HC-One Limited

Pytchley Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This responsive focussed inspection took place on 25 September 2018 and was unannounced. This inspection was carried out following concerns received from relatives and commissioners. This inspection focussed on the safe and well led domains to establish whether people were receiving safe care.

This was the sixth inspection carried out at Pytchley Court since February 2016. The provider has failed to maintain compliance with the regulations; they have repeatedly breached two regulations relating to safe care and treatment and good governance.

Our last comprehensive inspection on 18 April 2018 rated the service as Requires Improvement in all domains. The provider was in breach of three regulations relating to medicines management and staff not referring to health professionals in a timely manner. The provider was required to submit action plans demonstrating how they were to achieve compliance with the regulations. We were not satisfied the providers action plans as they did not adequately demonstrate how they would ensure people would be referred to health professionals in a timely manner.

There had been a period of one year without a registered manager, in that time the home had four different managers. The new registered manager had been in post since June 2018, they registered with CQC in August 2018. 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 living at Pytchely Court Nursing Home received either Nursing or Residential Care. We found concerns relating to the clinical care of people receiving Nursing Care.

People were at risk of not receiving prompt medical care as there were a combination of factors that affected this. The registered manager was new to the service and most of the nursing staff were agency; they did not know people well and did not recognise when people were unwell. There was no clinical lead to oversee the nursing care. When people became unwell there were no systems in place to compare their condition with their 'healthy' condition as no baseline observations had been recorded. When people did show signs of being unwell there was no system in place to take people's clinical observations and assess these for referral for medical care. These factors led to delays in receiving medical care; some people were admitted to hospital for emergency care.

During the inspection we found serious concerns relating to recognising when people were unwell and referring people for medical care. We raised safeguarding alerts relating to the care and welfare of 11 people.

People did not have accurate or up to date risk assessments. People with long term conditions did not have risk assessments, care plans or protocols to mitigate their risks.

People did not always receive their medicines safely. People receiving medicines in skin patches were at risk of not receiving their medicines as prescribed as there was no reliable system in place to demonstrate people had their patches applied and removed. People who received their medicines covertly had safeguards in place.

The provider had not ensured there were sufficient processes in place to assess, monitor and improve the quality of the service to maintain the health, safety and welfare of service users. The provider failed to have the systems and processes in place to identify the impact of not having clinical management; people experienced delays in receiving medical attention.

The provider placed resources into Pytchley Court Nursing Home to support the registered manager in setting up some of the governance and corporate processes. However, the evidence from the inspection demonstrated that the resources provided did not adequately address the issues of recognising when service users became unwell, resulting in delays in service users receiving medical treatment.

At this inspection we found that Pytchley Court Nursing Home were in breach of four regulations relating to safe care and treatment, governance, safeguarding and notifications. The actions we have taken are reported at the end of the full report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Further information is in the detailed findings below.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pytchley Court Nursing Home on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider failed to ensure clinical management; people experienced delays in medical care as staff did not recognise they were unwell.

People were not always assessed for their risks, or have plans to mitigate risks.

There were not enough skilled staff deployed to meet people's needs.

The provider did not have systems in place to recognise or report abuse.

People did not always receive their medicines safely.

The provider followed safe recruitment procedures.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have suitable systems in place to monitor, assess and make improvements to the health, safety, welfare and quality of care of people using the service.

The provider failed to notify CQC of safeguarding concerns, as required by law.

Pytchley Court 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 checked 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 responsive focussed inspection took place on 25 September 2018 by two inspectors and a specialist nursing advisor. This inspection was brought forward due to concerns raised by relatives and commissioners.

This was the sixth inspection since February 2016, the last comprehensive inspection was on 18 April 2018. We checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with two people using the service. We spoke with the registered manager, the provider's quality area manager and two nurses. We also contacted the local authority that commissioned people's care who told us they had serious ongoing concerns.

