told us, "[Staff] are really good and make sure [my relative] uses their frame which they sometimes forget."

People we spoke with told us they felt safe living at Eckington Court Nursing Home. One person told us, "I feel safe with them [staff]; they are marvellous." Family members also shared this view. One family member commented, "Our relative had a number of falls and really wasn't safe but since they have been here we know they are getting well looked after."

Records showed and staff told us, they received training in safeguarding people from abuse. Staff we spoke with were understood how to identify potential safeguarding concerns and how to report any concerns. Staff recruitment files showed that staff employed at the service had been subject to pre-employment checks. These helped to ensure staff were suitable to work with people using the service. For nurses, the provider had checked their registration with the Nursing and Midwifery Council (NMC) was valid. The provider had taken steps to reduce the risk of abuse to people using the service.

People had personal emergency evacuation plans (PEEP's) in place to help them. PEEP's provide details on what equipment or assistance people would need to help them evacuate the building, should they need to. We made the registered manager aware of one person's PEEP that had not been updated to reflect a change in the assistance they would need to evacuate the building.

Good

# Is the service effective?

## Our findings

Staff were not fully trained and competent for all the tasks they were asked to complete. For example, staff did not have all the skills and knowledge to identify when mattresses had not been set up correctly. Staff signed twice a day to confirm they had checked air mattress settings were correct. However, staff we spoke with told us they had not had any training on how to check air mattresses had been set up correctly. We found one person's pressure mattress had not been placed on top of a foam mattress as required to ensure its effective use. We brought this to the attention of the nurse who immediately put in place a foam mattress.

Staff had been supported to gain skills and knowledge in other areas relevant to their work. One person told us, "[Staff] look after me really well." One family member told us, "My relative was in a terrible state when [they] first came here. [They] had been bed ridden for six weeks but they have worked a miracle and got [them] back on [their] feet." Another relative told us, "My relative had a [pressure sore ulcer] which developed while [they] were in [their] own home and [they] had to go into hospital. The hospital staff said they didn't think it would ever heal up but since [they] have been in here, it's healed completely. I can't praise them enough."

Records confirmed that staff training was regularly provided in areas relevant to people's needs, for example, moving and positioning people, dementia care, infection control and understanding and managing behaviour that challenged. Staff told us they had the training they needed to provide care to meet individual people's needs and that training was kept up to date.

Where people did not have capacity to make a decision we saw arrangements were in place so that any decisions relating to their care followed the principles of the Mental Capacity Act 2005 (MCA). 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 they are appropriately supported to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be made in their best interests and as least restrictive as possible.

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). The provider had identified and submitted the relevant applications for where people required an assessment and authorisation for a Deprivation of Liberty. We also saw that mental capacity assessments and best interest decision making processes were followed when specific decisions were being considered.
People's freedom was not unlawfully restricted.

Most staff asked people for their consent to care and support before they provided any assistance. For example, we heard most staff asked people very clearly whether they would like to use any clothing protection over lunchtime. However, we saw two members of staff placed clothing protectors on people

without first checking whether this is what they wanted. Other staff we spoke with provided examples of how they checked consent with people, and the different methods they would use if people were not able to communicate their preferences verbally. One staff member told us, "[We] explain everything that we do; [we] check choices and preferences."

Staff told us they felt well supported by the registered manager and commented that their colleagues were supportive and worked as a team.

Staff told us they received supervision, and records showed dates for this had been planned in advance. Supervision sessions help staff to work effectively as they evaluate staffs' performance and identify any further training and support needs. Staff confirmed they could approach their managers for support in between supervision meetings. One staff member told us, "If I have a problem [registered manager] is there." In addition, staff meetings were held. This showed that staff were supported to develop their skills and knowledge to provide care and support to people using the service.

We observed that people were supported to enjoy their lunchtime meal. One person told us, "The food is wonderful; I really enjoy my meals." Another person told us, "I love the food, I nearly always have two puddings at lunchtime. The chef has got some sort of medal for his cooking." We saw people's preferences for different food and drinks were met. For example, one person told staff, "I'd like a nice cup of tea; I don't like these water things, they all taste the same to me." We saw staff ensured the person had a cup of tea rather than a drink of juice over lunch.

Kitchen staff understood how to increase people's nutritional intake and were aware of people with any special dietary requirements, for example modified texture diets or people with a diabetic diet.
We saw aids and adaptions were used to help people maintain their independence with dining. For example, plate guards were used to help keep food on some people's plates. People were supported to receive sufficient food and drink of their choosing.

We saw that external health and social care professionals were involved in people's care. We saw a visiting chiropodist and records showed people had access to the GP who made regular visits. This meant people received appropriate care and support for their health and care needs.

Good

# Is the service caring?

## Our findings

Most of the time care and support respected people's privacy and dignity, however we observed one occasion when it did not. Staff assisted one person to find a toilet. The privacy lock did not work and the door was left a jar. Whilst the person was in toilet, another member of staff went into the toilet to retrieve a piece of equipment. There was nothing to indicate the toilet was in use. This person's privacy and dignity was not promoted because there was no way to indicate the toilet was engaged. The registered manager confirmed they would make improvements.

People told us they felt staff were kind and caring. One person told us, "I'm very happy; I tell [staff] what I need. [Staff] are very cheerful and nice. I like [name of staff member] very much." Another person told us, "They [staff] are wonderful people; nothing is too much trouble for them. I am very lucky to be here."

