Mr Charles Otter

Cranhill Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Cranhill Nursing Home provides accommodation and personal care for up to 31 people. At the time of the inspection there were 22 people living at the home.

We undertook this unannounced focused inspection of Cranhill Nursing Home on 23 February 2018. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on the 3, 7, 9 August 2017 had been made.

Two breaches of legal requirements were found following the comprehensive inspection. We used our enforcement powers and served a Warning Notice on the provider on 4 December 2017. This was a formal notice which confirmed the provider had to meet the legal requirement by the 29 December 2017 for good governance and the 5 December 2017 for protecting service users from abuse and improper treatment.

We undertook this unannounced focused inspection to check two of the five questions we ask about services: is the service safe and well led? This is because the service was not meeting some legal requirements. This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cranhill Nursing Home on our website at www.cqc.org.uk

No risks or concerns were identified in the remaining Key Questions through our on going monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

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 2008 and associated Regulations about how the service is run.

We found action had been taken to improve the governance of the service. However there was a lack of accurate monitoring of the suitability of air pressure cushions. We found one person had no clear guidance on what their individual cushion pressure should be set to.

New systems had been implemented for auditing the service, which identifies risks and concerns. There were associated action plans in place to address any shortfalls.

The new system was proactive in spotting risks and concerns early so action could be taken to prevent incidents from occurring.

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

We found improvements had been made to people's safety and safeguarding referrals were being made when required.

Is the service well-led?

Requires Improvement

We found improvements had been made to the quality of the audits and there were clear actions plans in place. Although there was no system for checking people's air pressure cushions.

Cranhill 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 23 February 2018 and was unannounced.

This inspection was done to check that improvements to meet legal requirements after our comprehensive inspection on 3, 7, 9 August 2017 had been made. We inspected the service against two of the five questions we ask about services: is the service safe and Well Led. This is because the service was not meeting some legal requirements.

This inspection was undertaken by a Adult Social Care inspector and a Specialist professional advisor. The Specialist professional advisor was a nurse.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received from the service including their action plan following the last inspection which detailed the improvements they intended to make.

During our inspection we spoke with the Registered Manager, and three staff including one nurse. We also spoke with five people and three relatives to gain their views about the service.

We also looked at the care records of five people living in the home and other records including staff and relative meetings, audits, action plans, training matrix and the questionnaire results for 2017.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of this service on 3, 7, 9 August 2017 we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some aspects of the service were not safe as actions were not being taken when concerns for people's safety were raised. This was due to safeguarding referrals not being actioned as required.

At this inspection we found improvements had been made and action was now being taken when concerns for people's safety were identified.

People, staff and relatives all felt the home was safe and if they had any concerns they would raise them with the registered manager or they would speak to the local authority. One person told us, "Yes, I feel safe". Out of the recent satisfaction questionnaire, thirteen people had answered yes, to feeling safe and secure. One relative said, "[Name] is very well cared for. Staff are really good. We are very pleased with [name] here". Another relative said, "It is very good here, I didn't have any concerns before". One member of staff told us, "Yes, I feel people are safe". Another member of staff said, "Oh, yes I think people are safe". Another member of staff told us, "If I had concerns I would raise them with the matron, or the Local authority safeguarding team. I think people are safe". Staff were able to identify the different types of abuse and where they would raise concerns if they had any. We found various posters up around the home and in the office informing people, visitors and staff what to do if they suspected abuse.

At the last inspection we found the registered manager was not always raising concern with the local authority or ensuring The Care Quality Commission (CQC) were notified as required. At this inspection the registered manager confirmed they had attended a management course on safeguarding adults. This they found had highlighted the importance of notifying and raising concerns in an open and transparent way. Records confirmed safeguarding referrals had been made including notifications made to CQC and actions had been taken when concerns for people's safety were identified.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection of this service on the 3, 7 and 9 August 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to internal systems not identifying shortfalls relating to concerns raised through people's feedback, safeguarding people, suitability of air pressure mattress settings, medicines storage, lack of best interest decisions and people at risk of losing weight.

At this inspection we found improvements had been made and checks relating to previous shortfalls were in place and had clear action plans. The requirements of the Warning Notice had been met but areas for improvement remained.

The most recent customer survey questionnaire undertaken in 2017 was mostly positive although two people when asked, 'Do you feel staff at the home and do staff show you adequate respect'. One person said sometimes and two other people ticked 'no'. This feedback had been shared with the staff team to enable improvements to be made. The staff minutes confirmed, 'Two people said they were not, shown respect or addressed properly, this could be due to the wrong box being ticked'. We spoke with the registered manager about the questionnaire responses. They felt the two people had picked the wrong box and that next year they will make improvements to the questionnaire so that it is easier to answer. We found no information that confirmed the questionnaire could have been inaccurately filled in by these two people. Addressing people's feedback enables the improvement of people's care experience for people and supports an open and transparent culture. An action plan was in place to address how staff addressed people for example by their chosen names.

There were regular audits undertaken for air pressure mattress settings and daily checks in place. Although there were these audits in place we did find during the inspection one person who did not have their cushion set to the accurate setting. Although they were not in bed at the time of the inspection we did find the air cushion they were sat on had no setting guidelines in place to ensure it was set accurately. We raised this with the registered manager. They confirmed no one at the time of the inspection had any pressure ulcers and that there was not a system in place for checking people who used air cushions. Following the inspection the registered manager confirmed action had been taken.

We found some shortfalls relating to the recording and safe storage of medicines. For example, one person medicines was not always being signed for as given, or refused to enable accurate monitoring of their medicines. They required their topical cream administering twice a day or when required. We found no record for the last nine days of the cream being administered or refused. We found the fridge within the staff room had medicines stored in it but this fridge was not locked and was accessible to any member of staff. We also found one person who was self-administering their medicines had an accessible medicines cabinet which was not locked to secure the medicines.

People's mouth care records lacked a detailed record of what care had been provided. We fed this back to the registered manager for them to take the necessary action. Following the inspection the registered

manager confirmed what actions that had taken.

The registered manager confirmed during the inspection there were still actions required relating to staff training. For example, some staff still required safeguarding adults training. We found during this inspection although staff were able to demonstrate their understanding of safeguarding adults not all staff had received the training. An action plan was in place that confirmed what staff required this training and by when. Not all staff had been trained in how to prepare people's thickening agent in people's drinks. This is important as by staff receiving training in how to prepare this medicine enables them to identify any issues or problems. We raised this with the registered manager who confirmed staff had not received any training relating to this but they would arrange this.

People were not always supported to meet their individual nutritional needs. Some people had to wait until 1:45 in the afternoon to receive their lunch time meal, which the registered manager confirmed was due to staff breaks. This included one person who was at risk of losing weight and had been prescribed supplements to support their weight. The providers audit had identified this person's weights had fluctuated over the last few months. We asked kitchen staff what times breakfast had been and what time they thought this person might have had their breakfast. They replied, "8:45-9ish, I don't know exactly".

We found regular audits had been undertaken for monitoring safeguarding concerns, medicines, people's mental capacity assessments and people at risk of losing weight. All audits had a clear action plan in place including what actions and who was responsive and by when.