We looked at the care records for 10 people who used the service including their daily records and medicines charts. We also examined other records relating to the management and running of the service. These included staff recruitment files, training records, supervisions and appraisals. We looked at the staff rotas, incidents and accident reports and quality monitoring information.

Inadequate

Is the service safe?

Our findings

People who were living at Pytchley Court Nursing Home and receiving Nursing Care were not receiving safe care.

There was no clinical supervision of nursing staff. Staff failed to recognise when people were unwell and required medical assessment. Nursing staff failed to take appropriate clinical observations or always refer people for medical assistance in a timely way. From our findings at this inspection, we raised six safeguarding alerts relating to 11 people. These alerts are subject to an on-going safeguarding investigation. At the inspection we brought all of our concerns to the attention of the registered manager and the provider who took some immediate action to ensure people's safety.

People were at risk of not being referred to medical care in a timely way. Staff had recorded in daily notes that seven people showed signs of ill health. The signs included changes in people's behaviour, diarrhoea, vomiting, frequent falls, 'funny turns', reduced urine output, sleepiness, reduced communication, not eating or drinking and weight loss. Care staff reported these signs to the nursing staff. Nursing staff failed to take people's full set of clinical observations to assess whether they required medical treatment. Clinical observations are the measurements of people's temperature, respirations, pulse, blood pressure and oxygen levels; all of these observations are required to accurately assess people's clinical status. People's records showed people continued to be unwell, and nursing staff eventually sought medical advice when people were seriously ill. This was a concern as a delay in seeking medical help can result in people not receiving treatment for infections; which carries a risk of developing sepsis. Sepsis is a serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death. There had been three people admitted to hospital with sepsis in the last month.

People were at risk of becoming unwell and this not being identified. There was no system in place to accurately assess people's physical health. People who had been admitted to the home for commissioned nursing care had not had their baseline clinical observations taken. This is required to establish people's normal clinical observations and used to compare with observations taken when people show symptoms of being unwell. With these comparisons, nursing staff can assess whether people require medical treatment. Some people had long term medical conditions which required monitoring; for example, three people had heart conditions.

People were at risk of not receiving prompt medical care for injuries from falls. There was no reliable system in place to record people's clinical or behavioural observations for a planned period of time after a fall. People continued to be at risk after a fall as injuries may not be immediately apparent and continued observations over a time period would help staff to identify if a person has incurred an injury after a fall. For example, one person had frequent falls. Although staff took some observations they did not take a complete set of clinical observations, or take these observations regularly or for a set time. Where staff had recorded the persons observations, their blood pressure and pulse indicated they could be bleeding or in shock. We were concerned as staff stopped taking their blood pressure and took two hours to call the GP. Staff later recorded the person had a low oxygen level but staff did not call for medical assessment. This person

continues to have frequent falls with limited clinical and behavioural observations; they continue to be at risk of undetected injury.

People did not have all their risks assessed or care plans to mitigate these risks. There was not enough information available to staff to ensure they knew how to meet people's needs. For example, three people living with diabetes did not have risk assessments or care plans. These are required to give instruction to staff about the signs and symptoms of high or low blood sugars, or what action to take. There was no information about what would be an acceptable blood sugar level for each person, or when to seek medical advice. Although staff recorded people's blood sugars every Sunday, these records did not state when the blood sugar level was taken, for example before or after a meal. One person's records showed they regularly had blood sugar levels which were over the normal acceptable limits, no action had been taken to refer them to the diabetes team for assessment of their condition. Staff did not have information about people's on-going care, such as diabetic foot care, diabetic retinal screening, consultant reviews or diabetic nurse reviews. People living with diabetes were at risk of not receiving the appropriate care for their diabetes as staff did not have all the relevant risk assessments and care plans to refer to.

