TC Carehome Limited

Fosse House Nursing Homes

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Fosse House Nursing Home on 19 December 2017 and 9 January 2018. When the service was last inspected in October 2016 no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

Fosse House Nursing Home provides accommodation and nursing care for up to 37 people. The home is over two floors with lounge and dining areas on each floor. The home provides care to older people. At the time of our inspection there were 27 people living in the home.

Fosse House Nursing Home is a "care home". People living in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post 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.'

There was a lack of a robust arrangements to ensure people's rights were protected where decisions were made on people's behalf specifically where actions were taken which could be viewed as restrictive practice such as the use of bed rails.

There were mixed views from people about the staffing arrangements in the home. Some were satisfied but others said there was not enough to respond in a timely way to care needs. There was no formal system to decide on the numbers of staff required to meet people needs safely and effectively. We have made a recommendation about the provider reviewing how decisions are made in relation to staffing arrangements in the home.

Whilst there were arrangements for the reviewing of people's care needs this was not always undertaken with the person and/or their representative.
We have recommended the provider review how decisions are made about staffing arrangements in the home.

People told us activities could be improved with one person telling us "There is nothing to do-not enough going on." This was an area recognised as requiring improvement because for some people group activities were not an option either because of their frailty or as matter of choice.

Efforts had been made to improve mealtimes for people in making them a more relaxed and a social occasion. However, this remained an area for improvement specifically to ensure there were enough staff available to support people when it was required.

There was a pathway for end of life care however, this had not been consistently followed for people who were deemed as requiring this care.

The arrangements for supporting people with their medicines were good and people received their prescribed medicines at the times required and people's health and welfare were protected.

People told us they felt safe and staff recognised and were confident about reporting any concerns about the safety and welfare of people.

The service was responsive to people's changing care needs and had good arrangements for getting support from outside professionals such as tissue viability nurses and dieticians.

People told us how they felt they received the personal care they needed. Care was provided in a person centred way with staff having a good understanding of the, at times, complex needs of people.

People were confident of having their views and concerns listened to by the registered manager. One person told us, "The manager is very good you see her around the home and can talk to her about any worries we have."

We have identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014: Safeguarding service users from abuse and improper treatment. 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?

Requires Improvement

The service was not always Safe.

People would benefit from a review of the staffing arrangements in the home are decided to ensure safe and effective care.

People were supported by staff who had received pre-employment
checks to ensure they were suitable for the role.

People were supported by staff who knew how to recognise and report concerns about possible abuse and the safety of people living in the home.

People's health and welfare was protected by the safe administering and management of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Decisions were not always made ensuring people's rights were protected.

People's differences around equality and diversity were recognised.

People were not always enabled and assisted to have their meals in a relaxed and timely way.

People benefitted from being supported by staff who were trained to provide effective care.

Is the service caring?

Good

The service was caring

People benefitted from an environment which was respectful and recognised people as individuals.

People had established warm and supportive relationships with staff.

People were able to maintain relationships with family and friends which were important to them.

Is the service responsive?

Requires Improvement

The service was not always Responsive

People would benefit from improvements in how activities were provided.

People did not always have the opportunity to be part of the reviewing arrangements of their care.

People who needed end of life care would benefit from arrangements which ensured their needs were formally assessed using the provider's end of life pathway.

People had the opportunity to express their views about the quality of care they received.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Systems in place to monitor and review the quality of care and identify areas for improvements were not always effective.

There was a lack of oversite and review undertaken by the provider.

People benefitted from an open culture but improvements in how the provider engaged with people could be made.

Fosse House Nursing Homes

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 checked 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.

The inspection took place on 19 December 2017 and 9 January 2018 and was unannounced for the first day and announced for the second day.

