Astley Care Homes Limited

Comberton Nursing Home

Inspection report

2 King William Street
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Tel: 01384262027

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 1 March 2017 and was unannounced. The provider had changed their registration with us and so this was the first inspection of the service under the new provider registration.

Comberton Nursing Home provides accommodation for up to 36 people who require residential and nursing care. There were 29 people living at the home when we visited.

The home had a registered manager, who was present during the visit to the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People were protected from the risks of harm or abuse and staff had been trained to recognise and report concerns. Risks to people's safety had been identified and staff monitored these closely. The arrangements for the management of people's medicines were safe. Staffing levels were reviewed to ensure there were enough staff available to meet people's needs. However we saw periods where there were no staff present in communal areas to help people. Recruitment procedures were followed to ensure checks were carried out on the suitability of new staff.

Staff had a planned induction to prepare them for their role and training and support to ensure they understood and met people's needs effectively. Staff understood the importance of seeking people's consent to care and how to support people whose liberty was restricted. Training in the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), was planned to support staff understanding. People enjoyed their meals and were supported eat and drink enough. People had access to health care professionals to promote their health and well-being.

The majority of people who lived at the home described the staff as being nice and kind. However some people told us a caring approach was not consistent. Some people experienced delays in accessing the toilet which could compromise their dignity.

People felt that staff knew their preferences and routines for how and when their care was provided. Activity provision was reduced but the registered manager had recruited to this post to enhance opportunities for people. Complaints were managed appropriately.

The quality of care was monitored. Audits and action plans had been effective in identifying improvements and these had been made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from harm and abuse by staff who had been
trained to recognise and report concerns.

Risks to people's safety were identified and safeguards were in place to keep them free from harm.

Staffing levels were arranged to meet people's needs safely.

Medicines were managed safely and people had support to take these as they were prescribed.

Is the service effective?

Good

The service was effective.

Staff had the training and support to meet people's needs effectively.

People's consent to care was sought and their liberty was not unlawfully restricted. Training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) had been arranged to support staff understanding.

People received input from a range of health care professionals to meet their healthcare needs. People's dietary needs had been identified and managed and they were offered meals that they liked.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most people described the majority of staff as being kind and caring some people said that they were not.

At times people's basic dignity needs were not always ensured by staff.

People's privacy and independence was promoted.

Is the service responsive?

Good

The service was responsive.

People and their relatives confirmed that the staff knew the people well enough to meet their needs.

The provision of activities had reduced but plans were in place to enhance this.

Complaints were investigated and responded to.

Is the service well-led?

Good

The service was well-led.

People and their relatives had confidence in the management of the home and staff said the registered manager was supportive to them.

Systems to monitor the quality of the service were effective in identifying improvements. People had the opportunity to share their experience of the service.

Comberton 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 inspection took place on 1 March 2017 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, their area of expertise is dementia care.

We asked the local authority their views on the service provided. We also reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as 'notifications'. We looked at the notifications the provider had sent to us. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

We spoke nine people living at the home. We visited a further twelve people cared for in their bedrooms to check the care delivered. As some people were unable to tell us their views of the service, we used a 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 also spoke with two relatives, four members of care staff, one nurse, the cook, and the registered manager. We looked at six people's care records and twelve people's medication records and monitoring records. We also looked at records kept in relation to staff recruitment and training, accidents and incidents, complaints and the provider's quality assurance audits.

Good

Is the service safe?

Our findings

People living at the home told us they had no concerns about their safety. One person said, "I do feel safe, I have my little bedroom, which is big enough for me and I can close the door or open the window whenever I like". Another person told us, "I have never felt scared or upset about anything". A third person told us, "Staff are very good to me; they wouldn't hurt me". A relative told us, "I have no problems whatsoever, I am very satisfied with the home and how they look after my relative. I think my relative would tell me if they were unhappy or if there was a problem".

Staff told us they had received training in safeguarding adults and knew how to report any concerns. One staff member told us, "Anything I notice, such as an injury that we can't account for or if someone hits someone else, I would report to the nurse who tells the manager. I know they then report to social services". We saw evidence of this where staff had noticed bruising and had reported this to the registered manager. We saw that a record of bruising had been made on a body map and the registered manager had reported this to the local authority as a safeguarding incident. The registered manager reviewed accidents, incidents or any safeguarding concerns and these were shared in monthly information reports with the provider. This demonstrated that there were systems in place for the sharing and learning from incidents.

