The Legrand Nursing Home Limited

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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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection was unannounced and took place on 19 February 2015.

The Legrand Nursing Home is registered to provide accommodation and personal care for adults who require nursing care and who may have a dementia related illness for a maximum of 38 people. There were 35 people living at home on the day of the inspection. There was a registered manager in place. 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.

Summary of findings

People told us that they felt safe and free from the potential risk of abuse. Staff told us about how they kept people safe. During our inspection we observed that staff were available to provide advice or guidance that reduced people's risks.

People received their medicines as prescribed and at the correct time. However, we found systems and processes needed to be improved. Staff had not monitored the amount of medicines used where people required medicines 'as needed'. The provider would then be able to identify where a person required a review of their medicines.

People and relatives told us there were enough staff to support people at the home. Staff at the home felt there were enough staff to meet the needs of people living at the home. However, the provider agreed that reviewing people's health and care needs would make better use of their current staffing group.

People told us they liked the staff and felt they knew how to look after them. Staff were provided with training which they felt reflected the needs of people who lived at the home. Nursing staff were limited in their clinical supervision and support, but a nurse had been recruited to support them.

Assessments of people's capacity to consent and records of decisions had not been completed in their best interests. The provider could not show how people gave their consent to care and treatment or how they made decisions in the person's best interests. Therefore, people had decisions made on their behalf without the relevant people being consulted.

People were supported to eat and drink enough to keep them healthy. We found that people's health care needs were assessed, and care planned and delivered to meet those needs. People had access to other healthcare professionals that provided treatment, advice and guidance to support their health needs.

People told us and we saw that their privacy and dignity were respected and staff were kind to them. However, on occasions we saw that people had not always received supported to have their choices and decisions respected.

People had not always been involved in the planning of their care due to their capacity to make decisions. However, some relatives felt they were involved in their family members care and were asked for their opinions and input.

People had not always been supported to maintain their hobbies and interests or live in an environment that supported their needs. Relatives we spoke with told us they were not aware of the provider's complaints policy, but were confident to approach the manager if they were not happy with their care. The provider had not reviewed or responded to all concerns raised. They had not used the information to learn and improve the service.

The provider and registered manager had not made regular checks to monitor the quality of the care that people received and look at where improvements may be needed. The management team had not kept their knowledge current. The management team were approachable and visible within the home which people and relatives liked.

You can see what action we told the provider to take at the back of the full version of this report.

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 consistently safe.

People received their medicines; however improvements were needed in managing people's medicines. People told us they felt safe and looked after by staff.

People and relatives told us they felt there were enough staff on duty. The provider needs to review the staffing to meet the care and social needs of people who lived at the home.

Requires improvement

Is the service effective?
The service was not effective.

People's needs and preferences were supported by trained staff.

The Mental Capacity Act (2005) code of practice was not consistently followed to ensure people were supported to make their own decisions.

People's dietary needs had been assessed and they had a choice about what they ate. Input from other health professionals had been used when required to meet people's health needs.

Requires improvement

Is the service caring?
The service was not consistently caring.

People received care that met their needs. Staff provided care that met people's needs whilst being respectful of their privacy and dignity and took account of people's individual preferences.

We found that some staff required further support to ensure that people were treated in a way that made them feel included and valued at all times.

Requires improvement

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

We saw that people were able to make some everyday choices. However, people had not been engaged in their personal interest and hobbies.

People were supported by staff or relatives to raise any comments or concerns with staff. However, these had not always been responded to or used to develop the service.

Requires improvement

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

Inadequate

Summary of findings

The registered manager and provider had not monitored the quality of care provided. Improvements were needed to ensure effective procedures were in place to identify areas of concern.

People, their relatives and staff were very complimentary about the overall service and felt the registered manager was approachable and listened to their views.