This inspection was carried out by one inspector, a nurse and an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that the provider completes to give some key information about the service, they tell us what they feel service does well and the improvements they planned to make. We also reviewed the information that we had about the service including safeguarding records, complaints and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

We used a number of different methods such as undertaking observations to help us understand people's experiences. We spoke with 11 people who used the service and four people's relatives. We also spoke with 13 members of staff. This included the registered manager, care staff, nurses, the activities co-ordinator and cook

During the inspection, we looked at nine people's care and support records. We also reviewed records associated with people's care provision such as medicine records and daily care records relating to fluid consumption. We reviewed records relating to the management of the service such as the staffing rotas, policies, incident and accident records, recruitment and training records, meeting minutes and audit

reports.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home. One person told us "It feels safe because I can rely on being looked after properly." Two people referred to feeling safe because the manager made regular checks. One said, " She's very good, calls in every day to check on us and see that everything's alright." Another person said it was because they could always have staff to support and help them when it was needed. However, there were mixed views from people about the availability of staff. One person told us "Sometimes I have to wait to get up when they're short staffed and it can feel like I've been forgotten because I can't do it on my own and I'm helpless". Others said that it could take some time when staff were busy to have bells answered. Six people and one relative said that there frequently were not sufficient numbers of staff to respond quickly enough to people's needs, although there was also an understanding of how busy it was when staff were sick.

Staff had varied views about the staffing arrangements. Some spoke of there not being enough staff whilst others were very satisfied with the staffing of the home. One staff member commented, "They base it on numbers of residents not dependency." We discussed this with the registered manager. They told us staffing was based on the formula of one staff member to five people. Whilst the provider assessed people's level of dependency this was not directly taken into account when deciding on staffing numbers (care staff) in the home.

The registered manager said there was some flexibility and where possible they would not admit people to the home if they were not suitable in terms of needs, complexities or capacity to meet their needs. They told us where assessment indicated "more intense level of staff support" a reviewing of costs to allow for additional staffing would take place. Where needs may change a review of funding would also take place to "Allow for additional support." However, there was no current system in place to calculate the staffing of the home against people's care needs.

We recommend the provider review their system for making decisions about staffing arrangements in the home and explore appropriate guidance and systems which may assist them in this review.

The provider had systems and processes which helped to protect people against the risks of abuse. There was a robust recruitment process which meant that all new staff were thoroughly checked to make sure they were suitable to work with people who lived at the home.

To further protect people, all staff received training to make sure they knew how to recognise and report any suspicions of abuse. The provider's policies and information gave staff details about how to raise concerns within the home and to outside agencies. Staff we spoke with had a good understanding of issues of abuse and all said they would not hesitate to report any concerns. They were very clear about their responsibility to keep people safe. All were confident that concerns raised would be taken seriously and fully investigated.

There had been a concern raised about possible abuse and the registered manager had followed guidance around reporting to the local safeguarding team. The concerns had been investigated and found to be

unsubstantiated.

Risks to people's personal safety had been assessed and plans were in place to minimise the risks. All of the care plans we looked at contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. All of these had been reviewed monthly. When risks had been identified, the plans contained clear guidance for staff on how to reduce the risks of harm to people. The guidance was personalised and where relevant, referred to people's medical condition. There were personal emergency evacuation plans available in the event of an emergency such as fire.

People told us they received their medicines at a time they were prescribed. Some people had time sensitive medicines such as for the treatment of Parkinson's Disease. These had been administered as prescribed. Medicines were stored safely and securely. There were individual protocols in place when medicines were prescribed to be given on an 'as required' basis (PRN) or where they were to be used under specific circumstances. This ensured people were given their medicines when they needed them and in way that was safe, consistent and effective.

Stock records were accurate including those medicines which required additional security. There was secure storage for medicines with daily checks of fridge and clinic temperatures to ensure they were stored safely. Audits of medicine administering records ensured they had been completed accurately. There were no gaps in these records and any amendments had been signed by the person making the amendment.

There were arrangements in place for regular reviews of people's medicines by the person's GP or on some occasions a pharmacist. This had resulted in some changes in people's medicines specifically where they were no longer required or effective. Other health professionals were also involved in monitoring or reviewing people's medicines, for example where people were on medicines because of mental health needs. This meant people's health and welfare was protected.

Staff told us how they ensured people were protected from the risk of cross infection. This was by the use of protective clothing which they said was "Always available when we need it." We observed staff using protective clothing when required. The provider employed full-time cleaning staff and had effective systems in place to maintain appropriate standards of cleanliness and hygiene which staff consistently followed. People commented, "It's nice and clean here" and "They are always cleaning."