People told us that staff supported them with their safety. One person said, "I feel safer now that I can use my walking frame; they say I didn't walk when I first came here due to something being wrong with my feet, that's been sorted out so now they don't have to watch me or walk with me. I can go to the toilet on my own now". A relative told us, "I have been present when they have hoisted my relative and taken them to the toilet; they are never rough or inappropriate". Staff we spoke with were able to identify those people at risk of developing pressure sores, falling, choking or not eating or drinking enough. One staff member told us, "We are kept up to date with any risks to people's safety at staff hand-overs. We are allocated to work with specific people so we know which people need their positions changed to protect them from pressure sores; we know who doesn't drink or eat or who might fall". There was a high number of people being supported in bed due to their frailty and medical conditions. We found that those people being cared for in bed had been attended to at the frequency they needed. Records showed their position was changed, that they had eaten and had a drink. This showed that risks to people's safety had been identified and staff were following the guidance available to mitigate such risks.

We saw that there were safe recruitment systems in place. Staff told us that before they started work in the home that a Disclosure and Barring Service (DBS) check had been carried out and references and identification had been requested. The registered manager showed us staff files which confirmed that pre-employment checks had been made.

People told us that staff were busy but available to assist them. A person cared for in their bedroom told us, "I have my buzzer to call for help and to be honest they do come". Another person told us, "I do call the carers to take me outside to have a smoke; I might have to wait now and then but you expect that". We observed that staff were allocated to different floors within the home to meet people's needs. Staff told us that the communal areas were always supervised by an allocated staff member but we saw short periods

during the day when no staff member was present. When we asked about this one staff member said, "Someone should be in here, I don't know why that is". Although staff had been allocated to the lounge there were short periods in which they were not visible and this leaves vulnerable people unsupervised. Staff told us that staffing levels were appropriate for people's needs but that recent sickness had impacted on staffing levels and they had used agency staff to cover. A staff member said, "We have agency staff or work extra shifts; the manager tries really hard to cover but if it is short notice it can be a bit difficult". Another staff member told us, "At the moment we are alright because we have low occupancy numbers; having said that we have a lot of people cared for in bed which can make it difficult, however we always make sure we attend to people". The registered manager told us that short notice sickness and staff vacancies were being managed. We saw staffing levels were reviewed on a weekly basis and a system was in place to use the same agency staff to provide some consistency. The registered manager was taking action to recruit to vacant posts for a nurse, two carers and an activities worker. We saw that additional staffing had been sought to support a person to their hospital appointment some days previously.

People told us they were happy with the arrangements in place for their medicines. One person said, "I take my tablets at the same time every day which is after breakfast". Another person told us, "The nurses always wait whilst I take my tablets and they come regularly every day". We observed the medication round and saw that the nurse checked medicines before administering them to people. We noted she was patient and caring; taking the time to explain to people what their medicines were for. We saw a daily check of balances was undertaken at each medicine round and we saw medicine audits were in place to identify any errors or gaps. A number of people had medicines prescribed on an 'as and when required' basis. Some people had medicines prescribed as 'anticipatory medicines' for pain relief for end of life care. Other people had their medicines administered through an artificial tube into their stomach The nurse was well informed about when and how such medicines should be used. We saw written protocols were in place to advise nurses on when and how these medications should be administered. The nurse explained to us that if agency nurses were used, she would check their competencies to ensure they were familiar with any new procedures so that medicines were administered safely. The nurse informed us that regular handovers and meetings between the nurses took place and that they worked closely with the palliative care team in regards to people's pain relief. Where people were prescribed controlled drugs to manage their pain, (controlled drugs are medicines that require extra records and special storage arrangements because of their potential for misuse), we saw that people were getting their medicine on time or as prescribed. We saw an assessment of these peoples' pain had taken place so that they did not suffer avoidable pain. We found that the medicines were stored securely.

Good

Is the service effective?

Our findings

People said that staff were trained and understood their needs. One person said, "There is a lot of training that goes on here for the carers; I feel they are well trained and knowledgeable". Another person told us, "They know where I need help and when they use the hoist they do it well; I've seen them with people who are confused and they seem to know how to look after them". A relative said, "I think the carers are well trained and very respectful; it is a comfort to me that my relative is getting good care".

Before staff worked in the home they had an induction. One staff member said, "I shadowed more experienced staff for two weeks and worked through the standards before I worked on my own". The registered manager told us that new staff were also enrolled on the Care Certificate. This is a nationally recognised induction that provides staff with the skills and knowledge they need to care for people safely and follow good practice guidelines. Staff told us that they felt supported and well prepared to carry out their care role.

