Imalgo Limited

Lower Farm Care Home with Nursing

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

Overall summary

This inspection was undertaken by two inspectors on 5 and 6 October 2015 and was unannounced.

Lower Farm Care Home with Nursing provides accommodation and care for a maximum of 46 people with varying healthcare and support needs. At the time of our inspection there were 39 people living in the home.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting

Summary of findings

the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager had returned to their post after being away for several months.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The deputy manager and nurses were knowledgeable about when a request for a DoLS would be required following changes in case law. Not all staff had received training regarding this subject and their understanding was variable. The registered manager had a good understanding and had appropriately made applications for DoLS.

Appropriate recruitment processes were in place, although sufficient improvements to the staffing situation had not taken place. People had to wait too long for their call bells to be answered and to receive assistance with their meals and personal care. The use of agency staff remained high as there were ongoing difficulties in recruiting nurses.

The majority of staff knew the needs of individual people well and how to meet their needs. People felt that the staff were kind and caring. Relatives were also made to feel welcome by the staff. Staff did not have time to support people with their hobbies and interests. Referrals were made appropriately to healthcare professionals as people required them. People's medicines were managed safely.

The standard of record keeping needed to improve to ensure that staff had clear, consistent guidance about how to meet people's needs.

The processes for assessing the quality of the care provided had improved but further improvements were needed. There was a lack of clear action taking place after issues were identified during audits.

This inspection identified two breaches of the Health and Social Care Act 2008, Regulated Activities (2014)

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

Risk assessments did not always consider all risks and provide clear guidance to staff about reducing risks.

The provision of staffing was not sufficient to enable staff to meet people's needs in a timely way.

Medicines were managed safely.

Requires improvement

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

Staff did not all have a good understanding of the principles of the Mental Capacity Act (2005) and the implications of this for people who lacked capacity to make decisions.

Referrals were made appropriately to healthcare professionals.

Staff received training in subjects relevant to their role but improvements were needed to ensure this was up to date for all staff.

Requires improvement

Is the service caring?
The service was not consistently caring

The delays in assisting some people with personal care compromised their dignity.

Staff were kind and caring in their relationships with people.

People had started to be involved in the planning and review of their care.

Good

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

People's individual needs were not met in a timely way.

Staff did not have time to spend with people on an individual basis or to support them with their hobbies and interests.

Requires improvement

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

Improvements had been made to the system in place for assessing the quality of the service provided but further improvements were needed.

The high use of agency staff meant that it was difficult for the staff team to always work in a cohesive way.

Requires improvement

Summary of findings

The manager was supportive to the staff.	

Lower Farm Care Home with Nursing

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.

The inspection took place on 5 and 6 October 2015 and was unannounced. The inspection team consisted of two inspectors.

Before our inspection we looked at all the information we had available about the home. This included the report from our last inspection and notifications made to us. Notifications are changes, events or incidents that providers must tell us about by law. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As some people were not able to tell us in detail about their care we spent some time observing care being provided in communal areas. We spoke to eight people who lived at the home and five relatives. In addition, we spoke to 10 care staff, including night staff, the manager and a visiting healthcare professional. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We completed general observations and reviewed records. These included care records, staff training records, medication records and records relating to audit and quality monitoring processes.

Requires improvement

Is the service safe?

Our findings

At our last inspection in March 2015 we identified a breach of regulation regarding the provision of nurses. The provider wrote to us to tell us that they had addressed this issue immediately after our inspection. During this inspection (October 2015) we saw that some improvements had been made but that further improvements were needed.

We noted that the registered manager was back in her post after a period of time away from the home. This meant that the deputy manager was able to resume the majority of her work as one of the nurses on duty. The registered manager told us that they were still having difficulties in recruiting permanent nurses and were using agency nurses. She said that they endeavoured to use nurses who had worked there before and so knew the people who lived there. However, this was not always possible.