The environment was clean, however, there were pressure cushions in use which were torn and presented an infection risk. These had been identified by the provider as requiring replacement but remained in use. On the second day of our inspection the home was closed to visitors because of concerns about number of staff reporting sick with sickness and diarrhoea. No people in the home had had such sickness. This was appropriate action to take in protecting the health and welfare of people living in the home.

The registered manager was open to looking at incidents and events which could result in changes in working practice and improve the safety of people living in the home. Staff recognised their responsibilities in reporting any concerns about areas which could affect or impact on the safety and wellbeing of people.

Requires Improvement

Is the service effective?

Our findings

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.

Where people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

There was a system in place around the undertaking of best interest's decisions. However, there were inconsistencies in ensuring the legal process was following to protect people's rights. Consent forms for influenza vaccinations had been signed by relatives or others who had enduring power of attorney but not in relation to health and welfare decisions. There were no mental capacity assessments to demonstrate the person lacked capacity to make this decision. However, there had been a best interest decision taken regarding the providing of specific care to a person in the home. In this instance, a MCA assessment had been undertaken to evidence the person lacked capacity to make this specific decision.

In discussion with the registered manager they acknowledged there was this inconsistency, This also applied to where measures had been taken to protect people's health and welfare. This included where people had bed rails, pressure mats and sensor devices to monitor movement in the person's room. These could be viewed as restrictive practice. This meant that people's rights were not robustly protected.

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

People's rights had been protected through the assessment and authorisation of DoLS. In one instance the registered manager had acted promptly to ensure the person was not being unlawfully detained in that an assessment under MCA and DoLS had been put in place.

Recently recruited staff were in the process of completing the Care Certificate, which is a nationally recognised induction training programme. The Care Certificate is designed to help ensure care staff that are new to working in the care service have initial training that gives them an understanding of good working practices.

We spoke with staff about their induction process. Staff told us they had felt well supported throughout the process and had always been with a more experienced member of staff when they started their employment. Staff spent time 'Shadowing' more experienced staff for as long as they needed before they were assessed as being competent to care and support people independently.

Staff received regular one to one supervision and yearly appraisals. Staff were positive about the opportunity through supervision to discuss any concerns, working in the home and training. Nursing staff received clinical supervision ensuring their practice was reviewed and monitored.

People told us they felt confident about the skills and knowledge of staff. One person told us, "The staff certainly know what they are doing makes me feel better knowing they know their job." Another person said, "Staff seem to get the training they need." This was confirmed by staff. One staff member told us they had received training about supporting people living with dementia and "This has really helped." Some staff had received more specialist training involving clinical skills. As part of this they had had their competency assessed through observation. This meant staff had the necessary skills and knowledge to meet people's needs effectively.

People had access to community health services such as a chiropodist, dentist and opticians. One person said, "I get to see my doctor whenever I need to-I only have to ask." Where people were assessed as needing specific support in areas such as diet and nutrition, referrals had been made to a dietician or speech and language specialist.

People spoke of food being very good and plentiful. One person said, "There is only one thing wrong with the food here... there's too much of it." Another person said, "There is plenty of food here, more than I need or would eat at home and it is very good too." People told us there was always a choice of foods, however, some said they were given a meal which was not of their choosing.

We observed people being given a meal and saying they did not want it and being offered an alternative. There were some people who would benefit from being shown the choices of meals particularly those who were living with dementia and perhaps could not recall their choice of meal they made from the previous day. Some people required their food and fluid to be monitored to ensure they were eating and drinking enough to prevent the risk of malnutrition or dehydration. There was a system in place for staff to record the amount of food and fluid people consumed during the day.

At our previous inspection we had raised concerns about how the mealtime experience did not provide a social and pleasant occasion. For example, tables were not laid and used, people sitting in the lounge having their meal rather than having the choice of eating in the separate dining area. The Provider Information Return told us how the provider had made efforts to encourage people to eat with others at dining tables. We saw how dining tables had been laid but there was no consistent approach by staff encouraging people to move from the lounge and have their meal with others.