There was a rolling training programme which provided essential training courses to staff for example, manual handling, first aid, and food hygiene. The nurse told us that in addition to her essential training she had been supported to undertake specific syringe driver training; this is a means of administrating pain relief to people. Staff told us they were happy with the training they had. We saw that staff had achieved various levels of national vocational qualifications (NVQ) which provided them with the core skills to be able to do their job effectively. A number of staff had completed training in dementia awareness and we saw this enabled staff to interact with and communicate with people who became confused or agitated. We observed for example a staff member supporting a person who was agitated and disorientated with success. Staff told us they had supervision and regular support. They also advised that the registered manager organised staff meetings and that regular hand-over between shifts enabled them to keep up to date with people's changing needs. One staff member said, "We have been made aware how to manage (name) as their behaviour is at times challenging".

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 people lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People told us that on a daily basis staff checked with them about how they wished to receive their care. One person said, "Staff will ask me if it's okay for them to do such and such, like take me to the toilet". We heard another person give consent to staff to use the hoist. People were asked if they wanted protective clothing at mealtimes and where they wanted to sit. Not all of the staff had received training on the MCA but we saw this was planned and we saw that staff understood the importance of seeking people's consent. Staff we spoke with were able to identify people who lacked capacity or had fluctuating capacity and described how they supported them. One staff member told us, "With some people we will explain clearly and wait for their response, sometimes we will try again later. Not everyone can give verbal consent but we

watch for body language and mood and can usually tell if they are happy for us to proceed". We saw that some people required the use of bedrails and where they were unable to agree to this a capacity assessment was in place. Care plans showed that decisions people had made in relation to Power of Attorney (POA) and do not attempt to resuscitate, (DNAR) were recorded. The nurse showed us the system for recognising people had a DNAR in place and for ensuring agency nurses understood people's resuscitation status.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service had applied for DoLS appropriately and whether any conditions on authorisations to deprive someone of their liberty were being met. Where people had identified restrictions on their care the registered manager had applied for DoLS appropriately, some of which had been approved. Staff were aware of who had a DoLS approved and how this impacted on the person's care. Where applications were waiting approval staff worked in the best interests of people to keep them safe. For example where people lacked capacity and were placing themselves at risk by attempting to leave the home, doors were coded to improve people's safety.

People we spoke with were happy with the meals provided. One person told us, "The food is very good and the cook is very nice, food is tasty and something you can eat; not like some restaurants". Another person said, "There is always a good choice of food and it is always appetising". Another comment shared was, "Food is good, and cook seems to be very good". People had a choice of two meals and we saw that specific dietary requirements were met. For example some people had their meals pureed due to swallowing difficulties. The cook showed us that she had information about people's likes and dislikes and described how she fortified some people's meals to provide additional nutrition. Specific diets needed for diabetic people or for other medical needs had been provided. No one required a cultural or religious diet but the cook told us this could be provided if needed. Some people needed support to drink enough; we saw that drinks were readily available and topped up throughout the day. People who needed their drink thickened to help their swallowing were provided with suitable drinks they could manage. The cook regularly provided milkshakes to enhance people's nutritional intake. People's care plans identified their nutritional needs and people at risk of weight loss were monitored. Appropriate referrals had been made to the doctor and the speech and language team, (SALT) to ensure people's eating and drinking was assessed and that they had the required food supplements to support their nutritional needs.

People told us they were happy that they were supported with their health needs. One person said, "I have not had need to see the doctor yet. The chiropodist comes round and sees me about every two or three months I think. I went to the dentist yesterday and had a tooth out. I went to the hospital for an appointment last week, it was very good, a carer came with me and we were taken there and dropped off by an ambulance driver". The nurse told us that if she was concerned with people's health she would contact the doctor. Relatives we spoke with had no concerns about people's health care needs being managed.

Requires Improvement

Is the service caring?

Our findings

People said that they were treated with dignity and respect. One person said, "I'm definitely treated with dignity and they respect my privacy when doing personal care". Staff we spoke with understood the importance of respecting people's privacy and dignity and had received some training in these areas. One member of staff said, "We discuss how we can promote people's privacy and dignity; I would involve the person, cover their body when washing them, give them time and a little privacy to do some bits themselves". A relative told us, "My relative is always clean and well dressed, they do a good job of that, their clothes are always clean".

Staff were seen to discreetly advise people when they required attention to their personal care and this was provided in private. Some people relied on staff support to access the toilet areas and whilst most people had no concerns about staff attending to their requests for the toilet, two people told us this was not consistent. One person said, "Some (staff) will help you to the toilet straight away when you need to go but others will make you wait, which isn't so good". We observed one person waiting for staff to attend to their request which took several minutes. The person told us, "I am dying for the toilet". They told us this had happened on a few occasions. We saw that staff arrived and assisted the person. This delay appeared to be related to the need for two staff to attend to the person. Although the delay was not intentional the lack of availability of staff could result in some people's dignity being compromised. Another person dropped their cutlery which went unnoticed by staff because there was no one in the lounge. As stated previously in this report there were times when the communal lounge was not staffed and as such delays in attending to people could compromise their dignity.