Legrand Nursing Home Limited

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 unannounced inspection took place on 19 February 2015 and was in response to concerns raised by the local authority and Shropshire Clinical Commissioning Group. The inspection team comprised of one inspector, one specialist advisor and an expert by experience who had expertise in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the home and looked at the notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection, we spoke with six people who lived at the home and five relatives. We spoke with seven staff, the registered manager and the provider.

We looked at four records about people's care, complaint files, falls and incidents reports, fire inspection report, food hygiene inspection and electrical checks.

Requires improvement

Is the service safe?

Our findings

People we spoke with felt the home offered a safe environment and had no concerns with the staff in the home. Relatives were confident their family members were "Kept safe from harm". One relative said, "I would not leave [person] here if I felt they were not safe".

We saw that people discussed concerns with staff who responded in a supportive way. For example, where people became upset or distressed staff would go over and speak about what was worrying them. Staff were also aware of people who may become upset or upset others. Staff distracted the person so others remained safe and free from potential harm. Individual plans were in place to support people which showed staff possible mood triggers and ways to calm a situation down.

Staff we spoke with were able to tell us what they understood by keeping people safe and how they would report concerns to the manager. They told us they knew they could share information with the local authority or CQC for advice and support if needed. Staff said they would not, "Hesitate to take action" if they suspected or saw something of concern. Therefore staff and people felt safe and free from the potential risk of abuse.

People managed their risks with support from staff if needed. Staff we spoke with were able to tell us about what help and assistance each person needed to support their safety. For example, where people required help with getting up from a chair or had health risks such as skin conditions. We saw that the risk was detailed in people's care plans and had been reviewed and updated regularly. This showed staff were aware of people's individual risks and how to monitor them.

Relatives we spoke with felt there were enough staff and they "Were attentive" and although "Busy at times", their relative was never left waiting long for assistance. We saw that staff were able to spend time with residents and respond in an appropriate manner to them. For example, staff spent time chatting to people as well as responding to requests.

Care staff told us that "There is always one carer (staff)" in each lounge and one on the first floor. This had been done so staff were available for people if needed. We saw that staff remained present and available with only short periods where staff left the lounge to fetch something. Care staff told us that "Mostly" there were enough care staff to meet people's needs, but at times this could be improved. The provider told us an additional care staff member would be on shift to support people by the end of the month.

The provider had assessed how many care staff were required to assist people with their mobility needs. However, the information had not been used to see how many staff would be needed to ensure all people had their needs met in a timely manner when they needed it. Nursing staff told us there were days where when an additional nurse on shift would benefit people. For example, if there was an increase in people's health needs or when they were giving people their medicines.

The provider and registered manager were aware of this and told us that two nurses had been recruited to assist the nursing staff and registered manager within the next three weeks. This would include one nurse leading on the clinical care and support the nursing staff.

We saw people were supported to take their medicine when they needed it. Staff on duty who administered medicines told us how they ensured that people received their medicines at particular times of the day or when required to manage their health needs. Where people had continually refused their medicines, appropriate action had been taken. For example, advice sought from the GP to review the person's needs.

People's medicines had been recorded when they had received them and we saw that Medicine Administration Records (MAR) had been completed. Nursing staff told us the local GP monitored people's medicines routinely every six months. The registered manager had not completed any checks regarding people's medicines. Therefore the provider had not reviewed the information available to know if people's medicines were appropriate to meet their needs or if further review or advice was needed.

Requires improvement

Is the service effective?

Our findings

We looked at how the Mental Capacity Act (2005) (MCA) was being implemented. This is a law that provides a system of assessment and decision making to protect people who do not have capacity to give their consent.

Some relatives we spoke with felt they were involved in decisions about their family members care. However, some relatives commented that did not feel they were involved in decision, even though they had the legal authority to make decisions when the person could not.

We looked at five records that showed where people did not have capacity to make a decision. We found the correct procedure had not been followed. For example, one person's appointed Power of Attorney (POA) had not been involved or asked for their views for a decision that required health and financial consideration. The registered manager had been aware where people had a POA appointed but had not acted in accordance with the MCA.

