Smallwood Homes Limited

Cale Green Nursing Home

Inspection report

Adswood Lane West
Cale Green
Stockport
Greater Manchester
SK3 8HZ

Tel: 01614771980

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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

Summary of findings

Overall summary

This inspection took place on 4 April 2018 and was unannounced. The inspection was prompted in part by notification of an incident. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident, however we did examine whether there were on-going risks to people living in the home.

At the time of our inspection the home had voluntarily suspended placements from the local authority. The local authority quality team had been working with the service to address some quality concerns relating to the levels of care within the home, particularly pressure area care. We did not ask the provider to complete a Provider Information Return (PIR) prior to the inspection.

Cale Green Nursing Home is a nursing home for up to 50 people. It is located in the Cale Green area of Stockport. Cale Green Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At this inspection we found the provider was in breach of three regulations of the Health and Social Care Act 2014. You can see the action we have told the provider to take at the end of this report.

People told us they felt safe and there were policies and procedures in place to protect people from abuse. This meant staff working in the home knew how to raise any concerns they had regarding the people living there.

During our inspection issues relating to the safety within the home were identified. Portable Appliance Testing (PAT) had expired, a scalding risk from a shower was present and two rooms posed a potential entrapment risk.

Sufficient levels of staff were on duty. Staff told us they received a good induction which gave them the skills they needed to provide care for the people living in the home. Some care worker training had expired and additional training that had been requested had not been provided.

People's medicines were managed safely meaning people received the correct medication at the right time. Staff received appropriate training to allow them to support people with their medication safely.

People's personal and cultural choices and preferences were respected and were included in the way their care and support was planned.

Care and support staff told us they felt well supported and received appropriate training to allow them to support people living in the home. Some care worker's training had expired meaning their practice may not have been in line with current guidance and may have put people at risk.

People told us they were given a choice of meals and enjoyed the food. Drinks were always available. Where people living in the home needed support to eat or drink, staff helped them with this in a patient and caring manner.

People living in the home told us they felt they were treated with kindness and compassion. Staff demonstrated they knew the people well and treated them as individuals and listened to them.

People were involved in planning and reviewing their care and encouraged to remain as independent as possible.

An activities coordinator provided a range of activities and encouraged people to take part in them. Where people were unable or chose not to join in communal activities, one to one activities were arranged.

People nearing the end of their life were treated with dignity and their needs were kept under review. Training for staff to enable them to use a syringe driver could allow people to have care from people they know and help prevent people having to go to hospital or having visits from district nurses to provide care.

At the time of our inspection the registered manager of the home was leaving. The management structure of the home was being changed to try to provide more management oversight.

People were encouraged to express their views about the service, and actions that had been taken as a result of feedback was clearly displayed. If people felt uncomfortable raising concerns directly with the service contact details for other bodies were displayed.

The ratings from the previous inspection by the CQC were on display within the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Issues relating to the safety of the home were identified during our inspection.

People told us they felt safe. Procedures were in place to protect people and staff demonstrated they understood the importance of them.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective. Staff told us they felt supported although some training had expired and they had not received the training in first aid they had requested.

People's care records contained information about their choices and preferences and they received support in line with these preferences.

The home was being decorated to make it more personal for people and signage was in place to help people suffering from dementia.

Is the service caring?

Good

The service was caring. People told us they felt they were treated with dignity and respect.

We observed staff interacting with people in a patient and reassuring manner and staff spent time with people so they didn't feel rushed.

People were involved in making choices about their care and support.

Is the service responsive?

Requires Improvement

The service was responsive. People told us they enjoyed the activities on offer within the home.

People felt able to complain and complaints were acted on and

reviewed to identify themes or trends.

Care for people at the end of their life could be improved by repairing equipment and training staff in its use.

Is the service well-led?

Requires Improvement

The service was not always well led. Issues relating to safety in the home and training should have been identified by the home's quality and audit systems.

People told us they found the manager to be approachable and were happy to raise concerns with them.

Regular meetings were held with people living in the home and their relatives and where improvements were suggested, these were followed through.

Cale Green 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 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 was prompted in part by notification of an incident. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident and we are making further enquiries in relation to it. However, the information shared with CQC about the incident indicated potential concerns about the safety of people within the home and this inspection did examine whether there were on-going risks to people.

The inspection took place on 4 April 2018 and was unannounced. The inspection team consisted of three adult social care inspectors, a specialist advisor in health and safety and a specialist advisor in nursing care.

Prior to the inspection we contacted the local authority and the local safeguarding team to see their views about the service. The local authority quality team had been working with the service to address some quality concerns relating to the levels of care within the home. We did not ask the provider to complete a Provider Information Return (PIR) prior to the inspection.