The registered manager said that people's dependency levels were assessed at the time that they moved into the home and that this was reviewed on a three monthly basis. However, no formal dependency tool was used to calculate the number of nurses and care staff that were needed to meet people's needs. There was a difference of opinion between the registered manager and the provider's representative in regard to who was responsible for determining staffing levels. Each thought it was the other's responsibility.

In discussions with the staff and through looking at the staffing rotas we could see that for the majority of the time the staffing levels as determined by the registered manager were in place. However, there were a few times when there was one nurse, or one care staff, short of the provider's specified levels. Our discussions with people indicated that even when the required staff were on duty there were times when they had to wait for long periods of time for assistance. Our observations showed that, at times, the deployment of staff was quite disorganised without clear direction from the nurse or senior carer to ensure that staff worked in the most effective way.

The nurses had started to review and update people's risk assessments and we could see that these had improved since our last inspection. However, there were some areas where further improvements were needed. For example, the second lift at the home was still not working and no risk assessment had been carried out to provide guidance to staff about how to support people if the other lift broke down. Risk assessments had not been carried out for all pieces of equipment in use or the fact that one of the bathrooms was used to store equipment. Staff confirmed that they had taken part in regular fire training and were aware of the action to take in the event of fire. However, the procedure was not displayed for the information of visitors to the home.

Staff we spoke with were aware of the risks associated with each person's individual needs and the plans that were in place to manage these risks. However, we saw that in some people's care plans clearer guidance was needed to ensure that action was consistently taken to protect people from harm. For example, for people living with diabetes there was not always a clear plan in place to inform staff what action they should take if the person's blood sugar level was outside the desired range.

We looked at the arrangements in place for the storage and administration of medicines. Medicines were stored securely and only the people who administered medicines had access to them. The majority of records were kept appropriately but the registered manager's audit had identified that the receipt of medicines arriving had not always been recorded. In addition, there were some times when people's medicines had been omitted but the reason for this was not recorded on the medication administration record.

From discussions with staff and a look at records we could see that appropriate recruitment processes were followed. This included taking up references and criminal records check to ensure that staff were not barred from working with people.

When we spoke with people about whether they felt safe living at the home they told us they did feel safe and that their main concern was that, at times, they had to wait for staff to assist them. One person said, "I feel safe here, particularly when staff move me in the hoist". Another said, "I feel this is my home and I do feel safe here".

Records showed that staff received training regarding safeguarding people. In our discussions with staff they were able to show that they were aware of the different types of

Requires improvement

Is the service safe?

abuse and the action that they needed to take if they thought this had taken place. They were confident that appropriate action would be taken if they reported this to the registered manager.

Requires improvement

Is the service effective?

Our findings

At our last inspection in March 2015 we identified a breach of regulation regarding the assessment of people's capacity to make their own decisions. The provider wrote to us to tell us about the action they were going to take regarding this breach. During this inspection (October 2015) we saw that improvements had been made.

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

Not all staff had received training about the MCA and DoLS. Some had already undertaken this training and others were booked to attend it over the coming months. Staff understanding of how this was put into practice was variable but all understood the importance of assuming people had capacity to make their own decisions. The registered manager and deputy manager had a good understanding of this issue and had appropriately made applications to the local authority regarding DoLS for four people.

One person told us, "The staff respect my decisions when I say no" and another said, "There are very caring staff and a flexible routine, I can do what I want". Records showed that, where appropriate, people had advanced wishes in their care plans regarding their future care. Improvements were needed to ensure that the records were updated to clearly show that where decisions had been made for people that this had been done in their best interests and with the involvement of the appropriate people.

The provision of training for nurses and care staff had improved since our last inspection. Nurses had received training regarding specific nursing interventions, such as the use of syringe drivers. It was not always clear in the records as to the training that agency nurses had received or their competency levels. Staff confirmed that the provision of training had improved over the last few months and that they appreciated this improvement as it helped them to carry out their roles more effectively. Night staff told us that they were also enabled to attend the same training as the day staff did.