Staff we spoke with understood how to promote people's independence and knew their preferences. Staff also spoke with us about how they provided personalised care. One staff member told us, "We treat everyone as an individual and spend time with people so we're not rushing in and then leaving."

Throughout our inspection we saw staff created a cheerful atmosphere and took action to make sure people felt included. For example, one staff member was talking with a group of people in a communal area. One person was seated with their back to the group of people engaged in conversation. The staff member went over to them and asked whether they wanted assistance to come over and join in the conversation. Staff valued people and included them in conversations and activities.

Care plans were written to support people's involvement in their care. For example, people's memories and experiences from when they were younger had been recorded so as to help staff understand the person more. People's views were listened to and people were involved in their care and support.

Good

# Is the service responsive?

## Our findings

People received personalised care. People told us they enjoyed trips out to places they were interested in visiting. One person told us, "I like shopping and sometimes [the staff] will arrange to take me to [a shopping centre]." Another person told us, "The staff do everything they can for us. We go to the boozer [pub] sometimes for lunch and a drink; I look forward to that." Another person told us, "We have singing and entertainment as well; I really enjoy the man who plays the guitar." Other people told us their spiritual needs were supported. One person told us, I have been Methodist all my life and I am taken to the coffee morning at the Chapel most weeks."

During our inspection we saw some people were busy preparing decorations for Christmas. One person told us, "We're having a Christmas Fayre at the weekend." Other people choose to spend time in their own rooms reading or watching the television. A relative told us, "My relative is happy as long as they get the newspaper every day and [staff] make sure that they do." Other people told us, "I like colouring in and dot to dots." We spoke with the activities coordinator who told us, as well as group activities they would spend time with people who preferred individual company or who were cared for in bed.

People and their families were able to contribute to their care and support. One family member told us, "We have been really impressed with what goes on here. There is always something happening and families get involved as well. We've had summer parties and now everything is gearing up for Christmas." Care plans also reflected families had contributed to reviews of their care. In addition, letters inviting people and their families to be part of care plan reviews were displayed in the service.

From the care plans we reviewed we could see how the care and support provided was responsive to people's needs. Staff were provided with guidance on how best to engage people whose behaviour, may at times, provide some challenges. For one person, staff were guided to discuss the person's interests in clothes, coats and shoes as they were usually less distressed when discussing these subjects.

We saw a meeting had been held with people and their families and a further meeting had been planned for the day after our inspection. Meeting records showed people had been asked for their ideas and views regarding the services they received.

Information on how to complain was displayed in the service. We reviewed records of complaints and found the provider had recorded when a complaint was made and the response they had taken to investigate and reply. Procedures were in place for people to raise any concerns and people were able to share their views.

Requires Improvement

# Is the service well-led?

## Our findings

Registered managers and registered providers are required to submit statutory notifications to the CQC. Notifications are changes, events or incidents that providers must tell us about. The registered manager had submitted most notifications as required prior to our inspection. When we discussed the requirement to notify the CQC for a person with a grade three pressure ulcer the registered manager submitted this notification to us shortly after our inspection.

Systems were in place to check on the quality and safety of services. These included quality assurance audits. These incorporated observations of staff interactions and the environment as well as reviews of records. The registered manager also completed regular audits, including audits of care plans and records. However, we found some audits were not effective. This was because checks had not identified a person's mattress had been set up incorrectly. In addition, although significant medicines events had been investigated, systems to help learn from less significant errors were not always effective.

Where improvements had been identified as required, we found these had not always been consistently achieved. For example, although care plans and records were up to date, they were not always clear. For example, the progress of a person's pressure ulcer was not clearly documented. In addition, a quality assurance visit had identified staff were 'task orientated' in September 2016. Although we saw staff deployment and staffing levels had been reviewed in response to this, arrangements to cover staff sickness did not always ensure staff were effectively deployed to meet people's needs.

Eckington Court Nursing Home is required to have a registered manager and a registered manager was in place. People using the service knew the registered manager and told us they would be happy to talk to them about any issue. One family member told us, "[Registered manager] is wonderful. I can't praise them enough. You never used to see the [previous] manager and if you wanted to, you were told to make an appointment. [Registered manager] is out and about in the building; not hidden away in the office, and if you want them, unless they are physically not there, they come straight away. If they are out, then the deputy comes instead. It's getting better all the time." Throughout our inspection we saw the registered manager and deputy manager both spending time talking to people. We could see that both managers knew people, their families and staff well.

Staff working at the service understood their roles and responsibilities and told us they worked together as a team. One staff member told us, "[I've] noticed a better bond of staff and team work." Staff also told us both the registered manager and deputy were approachable and helpful. One staff member said, "[Registered manager] is very approachable; always listens." Another staff member told us, "I get on well with [registered manager and the deputy manager.]"

Staff also told us they felt their views were listened too and helped to develop the service. One staff member told us, "We have general meetings and [registered manager] takes on board issues. For example, making the activity room into 1940's style." Another member of staff told us, "[Registered manager] always checks that everyone is alright." The service was being developed with an open and approachable leadership style

that involved and valued staff.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People did not always receive their medicine as prescribed. Regulation 12 (1) (2) (g) |