People's risk assessments were not always accurate. People had been assessed for their risks of acquiring pressure ulcers, however, staff had not used up to date information about their weight or accurately added all the scores together to reflect people's risks. This meant that people had been assessed as at less risk than they were. For example, one person had been assessed as at medium risk of acquiring a pressure ulcer, whereas their actual risk was high; this would require staff to assist them to move more regularly to relieve their pressure areas. On the day of inspection, staff recorded on handover this person had acquired skin problems associated with poor pressure area care.

People's care plans were not updated when their needs changed. For example, one person had been assessed by a speech and language therapist (SALT) as at increased risk of choking. They prescribed a pureed diet with thickened fluids due to their swallowing difficulties. The person had a risk assessment and care plan for the risk of choking which had not been updated to reflect they no longer had a soft diet, and required a pureed diet. This person was at risk of not receiving a pureed meal or thickened fluids and was at risk of choking. We brought this to the attention of the registered manager who ensured all staff were aware the person needed a puree diet and updated their care plan.

People did not always receive their prescribed care. One person living with dementia had fractured their arm when they fell in the home. On return from hospital they had been prescribed an exercise plan by the physiotherapist. Staff had not created a plan of care or recorded anywhere that the person had been supported to carry out their physiotherapy. This person was at risk of not regaining the full use of their arm as staff had not supported them to carry out their physiotherapy exercises.
People did not always have suitable wound management. For example, two people had not had their wounds redressed at the prescribed frequency, increasing their risk of infection. Another person had been identified as having a wound three days before our inspection, but did not have a wound care plan and no action had been taken to assess or dress the wound.

People had not been referred to health professionals when they had lost weight and systems were not in place to ensure they received a fortified diet. Four people had lost weight in the last few months. Their risk assessments recommended fortified foods and drinks; however, there was no system in place to ensure people received these. People had not been referred to the GP or to a dietitian for their recent loss of weight.

People were at risk of dehydration as there was no reliable system in place to identify if people had drunk

enough to maintain their health and well-being. Although nursing staff calculated how much drink each person required every day to stay hydrated, nursing staff did not accurately calculate how much people were drinking or compare this with their output to ensure they were medically stable. Where people had not met their daily target for drinks, nursing staff did not take any action. There is no reliable system in place to ensure people are getting enough to drink to remain hydrated.

People were at risk of not receiving safe care as there were not enough permanent staff who understood people's needs. There were three permanently employed nurses, however, one of these had handed in their notice and was off sick. There were agency staff employed who relied on the risk assessments and care plans which were not always complete or accurate. Staff told us the rotas were not a true reflection of staff on duty. They told us staff would often call in sick, but the rotas did not change to reflect this. On the day of inspection there were two nurses, one of whom was an agency nurse. People were not receiving their care in a timely way, such as having their meals later than planned. For example, we observed one person received their breakfast close to lunch time, which meant they were unable to eat their lunch and missed a meal; this person had lost 11% of their body weight in six weeks. People were at risk of falls as there were not enough staff deployed to supervise people who were at high risk of falls to communal areas. People did not receive their planned care as there were not enough regular staff that knew people's needs to ensure people did get their care even when the care plans were not updated.

People could not be assured they would receive all their medicines safely. Staff did not reliably record when two people received their medicines via a patch. There was a risk that previous patches had not been removed, or staff rotated the sites they applied the patches. There was a risk that people could receive too much or not enough of these medicines as there was no reliable system in place to manage when and where the patches were applied and removed. There had been a recent medical alert regarding the risks to people relating to the management of medicines in patches; the provider had not implemented any systems to mitigate this known risk.

Two people were receiving their medicines covertly. Covert medicines are medicines which are given to people without their knowledge or consent, usually in food. During the inspection, nursing staff could not provide the information to confirm that all the safeguards were in place. Following the inspection the provider produced the documentation that showed there had been an assessment of their mental capacity to make decisions about their medicines and a record of a best interest meeting by a multi-disciplinary team to make decisions on their behalf. People receiving their medicines covertly had the required instructions from a pharmacist to state how each medicine could be given in food or drink safely. Staff also crushed another person's medicines and put these in water; however, they did not have pharmacy instructions to state this was safe.