Staff told us that they felt well supported by the registered manager and deputy manager. They said that they had, very recently, started to have formal supervision sessions at which they could discuss their work and any development needs. One new member of staff told us that they had been appointed a mentor to provide additional support to them.

We received positive views about the meals provided. One person told us, "The food has got better and is good now. We are asked what we would like to eat and we can have something else if we do not like the choice". A visitor told us that vegetarian meals were provided for their relative. However, whilst people were provided with choices, these were offered several hours before the main meal and people were not offered a choice at the time of the meal, nor reminded of what they had ordered. Meals were delivered to people already plated up and the majority of staff did not check with the person that they were still happy with their choice of meal. One person was not asked if they wanted an alternative when they said that they did not want what was offered to them. We also noted that people were not asked if they wanted to have second helpings when they had finished.

We observed the lunch time meal and this was quite chaotic with people having to wait up to half an hour to be assisted with their meal. The meals were already plated up and were not reheated when staff did arrive to support the person. The provision of staff at the mealtime was not well organised. At one point one of the people who lived at the home was trying to assist another person with their meal as there were no staff available to do so. We did see that people were provided with drinks and snacks during the day to support them to eat and drink enough.

We did also observe some good practice with staff taking their time to support people to eat their meals in an unhurried and patient way. They chatted to the person, explaining what they were doing and encouraging them to eat their meal. They let the person have enough time to eat at their own pace and to respond when they were encouraging them.

Requires improvement

Is the service effective?

People's care plans included assessments of their nutritional needs which had been regularly updated. However, some of the records needed additional clarity to ensure that they provided clear guidance to staff about how to ensure people ate and drank enough.

People told us that the staff contacted the GP and other health professionals when they needed to see them. A visiting healthcare professional told us that the staff made appropriate referrals and that they followed any recommendations and guidance that they gave them. They said that the staff always had a good understanding of people's individual needs when they came to see anyone.

Good

Is the service caring?

Our findings

The length of time that people sometimes had to wait for assistance to use the toilet or other aspects of personal care meant that, on occasions, their dignity was compromised. One person told us, "You learn to pull the call bell before you are desperate because the staff are often busy".

Although staff were respectful when speaking to people who lived at the home we heard them using disrespectful language when talking about people to each other. For example, they referred to people by their room number rather than their name, they also referred to people who required assistance with meals as, "Feeders".

People spoke highly of the staff and told us that they were kind and friendly. One person told us, "I would recommend this home if someone asked me, it is a good place with lovely staff". Another person said, "The staff are good and will do anything you want". We observed staff take their time when supporting people, they spoke kindly and were patient with people, encouraging them to take their time. Relatives told us that the staff were kind and caring towards them as well as the person living at the home. One told us, "I am made to feel very welcome when I visit and I find the staff very friendly".

We received mixed views from people about whether they were involved in the planning of their care. Some people knew that they had a care plan and told us about the staff talking to them about this whilst other people could not remember whether they had been involved or not. This was also true of relatives with one telling us that they were involved and another saying that they had not been asked about their relatives care needs. The care plans that we saw included the views of the person themselves as well as their relatives where this was appropriate.

Requires improvement

Is the service responsive?

Our findings

At our last inspection in March 2015 we identified a breach of regulation regarding the provision of person centred care that met people's individual needs. The provider wrote to us and told us that they would be compliant with this regulation by July 2015. During this inspection (October 2015) we saw that some improvements had been made but that the provider remains in breach of this regulation.

People who lived at the home, relatives and staff all told us that there were often times when the staff were too busy to provide care to people at the time that they needed it. Our observations on the two days of our visit confirmed this. On one day people were still being assisted to get up at 1pm and the staff said that this was not due to people's preferences but because they had been too busy to assist them earlier in the day. One person told us, "I have no complaints except I do have to wait a long time sometimes when I ring the call bell. The staff are so busy". Another told us, "They seem short of staff sometimes and we all have to wait for help".