The majority of people we spoke with told us that the staff were caring and polite. One person told us, "The carers are very kind and look after me". Other comments we received were: "I can't fault the care in every aspect; they really look after me; they are kind and caring and helpful, they all know me quite well and we all have a laugh sometimes", "It's not too bad here; they look after me well, some of the carers are really good and I really get on with them". However, at least four people told us that some staff were not as caring and this resulted in them not always feeling they were respected or valued. For example one person said, "I think some of them should take more care of you, sometimes it's just their general attitude; they can be a bit rude and thoughtless". Another person told us, "They are mostly caring, but some of the night staff are quite rough with you but I don't say anything and they don't like you getting up in the night to use the loo either". From some people's experiences we found there could be a lack of consistency in the caring approach of some staff.

We observed some staff and the people who lived there chatted with each other in a friendly, caring way. Some staff were attentive to people; they checked with people if they were comfortable; or needed a drink. The nurse demonstrated a warm kindly manner when administering people's medication. She sat with the person, took time to explain what the medicine was and patiently waited for the person to take it.

At times staff sat with people to respond to their emotional needs. For example one person who was becoming upset and confused repeatedly asked staff, "What should I do, what do you want me to do?" The

staff member comforted the person and held their hand and told them in a soft voice, "The only thing I want you to do is stop worrying; we will sort it out". This calmed the person who then proceeded to smile and chat to the staff member about other things.

Staff we spoke with had a good understanding of people's needs and had taken the time to get to know how to converse with people in a way that they could understand. People who struggled to communicate or remember events responded to this approach and we saw it made them happy; they smiled or held the staff members hand. We saw some staff promoted good communication with people by speaking slowly, using short sentences and explaining to the person. This demonstrated that staff had an understanding of people's dementia and how this might affect their understanding and their emotional mood.

Relatives were complimentary about the staff and told us, "They all seem like friendly girls and they always offer me a drink when I visit", and, "I think the carers are well trained and very respectful".

We saw that people were supported to make choices. Staff provided explanations to people and waited for them to respond. For example we saw a person being helped into a stand aid hoist. The two staff supporting them were encouraging and reassuring and checked with the person if they were comfortable throughout the transfer. We saw that when staff assisted people in wheelchairs that they asked them first before moving the wheelchair. Early morning we saw staff settle people into the lounge and observed the staff member asked the person what they wanted for breakfast. Whilst this was being organised the staff member sat and chatted briefly with the person checking they were comfortable. The same process was followed prior to lunch which showed that people were not being rushed.

People told us they were encouraged to maintain their independence in aspects of their care. One person told us, "The carers encourage me to be quite independent; I have my own space in the smaller communal lounge and I like to keep that tidy myself". Another person said, "When they assist me they always ask if I want to do certain things for myself and I do prefer that". We saw that where people were independently mobile they walked freely around the home without any restrictions. The registered manager was aware of how to access advocacy support where people may need support to express their choices.

People told us they had visits from their family and this was supported by having no restrictions on visiting times. One person said, "Oh yes, my family come whenever they want to and staff are very welcoming to them".

Good

Is the service responsive?

Our findings

People told us the care they received met their needs. One person said, "I can go to bed or get up when I want to; they know my routine and help me at times I want it". Another person told us, "I don't feel under any pressure to do anything; I can spend time in my room, come down for my meals and I don't like activities, but that's fine".

People told us they had been involved in the assessment and planning of their care. One person told us, "When I first came they asked me about walking, my medicines, what I ate and things like that". People told us that staff knew them well and were responsive to their needs as well as their preferred routines. For example one person said, "The carers are all very nice and they allow and encourage me to be quite independent". Staff were able to confirm this person's routines and the tasks they did independently. One staff member told us, "We will go and ask (name) and they will tell us what they want to do and when, (name) manages most aspects of their care independently, we just support them in other areas". We saw staff were aware of people who needed support to change their positions due to fragile skin. We saw that staff responded to these needs at the times people needed the support. Staff were able to tell us how they supported some people who regularly refused any care. One staff member said, "We know that (name) is refusing care so our strategy is to try different approaches when (name) might be in a more receptive mood". Care plans provided details about people's needs as well as their personal routines and the tasks they wished to do for themselves. Staff said that care plans provided them with information they would need to support people safely and according to their needs and preferences. Staff confirmed that handovers between shifts enabled them to keep up to date with people's changing needs. We saw that care plans had been updated to show people's changing needs.