The provider failed to assess all the risks to health and safety of service users, do all that was practicable to mitigate such risks. The provider failed to ensure staff had the competence and skills to recognise unwell adults and provide medicines safely. This constitutes a breach of regulation 12 (1) (2) (a) (b) (c) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and treatment.

People could not always be assured that all concerns would be reported to the relevant authorities. For example, staff had recorded in the daily notes that two people had unexplained bruising; no action had been taken and these incidents had not been reported to the local safeguarding team. Most staff had received safeguarding training, but due to the amount of agency staff in use there was no reliable system in place to ensure all processes were followed and all incidents reported. Staff had detailed information about the safeguarding process in their staff room, however, there was no simple guide or readily available information for staff to follow.

The provider failed to have systems in place to recognise or report safeguarding concerns. This constitutes a breach of regulation 13 (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

The registered manager followed safe recruitment and selection processes. Staff recruitment files contained all relevant information to demonstrate that staff had the appropriate checks in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

There were regular fire drills and checks to fire systems. People had individual personal evacuation plans in the event of fire which were readily available to staff. Staff had access to the emergency procedure which included where all the main stop cocks, gas valves were located in the building and a contingency plan was in place.

Inadequate

Is the service well-led?

Our findings

We have carried out five inspections at Pytchley Court Nursing Homes since February 2016, we rated the service Requires Improvement in four out of the five inspections. During these inspections the provider has repeatedly been in breach of regulations 12, safe care and treatment, Regulation 17, Good governance.

During our last inspection on 26 April 2018 the provider had been in breach of Regulation 12 as they had not ensured people were referred to health professionals in a timely way and had not managed people's medicines safely. The provider was in breach of Regulation 17 as there was significant instability with the management team and a lack of clinical oversight. The provider was required to provide an action plan. However, the action plan did not satisfactorily demonstrate how the provider was going to be complaint with the breached regulations.

A previous inspection on 6 July 2017 had also been brought forward due to concerns about people's care. The service was rated as requires improvement. The service was in breach of four regulations. Regulation 11 Need for consent. Regulation 12 Safe care and treatment. Regulation 16 Receiving and acting on complaints. Regulation 17 Good governance.

The inspection history demonstrates the provider has been unable to maintain compliance with the regulations and there continues to be concerns raised about the care people receive.

Before this inspection we had been advised by commissioners about concerns with the lack of clinical oversight in the home. We asked the provider to demonstrate how staff recognised when people were unwell and what actions they took. The provider's report showed staff were undergoing training to recognise an unwell adult and implementing a recognised system of recording and evaluating clinical observations, two weeks before the inspection. However, during this inspection we found the provider failed to ensure staff had the competence and skills to recognise unwell adults.

There was a registered manager who registered with the Care Quality Commission on 22 August 2018. 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 the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There had been a period of one year where there had not been a registered manager; where the provider had employed four managers these had not stayed. Although the provider had supported the home by placing area managers and at times managers from other homes to oversee the home, this had not included continuous clinical oversight of the home. The previous clinical lead had left in July 2018; the provider did not ensure that a clinical manager had been appointed to the home to oversee the nursing assessment and care of people receiving nursing care.

The provider had not recognised how people receiving nursing care had been put at risk. The provider had

not assessed the risk of not providing a clinical lead in August and September 2018. The provider had not mitigated the risk of using mainly agency nursing staff; they did not always have regular agency staff who knew people well, or involved them in the implementation of systems to protect people, such as recognising an unwell adult. A clinical lead had been recruited, they were due to commence employment in the home from 8 October 2018, but no clinical oversight had been provided whilst they waited for the clinical lead to start employment. There were only two permanent nurses available for duty in the home, all other nurses were employed from an agency. Nurses did not have the clinical systems in place to assess and monitor people's health and well-being, nor the clinical guidance they required. Staff were not using the provider's policies and procedures to assess and monitor people's health regularly, when they were ill or when they had incurred a fall.