As part of the inspection we spoke with four people living in the home, two relatives of people living in the home, six members of support staff, the maintenance person, the quality and training officer, the registered manager and the nominated individual. We also spoke with a GP who was visiting the home.

We looked at the recruitment records of five staff, five people's care records and records relating to the running of the service which included staff rotas, records of accidents and other incidents, training records, servicing and maintenance records and quality audits and checks carried out.

Requires Improvement

Is the service safe?

Our findings

People living in the home told us they felt safe. One person we spoke with said; "I feel safe. The staff will sort out any issues I have." Another person said; "I feel safe and well looked after." Staff were able to explain the sorts of abuse they needed to look out for and what steps they should take if they suspected anyone was at risk of abuse.

People's care records contained assessments identifying what support people needed with a variety of daily living tasks such as dressing and personal care. There were also assessments of the risk of the person falling or developing pressure sores.

Where risks had been identified plans had been put in place to minimise the risk to the person. In one of the care files we looked at the initial care plan for the person had not been fully completed meaning the person's capacity to make decisions had not been recorded and details of other health professionals involved in their care had not been recorded. We recommend the service review people's care plans to ensure they are an accurate, complete and contemporaneous record in line with Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily care tasks for people were written on a whiteboard in the nursing office. We checked the daily care records for people and found the records were well maintained and correlated with the daily care the person needed. We observed a review of people's care between a senior care worker and the visiting GP and noted the review related to both the person's physical and mental health and current monitoring regimes and whether any additional support was required from other agencies.

We saw checks had been made on the safety of utilities such as gas and electricity in the home. At the time of our inspection we observed that portable appliance testing (PAT) had been completed for some appliances but not others with some certificates indicating the appliance had last been tested in 2014. The nominated individual told us the testing was taking place at that time and we saw evidence shortly after the inspection that the testing had been completed.

Two unoccupied bedrooms were being used to store equipment such as hoists, wheelchairs and mattresses. The doors to these bedrooms were unlocked and there was a risk people living in the home could enter the room and become trapped. When this issue was highlighted with staff the rooms were immediately locked.

During our inspection we found the shower outlet used by the hairdresser was able to reach a higher temperature than recommended for care homes and posed a scalding risk to people. Appropriate control measures should be in place to ensure that water hotter than 44 degrees Celsius is not discharged from taps and showers. We asked to see the records relating to weekly checks on hot water and found that records were not fully completed. It was explained by the nominated individual that this was due to a change in staff and that records were now being completed.

The above demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People living in the home told us they felt there enough staff on duty. One person we spoke with told us; "They come quickly if I ask for help or support." During our inspection we saw call bells were answered promptly and staff had time to interact and provide support to people in an unhurried way meaning the staffing was appropriate for the number of people living in the home.

The home demonstrated safe recruitment practices. Recruitment files of staff that had been recently recruited showed appropriate checks with the Disclosure and Barring service (DBS) had been made before people started work. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks helped to ensure only suitable applicants were offered work with vulnerable adults.

Processes were in place to ensure people received their medications safely. Medications were stored appropriately and where necessary they were stored in a locked medicines fridge. The temperature of the fridge was monitored daily to ensure it was at the recommended temperature as was the room in which the medicines were stored. Some medicines can lose their effectiveness if they are stored at too high or too low a temperature.

Appropriate steps were being taken in the home to try to protect people from infection. Communal areas were cleaned regularly and each resident's bedroom was cleaned daily along with a periodic deep-clean. A range of personal protective equipment such as disposable gloves and aprons were available throughout the home and we observed staff using them as they supported people. A number of hand-sanitiser gel dispensers were also positioned throughout the home and signage asked all visitors to the home to use the gel before entering.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us they felt supported by management and received regular supervisions. One member of staff we spoke with said; "A lot more support is offered and a lot more training." Moving and handling training for some staff was out of date. The training officer explained this was due to them spending more time as the provider's other home but they would ensure the training was updated.

We saw the home had suction machines available but staff on duty were unclear who was trained to use them. One member of staff told us they thought the nurse on duty was trained. Staff told us they had asked for first aid training on a number of occasions but had not yet received this. We discussed this with the nominated individual who told us that an appropriate first aid course was being sourced.

The above demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

People's care records contained information about their choices and preferences, for example how they liked to sleep, whether they preferred a bath or shower and how they liked to dress. Information was recorded about their likes and dislikes and a "this is me" document describing the person's life history and things that were important to them. Some of the initial care plan records we saw were not fully completed but the daily monitoring sheets to record the support people had throughout the day and to monitor their food and fluid intake were well maintained.