A relative told us, "The call bells are often ringing for a long time before they are answered. There does not always seem to be enough staff and my relative often has to wait for over ten minutes for their call bell to be answered". Another told us that the high use of agency staff meant that staff did not always know how to support their relative and had to find another member of staff to assist them, which added to delays in their relative receiving assistance.

Staff told us that they were not always able to support people's choices about what times they got up and went to bed due to the staffing situation. They said that during the afternoon people were often assisted to bed very early, for example from 4pm, as there were not enough staff to support people to go to bed throughout the evening.

The nurses had been working on reviewing the care plans since our last inspection and at the time of this visit they were still not completed. The staff told us that there were different places to record information about what care had been provided to people and they were not clear as to where the information should be recorded. The high use of agency staff means that the lack of clarity within people's care plans means that there is a higher risk that people will not receive the care they need in a consistent way.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People also told us about the positive aspects of living at the home. One person told us, "Staff do not rush me and let me take my time". Another told us, "This is a good home and I am glad I moved here". Staff told us that they tried hard to meet people's individual needs and preferences with regard to how and when they wished to receive care. They confirmed that the care plans were in the process of being reviewed by the nurses. Staff we spoke with had a good understanding of individual people's needs.

The home employed an activities co-ordinator who provided activities that took place within the home, such as quizzes, exercise sessions and craft sessions. However, when this person was not on duty the staff did not have time to support people to take part in individual hobbies or interests. One person told us, "The staff are kind and friendly but do not always have time for a chat, just a cheery word". Another told us, "Some days there is nothing to do, the staff are too busy and the activities lady is not here every day".

Some people's care records included detailed information about their past history and any hobbies and interests they used to have whilst others contained little of this information. This meant that, particularly for those people living with dementia, staff may not be able to have a meaningful conversation with them about their lives prior to moving to the home.

One of the relatives we spoke with confirmed that they had raised some concerns with the manager and that these had been listened to and action taken to address them. People told us that they would tell the nurse if they were not happy about something. However, people also said that no improvements had been made to the staffing situation and that they still had to wait too long when they rang their call bell.

Requires improvement

Is the service well-led?

Our findings

At our last inspection in March 2015 we identified a breach of regulation regarding the quality assurance processes in place. The provider wrote to us and told us about the action that they were going to take and that they would be compliant with this regulation by July 2015. During this inspection (October 2015) we saw that some improvements had been made but that the provider remains in breach of this regulation.

The registered manager told us about the audits that she carried out on a range of areas of the service provided. This included the care plans, medication, infection control and risk assessments. The records confirmed that audits were taking place but they lacked detail about what action had been taken as a result and whether this had been effective in dealing with the issue. We spoke to the registered manager about their audit of complaints and accidents. They said that they did review these and took action where needed but that they did not keep any records of this.

Despite an action plan stating that improvements would be made to the quality of the care provided we found during this inspection that these had not all been effective. The issue regarding the staffing situation had not been effectively dealt with. The registered manager was not clear whether the problem was due to the numbers of staff or the deployment and organisation of staff on duty for each shift. The ability of the staff team to provide person centred care remained compromised by the staffing situation.

The care plans had not been fully reviewed and updated which meant that there was a risk that people would not consistently receive care that met their needs.

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

The people who lived at the home had recently been asked for their views about the service but the results of these had not been received at the time of our inspection. The registered manager said that staff and visitors would be surveyed for their views in the coming months.

The staff told us that they felt well supported by the manager and that they had an 'open door' policy which meant that they were able to speak to them when they wanted to. In general, the view of the staff who spoke with us was that the staff team worked well together. However, we observed staff arguing about why tasks had not been completed and blaming each other for this. The staff we spoke with all told us that they tried to provide the best care they could but other than that they did not have a clear idea about the culture and values of the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People did not consistently receive individualised care.** Regulation 9 (1) (b), (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Quality monitoring systems did not adequately assess and manage risks to people and take into account the way people's records were maintained.** Regulation 17 (2) (a)