We looked at three 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms that had been in place. However, the registered manager had signed as a healthcare professional, but was not qualified to do this. It had been countersigned by the GP. There were no capacity assessments completed and no record of any consultation with the person or their families.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also looked at Deprivation Liberty Safeguards (DoLS) which aims to make sure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

The registered manager told us that they had been asked to submit four urgent DoLS applications following a visit by their local authority. The provider and the registered manager told us that they now needed to review all people in the home. However, the provider and registered manager told us that further training was needed to understand their role in protecting people at the home from their having rights and freedom restricted. People who lived at the home had not been supported by staff that knew when an application may need to be made. This meant that people had their liberty restricted without the correct process being followed.

This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff we spoke with told us they were aware of a person's right to choose or refuse care. One staff member said, "You should always ask them" and "They can of course say no". They told us they would refer any issues about people's choice to the registered manager or senior care staff on duty.

Relatives told us that staff met the needs of their family member and that staff did "Things the right way". For example understanding their family member's personal preferences. Care staff demonstrated that they had been able to understand people's needs and had responded accordingly. They told us about the courses they had completed and what this meant for people who lived in the home. For example, how to provide care for people who were unable to assist themselves.

Care staff felt supported in their role and had regular meetings with the registered manager to talk about their role and responsibilities. They also knew the provider and felt comfortable to approach them. One said, "I am very well supported by the management team here". The registered manager felt they kept their care staff knowledge up to date with the training provided. Care staff told us they had access to training when needed. For example, staff told us about the national vocational qualifications (NVQ) or Qualifications and Credit Framework (QCF) they had achieved.

The nursing staff told us although they were confident in medicine administration and providing care and treatment, there had been a lack of a clinical lead. They had not received any clinical support since September 2014. They also felt they needed additional training in the Mental Health Act and safeguarding which would support people better. The registered manager was considering further training and support once they had employed a clinical lead nurse.

Requires improvement

Is the service effective?

All people that we spoke with told us they enjoyed the food and were always offered a choice at meal times. We saw that people had been supported to choose from a menu that included pictures of the meals to assist them to make their choice.

We saw that people received drinks and meals throughout the day in line with their care plans. For example, those people who needed a soft diet or required support to eat their meal. Where people required their fluid intake to be monitored this information was recorded by staff.

We looked at four people's care records and saw that dietary needs had been assessed. The information about each person's food preferences had been recorded for staff to refer to. Staff told us about the food people liked, disliked and any specialised diets.

People had recently seen an optician and we saw staff discussing with one person about their new glasses. People were also able to see the GP and visits were arranged. There had been a period of time when a chiropodist had not been available for people to access. One relative said they had become concerned about their relative foot care, and had requested a chiropodist visit. On the day of our visit we saw a chiropodist had provided this care.

Other professionals had attended to support people with their care needs. For example, speech and language therapist. We also saw that where people required a regular blood test to monitor and maintain their condition, these had been arranged and completed as required.

People had not always received regular dental care. The registered manager told us they were in the process of speaking with local dentists to see what services were available. Two relatives felt that their family member would benefit from dental treatment.

Requires improvement

Is the service caring?

Our findings

We saw one person was ignored after making a request to go to their room once they had finished their meal. Care staff ignored the person and when asked one care staff told us, "Yes, [person] does go for a sleep after lunch. We will take him when lunch is finished". One staff member later acknowledged the request and said "I will help you in two minutes", but did not take any action. After fifteen minutes it was necessary for us to alert the registered manager because the person had become anxious and upset which had disturbed other people in the room. Therefore, staff had not consistently listened or responded in a manner that assured the person felt valued and supported.

