Guysfield House Limited

Guysfield Residential Home

Inspection report

Willian Way,
Willian
Letchworth Garden City
Hertfordshire
SG6 2AB
Tel: Tel: 01462 684441
Website: www.caringhomes.org

Date of inspection visit: 14 July 2015
Date of publication: 20/08/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection was carried out on 14 July 2015 and was unannounced.

When we last inspected the service on 10 and 18 March 2015 we found them to not be meeting the required standards. This was a focused inspection to check if they were meeting the required standards. We found that they had made some improvements but had failed to support people appropriately with eating and drinking and to ensure good governance in the service.

Guysfield Residential Home provides accommodation and personal care for up to 51 older people. At the time of the inspection there were 24 people living at the home.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

People did not always receive the appropriate support with eating and drinking and where needed, this was not monitored.

Systems in place to assess, monitor and improve the service were ineffective and did not identify issues we

Summary of findings

found during our inspection. This was in relation to record keeping, which included care plans, monitoring of accidents and incidents and incomplete action plans developed to improve the service.

People received person centred care and staff knew them well. People were supported to access the toilet regularly, received appropriate pressure care and were supported to get washed and dressed when they requested it. People felt that staff were available when they needed them. Staff were visible and responded to people as they needed them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Falls were not reviewed to ensure the necessary steps had been taken to reduce a reoccurrence.

People were supported by sufficient numbers of staff.

People had access to means of calling for assistance.

Requires improvement

Is the service effective?
The service was not always effective.

People did not always receive the appropriate level of support to ensure the maintained sufficient intake to promote their well being.

Requires improvement

Is the service responsive?
The service was not always responsive.

People's care plans and daily records were not always accurate and up to date.

People received care that was person centred.

Requires improvement

Is the service well-led?
The service was not well led.

There were ineffective systems in place to assess, monitor and improve the service.

Inadequate

Guysfield Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This visit took place on 14 July 2015 and was carried out by an inspection team which was formed of three inspectors. The visit was unannounced. Before our inspection we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with 10 people who lived at the service, four members of staff, the registered manager, the peripatetic manager and the operations director. We received feedback from health and social care professionals. We viewed five people's support plans. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection on 10 and 18 March 2015 we identified a breach of regulations, 9, 14, 10 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to regulation 9, 14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people did not always receive safe and effective care due to insufficient staffing levels, ineffective risk management and poor governance.

At our focused inspection 14 July 2015 we found that the provider had met the requirements of Regulation 9, and 18. However, there were continued shortfalls found in relation to governance in the home.

At our inspection on 10 and 18 March 2015 we found that accidents and incidents were not reviewed and as a result the appropriate action to reduce a reoccurrence or injury was not taken. At this inspection we found that the manager had not implemented an accident analysis system or developed actions to address themes and trends. For example, the number of falls was greater during night time hours. At this inspection we found that there had been more improvement to the way in which accidents and incidents were reviewed. We found that the number of accidents during night time hours was still greater than other times of the day and there had been no remedial action taken. We viewed the provider's reporting system and found that this did not provide analysis to enable them to identify themes and trends. This shortfall had not been addressed as a result and therefore they had not met the conditions of the warning notice.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received support promptly when they needed it. Whilst speaking with a person in their room they wanted to be repositioned and rang the call bell which was answered promptly. People told us that staff were available most of the time. One person told us, "You can't expect them to come too quickly they are probably helping someone else."

We saw that call bells were responded to quickly and staff were on hand to meet people's needs. People had access to call bells and where they were unable to use a call bell, sensor mats were in bedrooms to alert staff to their need for assistance. In addition, people who were supported in their rooms were checked hourly by staff.

People who were at risk of developing a pressure ulcer were supported appropriately to help reduce the risk of this occurring. We saw that people received regular position changes, the appropriate equipment and access to toilet facilities at regular intervals. Staff were able to tell us who was at risk of developing a pressure ulcer and how to prevent it.

Requires improvement

Is the service effective?

Our findings

We found that people did not always receive appropriate support and monitoring to ensure they were eating and drinking sufficient quantities. At our comprehensive inspection on 10 and 18 March 2015 we identified a breach of regulations 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 14 July 2015 we found that there remained shortfalls in relation to nutrition and hydration. We were told by the chef that all the food was fortified to boost calorific intake where possible. We also saw that people who were assessed as being at risk of having a poor intake had their meals delivered on a red tray. We were told by staff that the red tray system was in place to raise awareness to staff about who was at risk of not eating enough. We noted that the deputy manager offered people in the dining room, who were declining their lunch alternatives.

People did not have their food intake appropriately monitored. We found that five people who were assessed by the service as having a Malnutrition Universal Screening Tool (MUST) which showed they were at high risk of malnutrition, did not have their food intake monitored in accordance with the assessment tool's instructions. Staff spoken with were unaware of the need to monitor the food and fluid intake for these people. We were told by staff that one of these people had their intake monitored by a dietician for two weeks prior to our inspection but this had not been continued by the service. We observed this person struggled to eat their breakfast which had spilt onto the table cloth. Staff did not offer the person assistance for 30 minutes. We also noted that their breakfast of scrambled eggs and toast would have been cold but a fresh plate was not offered or provided. We saw that during breakfast there were other people who had sat for long periods of time with cold food, such as porridge and toast, in front of them. Staff eventually took the food away. It was not recorded who had not eaten. One person's breakfast tray, which included uneaten porridge and toast, was not removed until lunchtime. This meant that people were at risk of not eating and drinking sufficient amounts to maintain their health and wellbeing.

