Mr & Mrs J B Wescott

Neilston Residential Care Home

Inspection report

47 Woodway Road
Teignmouth
Devon
TQ14 8QB

Tel: 01626774221
Website: www.neilstoncarehome.co.uk

Date of inspection visit:
22 August 2016

Date of publication:
17 October 2016

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Neilston residential care home provides accommodation and personal care for up to 22 older people who may be living with a dementia. At the time of our inspection there were 20 people living at the home. The home offers both long stay and short stay respite care. The service was previously inspected on the 13 January 2016. The overall rating was requires improvement

After that inspection we received concerns that people's medicines were not being managed safely; that the service had not sought advice from healthcare professionals in a timely manner; the home was not following dietary guidance for people who required a soft or pureed diet and that there were insufficient staff on duty to meet people's needs.

As a result we undertook a focused inspection on the 22 August 2016. We inspected the service against one of the five questions we ask about services: is the service safe? At our previous inspection we rated this key question as requires improvement. This report only covers our findings in relation to those concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for residential care home on our website at www.cqc.org.uk".

We found there were not always enough staff on duty to meet people's needs. The management team had recognised this and were attempted to recruit additional staff. Some records were not always well maintained, clear or up to date, although the manager took immediate action to remedy this. We did not find evidence to support the other concerns and have asked the manager to keep these under review.

The home had a registered manager. 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.

People told us they felt safe and well cared for at Neilston. People told us they thought there could be more staff on duty so they did not have to "wait for someone to come". Relatives told us they were happy with the care provided by the home and said people were well looked after. However they also said the home could do with more staff. Staff told us there were enough staff. They said they needed at least one more person during the day, especially in the morning, when people needed more assistance. During our inspection we saw people were left unsupervised for long periods of time while staff were attending to people's needs in their bedrooms. Staff interacted with people in a friendly and caring manner and people seemed comfortable in their presence. However many of these interactions were task related. Although staff did not appear rushed, some people did have to wait for their needs to be met. We raised these concerns with the registered manager who told us they had already identified the need to increase staffing levels and had a clear plan in place to address this. They planned to increase staffing during the day from two care staff and one senior to three care staff and one senior. We saw a new senior had recently been appointed, adverts had been placed to recruit more care staff and interviews were planned for the following week to appoint an

activities co-ordinator.

We received information that one person had fallen and the home had not sought advice from an appropriate health care professional. We looked at the care records of this person and found the incident had been appropriately managed and documented. However not all records relating to this person were accurate, clear or up to date. The manager addressed this immediately.

People received their prescribed medicines on time, in a safe way, and were given the time and encouragement to take their medicines at their pace. There was a safe system in place to monitor the receipt and stock of medicines held by the home. Medicines were disposed of safely. Staff had received training in the safe administration of medicines.

People's care records contained food and fluid intake charts, nutrition, hydration and swallowing assessments, which were reviewed and updated regularly. We observed lunch and saw; where people required a soft or pureed diet this was being provided.

We found a 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 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

Some aspects of the service were not safe.

People were not receiving care and support in a timely manner.

There were not always sufficient numbers of staff on duty to meet people's needs at all times.

People's health care needs were monitored and referrals made when necessary.

People were protected from the risks associated with unsafe medicine administration because medicines were managed safely.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

Neilston Residential Care 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 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The service was previously inspected on the 13 January 2016. The overall rating was requires improvement. Following that inspection we received concerns that people's medicines were not being managed safely; that the service had not sought advice from healthcare professionals in a timely manner; the home was not following dietary guidance for people who required a soft or pureed diet and there were insufficient staff on duty to meet people's needs. As a result we undertook a focused inspection on the 22 August 2016 which was unannounced, to look into those concerns.

The inspection team consisted of one adult social care inspector. Prior to the inspection, we reviewed the information held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events, which the service is required to tell us about by law.

During the inspection, we met with five people individually who used the service. We looked at the care of three people in detail to check they were receiving their care as planned. In addition we spent time with people in communal areas and observed how staff interacted with people throughout the day, including during lunch. It was not possible to speak with some people about their experiences of the service due to their complex care needs. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not comment directly on the care they experienced.

We looked at people's care records, staffing rotas and we reviewed how the service managed people's

medicines. We spoke with four members of staff, the chef, cleaner and registered manager. We looked around the service and grounds which included some bedrooms (with people's permission). We also spoke with four relatives of people currently supported by the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection which took place on the 13 January 2016, we rated this key question as requires improvement and this has not changed. Following this inspection we received concerns there were insufficient staff on duty to meet people's needs; the home was not following dietary guidance for people who required a soft or pureed diet; that the service had not sought advice from health care professionals in a timely manner when one person had fallen. We also received concerns that people's medicines were not being booked in correctly, which had led to medicines not being available when people needed them; that medicines were being left in people's rooms; and that one person had not had regular blood tests, needed to determine the correct dose of medicine to be given.

We explored these concerns and found people were not always safe because there were not always enough staff on duty to meet their needs in a timely manner. Records were not always well maintained, clear or up to date. We did not find evidence to support the other concerns and have asked the manager to keep these under review.