There was not enough clinical management to oversee the safe care of people receiving nursing care with long term conditions such as diabetes and heart conditions. Staff did not have systems to monitor people's blood pressure, pulse, breathing or blood sugars for indicators they were out of normal or acceptable range. People were at risk of not receiving care that met their needs, as staff did not have systems in place to know or recognise when people were unwell. People were at risk or acquiring infections as there were no systems in place to regularly assess and monitor people's wounds or urinary catheters.

The provider had not implemented a recognised system of recording and evaluating clinical observations. Although the registered manager had discussed using a tool to recognise when people were unwell with nursing staff, systems had not been implemented to record and identify when people were unwell. None of the staff used the tool, and there were no observations charts available for staff to record people's observations. During the inspection one person became unwell, staff took their clinical observations but could not relate these to the tool to assess how unwell the person was. The provider failed to ensure there were sufficient systems in place or staff competence to recognise when people required clinical observations and when to refer people for medical care.

The provider failed to have suitable systems in place to monitor and assess the quality of the clinical care people received. The audits that had taken place had not identified that people did not have care plans for all their needs, such as diabetes, complex behaviours, wounds, falls and long-term conditions. There was no audit to assess the content of daily notes and handover notes where staff had recorded indicators of ill-health or people not reaching their daily fluid target. There was no system to check the actions taken were appropriate for each person showing signs of ill-health. Failure to audit these had led to the provider not being aware of the shortfalls in clinical care.

The provider failed to ensure people receiving nursing and residential care had systems in place that protected them from the risks associated with medicines, fire safety and poor governance.

The provider failed to identify that medicines were not always managed safely. This meant two people were receiving their medicines covertly without the safeguards in place. People were not reliably receiving their medicines prescribed in patches. The medicines audits had failed to identify these issues, people remained at risk of not receiving their medicines safely.

The home had a fire risk assessment which had recommendations; the registered manager told us these had been addressed; however, there was no evidence the actions had been completed. There was no system in place to monitor the actions required in the action plan.

The registered manager carried out audits in areas such as training. However, they described how they were in a cycle of auditing without addressing the issues identified in the audits, so these issues were not being

resolved. The provider had not ensured there were sufficient resources in place to manage the findings of the audits.

The service had frequent visits from the quality monitoring teams of the local authority and local clinical commissioning group (CCG) who commissioned care at Pytchley Court Nursing Home. Their reports and feedback showed there were on-going issues with the clinical care at the service. The commissioners had placed a suspension on the service, which meant they were not placing any new service users in the home.

The provider failed to have systems and processes in place to assess, monitor and mitigate the risks to people's health, safety and welfare. This constitutes a breach of regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

The registered manager had not ensured that all safeguarding alerts had been reported to the Care Quality Commission. Daily records and body maps show care staff had reported two people had unexplained bruising, these had not been reported to us.

The failure to notify the commission of safeguarding concerns as required by law is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the commission of safeguarding concerns as required by law. Regulation 18 (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to have systems in place to recognise or report suspected or potential abuse. Regulation 13 (2) (3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to assess all the risks to health and safety of service users, do all that was practicable to mitigate such risks. The provider failed to ensure staff had the competence and skills to recognise unwell adults and provide medicines safely. Regulation 12 (1) (2) (a) (b) (c) (g) (h)

The enforcement action we took:

We imposed conditions on the registration:
To provide regular audits and action plans to demonstrate compliance with clinical oversight.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to have systems and processes in place to assess, monitor and mitigate the risks to people's health, safety and welfare. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

We imposed conditions on the registration:
To provide regular audits and action plans to demonstrate compliance with clinical oversight.