We observed lunchtime in the dining room and found it was noisy and somewhat chaotic. There were six staff, the registered manager and a regional manager in the dining room. Staff were seen supporting one person to eat and then leaving them to go to someone else. Many people's plates were taken away without much being eaten but people were not offered an alternative just a pudding. One staff member was talking loudly to one person to encourage them to sit down and finish their meal. This staff member did not acknowledge or talk with the other person who was also sitting on the same table.

People gave mixed views on the food. One person said, "Sometimes it's cool so as to help people not get burnt by hot food." Another said, "If I don't eat my lunch it doesn't matter there is no fussing." People told us that they used to get asked for suggestions for the menu they said they used to get asked but not anymore.

One person said they had no teeth so only ate soft food. We saw they had not eaten much of their porridge which they said had got cold. We called into their room at 1.30pm and found that they were asleep on the bed with their lunch tray untouched on their table.

This was a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection on 10 and 18 March 2015 we identified a breach of regulations 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the service had not maintained accurate records in relation to people and their individual needs.

At our focused inspection on 14 July 2015 we found that there remained shortfalls in relation to records held in relation to people's needs. We found that although people's care plans had improved and risk assessments set out people's needs there were still inconsistencies with care records. Although we found concerns with people's care records, people told us that they received the support they needed. One person said, "We get all the care we need. I get baths, I can't fault them." Another person said, ""If I want help they give it to me but I am independent and I prefer to do things my way. However they will come with me into the bathroom as I know it's important."

People were supported by staff who knew them well. Due to the smaller number of people living in the home, staff had been able to spend time getting to know people and this enabled them to provide care that was person centred. People were receiving regular support with using the toilet, getting washed and dressed and pressure care management. The deputy manager and team leaders had been working through a new dementia care programme following some recent training and told us this helped them see the person first and understand their needs. One staff member told us, "It's the best training I have ever had, it has really benefitted me, the team and our residents." As a result people were receiving more stimulation and appeared more content. For example, laughing, chatting and more alert than our previous inspections. This helped to ensure that people received personalised care and was an area that the staff had become proud of.

Inadequate

Is the service well-led?

Our findings

We found that the service did not ensure it had established and effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. At our comprehensive inspection on 10 and 18 March 2015 we identified a breach of regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was found to be in breach of this Regulation at our inspections in March 2015, January 2015, and July 2014.

We found that the service had not met the requirements of the fundamental standards and there were continued issues in relation to the management of the service.

Information held in care plans was not always accurate and this had not been identified through internal monitoring. We viewed the care plans for five people. We found where people had been identified as being at risk of malnutrition, the appropriate processes were not put in place. Care plan audits did not identify the shortfall and our observations of the support people received at lunchtime demonstrated that people were not receiving appropriate support in this area.

Care plan audits carried out by staff had identified gaps in recording dating back to January 2015. These shortfalls were consistent through each monthly care plan audit. On the day of our inspection we found gaps in daily recording of people's needs. We asked what the manager what had been done to address these shortfalls. The manager told us they had spoken with staff about this issue at a team meeting in April 2015. We asked the manager what action had been taken following the meeting as the issue continued. The manager told us there had been no additional action taken to address these shortfalls.

There was an ineffective system in place for the monitoring of accidents and incidents. The manager did not monitor accidents and incidents to identify themes and trends in relation to the time and place of events. As a result, they did not implement any actions to reduce reoccurrence of accidents and incidents. The provider had a reporting system that the manager was required to input information in relation to accidents and incidents. However, this system did not identify trends, such as the majority of fall occurring during night time hours, or ask what action the manager had taken as a result of the incident. There was also no formal review of call bell logs to ensure staff response times were not a contributing factor. This meant that people were at increased risk of falls, accidents and injury as the manager had not completed the necessary analysis.

A regional manager visit on 17 June 2015 identified that the governance in the service was inadequate. The manager was given time frames to improve the quality of the service. This included appraisals for staff which were to be completed within two weeks of their visit. The manager told us they had not completed the action plan given to them by the regional manager as they did not think the timescales set were realistic. There had not been a meeting with their regional manager to follow up these concerns and address these shortfalls and as a result, many of the issues remained unaddressed.

On Sunday 12th July 2015 there was staff shortage that affected the running of the service and impacted on people's wellbeing. Care staff told us that as a result of this staff shortage people were kept in their bedrooms. The manager told us this decision was made to keep people safe. However, staff told us that this had caused anxiety to some people. The manager had not informed the regional manager of the staff shortage. The manager told us there was not a business continuity plan for managing staff shortages. We did not receive a notification informing us that there had been an event that affected the running of the service and there was no record of the incident within the home.

Following our inspection on 10 and 18 March 2015 we issued the provider with a warning notice to improve how they monitored the quality and safety of the service. The provider sent us an action plan detailing how they would meet the warning notice. The manager could not locate the warning notice and was not aware of the action plan. The manager had not been working to complete the action plan and was unable to tell us what it included. In addition, the provider had not completed a robust review of the action plan to ensure it had been completed by the agreed deadline. As a result, the action plan had not been completed at this inspection.

Inadequate

Is the service well-led?

This failure to effectively monitor the quality and safety of the service and to take the appropriate action to make the necessary improvements was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in the home did not know who the registered manager was. One person said, “I don’t know who the manager is.” The deputy manager, along with the team leaders, led and guided the staff team. We saw that they provided guidance to staff throughout the day of our inspection and addressed any issues as they saw them. We noted that the deputy manager and senior team were involved in care provision and knew people well. This helped to ensure that staff had effective leadership and guidance for their role.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The service did not ensure people were appropriately monitored to ensure their nutrition and hydration needs were met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service did not operate good governance.**