We saw that people received foot care in a hall way of the home. The registered manager told us they would normally use the dining room. After discussion care was provided in people's room. We brought to the attention of the registered manager for further review. This meant that people's dignity and privacy had not always been considered in relation to their care and treatment.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw and were told people's dignity had not always been considered. One relative told us the registered manager had used their family member's room without their permission as a hairdressing salon. This had been done without their knowledge when they were in hospital and felt concerned this may happen again.

When we spoke to staff they told us what they did to support people in maintaining their dignity. One staff said, "If someone has a runny nose you wipe it discreetly, don't make a big scene". Staff also ensured that they always "closed doors and curtains" when providing personal care.

People told us the staff were caring and kind and knew them well. Relatives we spoke with felt that all staff were approachable, friendly and were good at providing care and support to their family member. One said, they, "Love [person] to bits" and another added that staff always said, "It's [person's] home". Relatives also told us they knew the staff well and how nice it was to be "On first name terms with staff" and "[person] always smile at staff".

We saw that staff spoke with people in a kind and caring way and people knew the staff well. We observed that people responded to staff by smiling, talking and holding hands with them. Staff told us they enjoyed chatting to people and "Got to know them well". Care plans we looked at showed people's likes, dislikes, life history and their daily routine.

All staff we spoke with told us they enjoyed working there and felt they demonstrated a caring approach to their role. One staff member said, "Showing (people) love and affection means more than anything". They told us they spent time getting to know people and this was part of their role as well as providing care. Staff were also aware that the provider was increasing the staffing levels of care staff to allow them more time to spend chatting with people and their relatives.

People were supported to express their views and be involved as much as possible in making decisions about their care and treatment. We saw that people were confident to approach staff for support or requests. Relatives told us that staff knew their family members well and respected their preferences. One relative told us their family member was supported to maintain their appearance and "[person] always took pride in their appearance" and they felt this was important to them as a family.

Staff were aware of people's everyday choices and were respectful when speaking with them. For example, people were able to request drinks. Staff ensured the person knew they were engaging with them and were patient with people's communication styles. Staff told us and we saw picture cards being used and staff respond to facial expression.

Requires improvement

Is the service responsive?

Our findings

Relatives we spoke with told us they had on occasion had cause to make a compliant. They were happy to approach the staff to raise issue or concerns. However, they had not received a formal response or acknowledgement of the actions taken or if any improvements had been made as a result. One relative felt "It's like it goes in the in tray and then something goes on top of it" and they had not received a response. We discussed this concern with the register manager. They told us they were not aware of the concerns that had been raised. One relative felt that there was a "Problem with communication" and some staff would "Shrug their shoulders". Two relatives told us they were unaware of any complaints procedure to follow or refer to.

Staff told us they were happy to support people and pass changes in people's care needs to nursing staff and felt they were listened to. However, the provider could not show that they had always used feedback from people and relatives to improve individual care and had not learnt from this feedback. For example, one person we spoke with preferred their bedroom door to be closed. Their relative told us they had "reported" this on many occasions. However, during the inspection we saw that each time the door was closed staff would then prop the door open. The registered manager was aware of this request and told us they had reminded staff.

Our observations showed that staff knew people well and had a good understanding of each person as an individual. Staff told us that people were treated as individuals and that information in people's care plans provided them with information about people's choices and individual needs.

Relatives felt "Care was focussed on individual needs", and felt they had been involved in planning the care of their family member. For example, one relative told us that as their family members needs had changed and the provider had ensured the right equipment had been provided, "Almost straight away". However, two relatives commented that they had not been asked or involved in any reviews about the care of their family member. The registered manager agreed that further involvement in the review of people's care would benefit people in meeting their individual care needs.

We saw some people were helped to be involved in things they liked to do during the day and had been provided with objects of interest that they recognised. For example, handbags and other personal items. Staff knew about people's individual hobbies and interests. However, this had not been used to offer activities for some people would enjoy. For example, we saw that people were offered magazines by staff, but without assistance people could not read them. We saw staff were available in lounges and were talking with some people. However, some people had limited verbal communication and had not been as involved. We saw this was a missed opportunity for staff to support people with any hobbies or interest they may have or provide other ways to include people. The provider and registered manager told us that improvements were needed to ensure people received individual interests.