At the time of our inspection there were 20 people living at the home. The registered manager told us that everyone required some level of assistance with personal care and four people required two staff to assist them with their mobility. Rotas showed there were usually three members of care staff on duty during the day. One of these members of staff was a senior who was responsible for administering medicines, arranging appointments and completing various care records. Care staff were also responsible for the laundry, assisting people during meal times and providing activities. Care staff were supported by a chef who worked between 8.00am and 3.00pm and a housekeeper who worked four hours a day.

People who were able to speak with us said they felt safe and well cared for at Neilston. They also said there were not always enough staff to meet their needs. One person said "I think there could be more (staff), then I wouldn't have to wait for someone to come". Relatives told us they were happy with the care provided and said people were well looked after. They also said they could do with more staff. One relative said "it has become normal for [person's name] to still be in bed waiting for assistance till 11.30am". Another said when we visit "we often have to go looking for someone especially in the morning and at weekends".

We spent time in the communal lounge and dining area observing interactions between people and staff. We saw that people were left unsupervised for long periods of time while staff were attending to people's needs in their rooms. We saw that when staff interacted with people it was in a friendly and caring manner and people seemed comfortable in their presence. However many of these interactions were task related, for example assisting people with personal care, making drinks, and serving people with their meals. Although staff did not appear to be rushed, some people did have to wait for their needs to be met until staff had time. For example in the morning we saw people who were sitting in the lounge were having to wait for assistance as staff were busy.

Staff told us there were enough staff to keep people safe and meet their needs, but they needed at least one more person during the day, especially in the morning, when people needed more assistance. One member

of staff told us they were concerned that staffing levels meant that people had to wait for assistance and "people were getting up later than usual". Another said "people can be still in bed at 11.30am". On the day of inspection most people's personal care needs had been met by 10.45am.

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

The registered manager told us people were able to choose when they got up and were able to stay in bed if they wished. They said on these occasions people were still supported with their personal care needs. The registered manager said they had already identified the need to increase staffing levels and had a plan in place to address this. They planned to increase staffing during the day from two care staff and one senior to three care staff and one senior, adverts had been placed within the local paper, three weeks prior to our inspection. We saw a new senior had recently been appointed and was due to start at the beginning of September, and interviews were planned for the following week to appoint an activities co-ordinator.

Prior to the inspection we received information that one person had fallen and the home had not sought advice from an appropriate health care professional. We looked at the care records of this person and found the incident had been appropriately managed and documented; the service had contacted emergency services and the person was taken to Torbay hospital for further treatment.

However we saw that not all records relating to this person were accurate, clear or up to date. For example records showed this person had fallen four days prior to our inspection and sustained an injury to their left arm. Staff confirmed they had spoken with the person's GP and they had monitored the person for signs of a head injury. However this information was not contained within the person's care plan. This was reported to the registered manager during the inspection who took immediate action to address our concerns.

We received concerns that people's medicines were not being managed safely. Medicines were not being booked in correctly; medicines were being left in people's rooms; and that one person had not had regular INR tests (international normalised ratio), which is necessary to determine the correct dose of warfarin medicine a person needs to take.

We observed the lunch time medicines round and saw people received their prescribed medicines on time, in a safe way. People were given the time and encouragement to take their medicines at their own pace. Staff stayed with people to ensure they had taken their medicine before completing the Medication administration records (MARs). There was a safe system in place to monitor the receipt of medicines held by the home and medicines were disposed of safely when they were no longer required. MARs identified people's allergies and protocols for 'as required' medicines (PRN). Staff told us they understood how the system for the safe administration and recording of medicines worked and that they had received appropriate training.

MARs showed that two people currently living at the home had been prescribed warfarin by their GP. Records showed these people received regular blood tests and they were receiving the correct amount of medicine (warfarin) as prescribed by their GP.

At our pervious inspection we identified a number of items that could present risks to people living with dementia if misused or ingested. For example, deodorant aerosol and antibacterial hand wash. Prior to this inspection we received concerns that medicines were being left in people's bedrooms. We looked around the service and some bedrooms (with people's permission). We found the provider had made improvements in way people's personal toiletries were stored to reduce the risks of people potentially ingesting harmful

items. We did not find any medicines which had been left unattended in people's bedrooms.

We received concerns that people were at risk because the home was not following dietary guidance for people who required a soft or pureed diet. We reviewed people's care records and found they contained food and fluid intake charts, nutrition, hydration and swallowing assessments, records of allergies, risk assessments and weight management records. These records had been reviewed and updated regularly. We spoke with the chef who told us they had been provided with detailed guidance on people's preferences, nutritional needs and allergies. In addition we saw there was a list of people's dietary requirements written on a white board in the kitchen. We observed lunch. Where people required a soft or pureed diet this was being provided. Each food item was processed individually to enable people to continue to enjoy the separate flavours of their meals. This meant there was a range of methods in place to promote people's dietary support needs.

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 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent and skilled staff employed to meet people's needs. Regulation 18(1)