We observed people sitting with their meals and needed prompting or support to have their meal. This was not always available. For one person they sat for ten minutes and ate very little unless prompted. There were not sufficient staff to provide the level of support and prompting needed to ensure people ate their meals before they became cold. We discussed this with the staff and registered manager. One staff member said, "I hate mealtimes-so many people need encouragement." On one occasion a member of staff went to the kitchen to make a coffee for one person who had finished their lunch despite there being people who were either waiting for a meal or required assistance to have their meal.

We raised with the registered manager how there was a lack of organisation at mealtimes. Staff though very task focussed did not have the capacity to focus on individuals and help in making mealtimes a relaxed and social occasion. We discussed other ways of managing mealtimes with the registered manager who agreed this was something they would discuss with people living in the home and staff with a view to improving the mealtime experience.

The environment had been adapted to meet the needs of older people. Rooms and communal areas were well equipped with specialist chairs and there were rails in corridors to support people when moving around the home independently. In bathrooms there was specialist bathing equipment and as with other equipment these had been regularly serviced and maintained.

Areas of the home were in need of refurbishment and decoration. This had been acknowledged by the provider in their 2018 Improvement plan identifying new carpeting was needed in lower lounge and redecoration in various areas. The plan noted the replacement of carpeting in 2017 in communal corridors. We noted the bathroom on the first floor was in need of decoration. There was equipment including commodes stored in the room and paintwork peeling.

Good

Is the service caring?

Our findings

People spoke positively and warmly about the approach of staff and the relationships they had with staff. One person said, "They are very kind, they take time to listen to me and they know what will help me." Another person said, "The staff are very busy but they can't do enough for you and they always take the time to explain things to me." A third person spoke of being, "Well looked after, I don't feel alone here."

People said their privacy and dignity were respected and we observed staff supporting people. For example this included when using a hoist to transfer a person into a chair ensuring their dignity was protected. Where staff assisted people with having a meal, this was done at a pace which suited the person and in a relaxed and engaging way. Staff spoke in a respectful and polite manner with people. One person told us, "You can have a laugh and joke with staff so things that might be embarrassing, like personal things, are not a problem because you feel comfortable."

People's equality and diversity was respected by the staff who supported them. Staff had a good understanding of their responsibilities in recognising people with specific needs related to their diversity. One staff member told us, "This is people's home and we are here to support them and it is their choice how they lead their lives." In discussion with staff about differing sexual needs, one staff member said, "It is not for us to judge, people can do as they wish and have relationships and friendships with whoever they wish and we should respect that."

People were supported to maintain relationships with their family and friends. One person said, "I get regular visits from family and friends which helps me keep in touch." This was also evidenced by talking to a relative who visited regularly who told us, " Whenever I visit everyone is very friendly and welcoming, they keep me informed which is good." Relatives said they could visit anytime they wished.

People spoke of being able to: "Do things for myself." and "Staff are very good I try and be as independent as possible and they see that is what I want." Staff spoke of people in a warm and compassionate way. Staff interacted with people in a friendly and warm manner and were able to explain how people preferred their care to be given. Staff were knowledgeable about the people they cared for explaining how people liked to spend their day and what their likes and dislikes were.

People sought staff out to chat and spend time with, staff genuinely cared for people which showed in the positive way they interacted.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt activities could be improved. One person told us they felt bored and said "I do not want to get up as there is nothing to get up for." Another person said, "If I go to the sitting room there is nothing to do there, so I stay in my room. They did start activities and I had a list somewhere, but I do not know what happened to it."

We spoke with the recently appointed activities co-ordinator. They recognised the need to review how activities were provided in the home. They spoke of how they wanted to focus on more one to one activities reflecting the frailty of people living in the home and perhaps unable to take part in group activities. They told us they were currently working through a training programme entitled "Living Well Through Activity In Care Homes."