The home employed an 'activities coordinator' to consider and involve people in individual activities. For example, playing dominoes and jigsaws which we saw people enjoyed. Due to the activity coordinator's limited time, they were unable to engage with all of the people at Legrand. The provider told us they are looking to recruit a further member of staff to concentrate on activities, both group and on an individual basis. The provider had a mini bus available but this was not currently being used to support people to go out on trips or attend events.

The four care plans we looked at contained information that centred on the person and the care and support required to keep them healthy. The wishes of people, their personal history, the opinions of relatives and other health professionals had been recorded. The care plans had been reviewed and updated regularly.

Inadequate

Is the service well-led?

Our findings

Relatives felt that whilst there was a good level of care provided the home could improve on "Paper work and written policies and procedures" and felt some improvements in the environment of the home were needed. The registered manager had not kept a record of all complaints or concerns raised. Therefore, no review of complaints and concerns had been completed to look at lessons learnt or make improvements when required.

The provider did not have systems in place to ensure the effective running of the service. They had not identified short falls we had found during the inspection. The registered manager confirmed that no audits had been completed which the provider had expected. For example, the provider was not aware that the medicines had not been audited. The provider had not assured themselves or supported the registered manager to have an effective system to check and improve the services offered.

We also found that other areas of maintenance and checks had not been completed. For example, we saw that yearly testing of portable appliances (PAT) had not been completed since October 2013. We found areas of concern relating to fire protection at the home and the provider was not able to show the outcome of any fire safety checks. We have shared information with other agencies as a result of our findings.

The registered manager was not a registered nurse and there had been no clinical lead since September 2014. Nursing staff told us they had not had help or support in their professional development or clinical discussions.

The registered manager and staff were not aware of their responsibilities in relation to the Mental Capacity Act. The manager and staff were not aware of current best practice in terms of people's capacity to make decisions. The register manager's skills and knowledge needed to be developed to enable them to drive improvements. This would support them to deliver high quality care to people through care staff that had appropriate guidance.

The provider had recently been visited by three other external agencies in response to two safeguarding incidents at the home. They had received support from these agencies to enable them to evaluate and reflect on where improvements were required. The provider and registered manager told us they were developing plans to improve the service. However, a plan of action had not been completed that prioritised improvements with dates for completion. They could not demonstrate how the service used best practice guidance to ensure that people's needs were met effectively. This needs to be in place to make improvements and identify an on going monitoring system to sustain any improvements made.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff felt involved with the registered manager and that the provider was "Brilliant". Whilst there were no regularly planned meetings or forums for feedback, the provider had held a recent relatives meeting. Although the minutes were not available we saw four letters from relatives. These were positive in support of the care and treatment that their family had received. They spoke of their confidence in the provider and how "Willing and approachable" the registered manager had been if anything needed discussion.

Care staff felt management was visible and felt supported to provide a good service. They were committed to supporting the provider to improve the service. Care staff felt able to offer suggestions for improvements. They told us, "We are a team" and "We are united in doing our best to get better".

Care staff told us they would whistle blow if necessary and felt they were listened to and respected by the management team. They said "Management are so supportive" and "We can go to the manager anytime for anything". Management and staff told us the visions and values of the service were "To create and maintain a caring homely environment".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met: People had not been supported with effective decision making and management of risk to their health, welfare and safety. Regulation 17 (1)(2)(a)(b)(c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met: People who use services were not protected against the risks associated with unlawful restraint. Regulation 13(5).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met: People did not always have their dignity and privacy protected by staff. Regulation 10.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met: People's consent to care and treatment had not always been suitably assessed or obtained. Regulation 11.**