One person told us, "There is nothing going on to keep me entertained; definitely room for improvement regarding activities". A relative we spoke with told us, "Not much for activities, will look at the paper if I bring it in but that's about it". There was no 'planned' activity occurring; staff and people told us that there had been some visiting entertainers such as singers, keep fit sessions. Occasionally quizzes, dominoes and board games were used. We saw that a game of dominoes took place in the afternoon, throughout the day people listened to music on the radio. Most people indicated they did not 'bother' with the TV. The provider had a dedicated activities worker who we were advised was on leave. The registered manager told us they had taken action to improve the availability of activities and had recruited to this post. She was confident this would enable them to plan and provide a range of things for people to do.

People and their relatives told us if they had any concerns or complaints they would speak with the registered manager. A relative told us, "I haven't had a need to complain about anything, it all seems calm and collected, I think they would listen and act appropriately when needed". We saw the complaint procedure was displayed and a suggestions box was available for people to make any comments. A complaints system was in place with records which showed the nature of the complaint, the investigation and outcome. The registered manager showed us that a written response was made to complainants with the outcome.

Good

Is the service well-led?

Our findings

People, relatives and staff told us that the registered manager was approachable, supportive and available to them. One person who lived in the home said, "I have met the manager many times I know who they are and they are never too busy to stop and talk to you. Very nice and friendly, will make time to see you if you have a problem and will take time to see if we are happy with the quality of the care we receive".

Staff told us the registered manager was supportive to them and listened to their views. One staff member said, "The manager will provide staff if we are short or will help us herself". There was evidence of trying to maintain an inclusive culture; people told us the registered manager frequently talked with them and enquired how they were getting on. We found that although the registered manager undertook this activity, people's comments to us indicated there was a lack of consistency in the caring approach of some staff. There may be a need therefore to ask people specific questions to obtain more detailed feedback which may help the registered manager to make improvements.

Relatives told us they had completed questionnaires and the registered manager was able to provide evidence of the results of people's feedback. For example improvements had been made to the environment with new flooring, empty bedrooms were being decorated and newly furnished and a raised sensory garden was planned. The registered manager had organised via Dudley Council, volunteers and the local pub to improve the garden for people to enjoy. Staff confirmed that regular team meetings enabled them to discuss their concerns and any changes needed. Staff told us that communication and support from the registered manager was good.

There was a management structure with a registered manager and nurses supporting the registered manager. Staff understood the management structure and told us they could approach the registered manager or the nurse in charge with any concerns. Staff understood that they could whistle blow if they had any concerns about the conduct of colleagues. One staff member told us, "I haven't ever seen anything that I felt was dangerous or inappropriate and I would certainly report it to the manager or approach whoever was involved if I needed to".

The registered manager told us that one of the key challenges at the home was recruiting qualified nurses. We saw that she was in the process of recruiting to these vacancies and that interim arrangements were in place from agency nurses. A new deputy manager post was also being created in order to provide additional management support to the team. The registered manager was taking action to improve gaps in the service and had recruited a new activities worker and advertised the care staff vacancies.

There were some established platforms in which staff could discuss their care practices. For example via staff meetings and supervisions. Topics such as managing falls, monitoring people's fluid intake and managing people's risk of developing pressure sores had been re-enforced. We saw that the monitoring of these risks was consistent. The registered manager had reminded staff about their responsibilities to keep accurate records and we saw staff were required to comment rather than tick any care interventions they provided.

Providers are required to inform the Care Quality Commission of important events that happen in the home. The registered manager had informed the CQC of specific events the provider is required, by law, to notify us about and had reported incidents to other agencies when necessary to keep people safe and well.

The provider had a system to assess the quality of the service. Monthly audits were undertaken on medication, accidents/incidents, safeguarding incidents and complaints. Health and safety, infection control and maintenance were also audited to ensure the premises were safe and clean. These audits were shared with the provider and any actions were identified in an action plan for the registered manager to address. We saw that the audit process had been effective in making improvements. For example written protocols were in place for the use of 'as required medicines' to guide nurses in how and when some people had their medicines. This showed the registered manager had taken account of the actions needed so that people could be assured of living in a home that was well managed where their care and safety were promoted.

The registered manager had plans to provide training to staff to support their understanding of The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Plans for the future were shared with us and included dispensing with the use of shared/double bedrooms. The registered manager told us they were experiencing more often that people who visited the home preferred their own bedroom and this had recently resulted in lower occupancy.