The provider had an "End of Life Care Pathway." This provided an opportunity for the person to discuss and set out how they wished to be cared for at the end of their life. It addressed all elements of the person's care from the practical to the spiritual. However, we identified with the home two people who were or had been admitted for end of life care. In neither case was this pathway completed. This meant there was a risk that people's end of life care preferences may not be understood or followed by staff.

People who wished to move to the home had their needs assessed prior to admission to ensure the home was able to support them. This assessment was then used to create a plan of care once the person had moved into the home. Care plans included information specific to the person about their needs and life history.

Care plans were comprehensive and contained up to date, accurate information. Care plans were reviewed and updated at least once a month to ensure they contained relevant information. Whilst there was some evidence people and their representatives or relatives had had an opportunity to discuss care needs and plans, for example as part of a placement or social services review, this was not always evident.

Care plans reflected the specific needs for people. For example, one person had complex needs because of their medical condition. There was a detailed care plan and records about the care and guidance on how staff should respond in an emergency. There had been continued liaison with outside professionals about how the home could be responsive to the person's needs. Staff spoke of how people had improved since coming to live in the home. They referred to one person who had previously been in bed, with poor if any ability to be independent and their mobility was limited. They explained how this person had improved to the extent they were now able to move around independently or with help from staff and was also now self-caring in some respects.

We spoke to some visiting professionals who reported they found the staff friendly and approachable. A GP spoke of a former patient who was over 100 years old bed bound and well cared for in terms of maintaining their skin integrity and nutritional needs. We also spoke to a podiatrist who was positive about the care they had observed and the approachability of the staff.

The service ensured people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

There was good communication between staff and people who understood each other very well. We were told of how one person had specific communication needs and this involved the use of cards to help the person communicate their needs. Information was available to people about how the service was responding to people's views through a regular newsletter and a "What You Said" which was distributed to all people living in the home.

There was a complaints procedure in place and people told us they knew how to make a complaint. It was also displayed in the home and people received a copy when coming to live at the home. One person told us, "I know I can make a complaint if I wanted but I always talk to the manager or staff and it gets sorted out." There had been two complaints since our last inspection in October 2016 and both had been fully investigated. In one instance it led to changes in the decisions made about how the person received care.

Requires Improvement

Is the service well-led?

Our findings

People told us how they found the registered manager approachable and felt they listened to their views. One person said, "The manager is always around for you to talk to." Another person said, "If it is something really important and serious you can tell her (registered manager)." This was echoed by staff who again described the registered manager as approachable and "Someone who knows what is going on and how people are." Another commented they were, "Always around if you need her."

Audits took place of the systems and processes in the home such as care plans, medication and infection control. Where these had identified areas for improvement action had been taken. However, they had failed to identify the shortfalls we identified from this inspection. For example they failed to identify the failings around best interest's decisions, the need to improve the dining experience for people and examine how decisions about the staffing arrangements are made.

The registered manager promoted a culture of providing care which was centred on the individual and providing a family environment. They spoke of trying to ensure people had a voice and central was respecting people as individuals. Staff said they enjoyed working in the home because it was a "Family environment" and recognised this was what the registered manager wanted to provide for people and their families.

Efforts had been made to engage with the local community particularly schools and community groups.

People told us that they were asked about their views and questionnaires had been given to people. These showed a positive response in relation to the quality of care and the supportive and caring staff. However, some people said they would like to have "Residents" meetings. There was a newsletter sent to people one newsletter we reviewed informed people about the changes in how meals were provided.

Staff told us that whilst they felt communication was good there were no regular staff meetings. They described morale in the home as good. One said, "Staff are happy to work here, we work as a team."

There was a management structure in the home, which provided clear lines of responsibility and accountability. The registered manager had overall responsibility for the home. They were supported by a deputy manager and a team of senior care workers and care staff. However, there was no oversight from the provider in terms of undertaking visits to the home or their reviewing of quality assurance audits which took place.

There were systems in place to review accidents and incidents and identify any improvements such as referral to outside agencies for support and obtain advice and implement any changes to the person's environment.

The registered manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to ensure people's rights were consistently protected when undertaking decisions as part of their care arrangements specifically where actions were taken which could be viewed as restrictive practice and people lacked mental capacity to give informed consent. Regulation 4(b)