The home had a dining room set out as a bistro with menus on chalk boards on each table. One person we spoke with told us; "I have a choice of meals and the food is good." Staff told us that alternative meals would be made if a person didn't want the choices on offer.

We observed a meal time and people were supported with their meals at the person's own pace and were not rushed. People had a choice of where to have their meal and those who chose not to, or were unable to, eat in the dining room were also given appropriate support. We noticed the main course and pudding was served at the same time and some people ate their pudding and left their main course and so may not have had a balanced meal. We raised this with the nominated individual who said this shouldn't have happened and would raise it with the kitchen staff.

Due to concerns raised with the local authority, the local authority quality team had been working with the home to try to improve the level of care to the people living in the home by providing guidance and training to staff within the home. At the time of our inspection the local authority team told us the staff and management had been receptive to the support they were being given and things had improved.

When people needed healthcare support from outside the home prompt referrals were made. A GP visited the home regularly and people were able to have their eyes tested by a visiting optician. A community dentist was also available for people to have both routine and emergency dental treatment.

At the time of our inspection some people's bedroom doors were being painted in the colour of the person's choice. New door numbers had been bought with the aim to make the bedroom door look like the person's front door and make the bedroom feel more like the person's own private space. There was signage designed to make it easier for people with dementia to find their way around the home.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The home was acting in line with this legislation and where appropriate, authorisations had been applied for to deprive people of their liberty. A record was kept of when the authorisations had been made and when they expired so if needed a new application could be made. We saw people being asked for consent before support was given by staff.

Good

Is the service caring?

Our findings

People living in the home told us they felt they were treated with kindness and respect. One person we spoke with said; "I love it [here]. All the people are so friendly. The staff always look after me." Another person living in the home said they liked the way staff always greeted their family when they visited.

Visitors were welcome in the home and the communal dining area had a sign inviting visitors to spend time in there with their relatives and to ask members of staff if they wanted a drink or snack.

Staff demonstrated they knew the people living in the home and approached them differently according to their preferences. We saw a member of staff sit next to a person and engage them in a quiet conversation. Shortly after, the same member of staff greeted a person entering the room and had a louder more animated conversation with them. We spoke with one of the people who told us; "The staff are very pleasant and you can have a joke with them."

A member of staff was always in the communal areas and we observed them include people in conversations about what was on TV and activities the people were involved in. Again, we saw care staff approach different people in different ways, with some people enjoying a boisterous conversation and some preferring a quieter conversation.

We saw care being given to people in a very patient and reassuring manner. One example we saw was where a member of staff was cleaning a person's finger nails. The member of staff explained what they would be doing and provided support at the person's pace and did not rush.

Staff involved people in the home in decisions about their care. We saw examples where people were given a choice about what they wanted to do and their choices were respected.

People's dignity and privacy was protected. We saw staff approach people when they needed support and speak to them quietly before helping them. People's daily care records were kept in the communal lounge where they were easily accessible to staff but people's privacy was protected by a member of staff remaining in the room at all times.

Requires Improvement

Is the service responsive?

Our findings

People's care records contained information about the person's life before they moved in to the home, for example, where they grew up, their employment history, their family background and their hobbies and interests. The records also had information about the person's cultural and personal choices and preferences allowing staff to understand how the person would like care and support to be given.

The records contained a communication passport where any communication needs the person had could be recorded. The passport was designed to be taken with the person if they received care from services outside the home so their communication needs could be shared with appropriate healthcare professionals.

The home employed a full-time activities coordinator who shared their time between Cale Green and a nearby home. On the day of our inspection the activities coordinator was on leave but we saw a schedule showing a variety of daily activities. For people who did not take part in group activities, one to one activities such as reading or conversations were offered.

People told us they enjoyed the activities in the home. One person we spoke with told us they liked having their hair done by the visiting hairdresser. Another person we spoke with told us; "I join in with the activities. [Staff] help me do things I enjoy like writing."

Complaints were recorded and stored in a folder in the office. Verbal complaints were recorded alongside more formal written complaints. The complaints received were analysed monthly to identify any trends or common themes. We saw minutes of staff meetings where learning points from complaints had been discussed and actions to improve the service were agreed.

At the time of our inspection two people were receiving care at the end of their life. Their amended medication was in place and safely stored and their care plans had been updated. We saw evidence that the plans for these people were kept under review and if their condition improved then their plans and medication would be reviewed in conjunction with their GP.

We spoke with the GP who commented that the home had a broken syringe driver that could be used for people receiving end of life care and save them being admitted to hospital or receiving visits from district nurses. A syringe driver is a small pump that delivers medication at a constant rate. We discussed this with the nominated individual for the service who told us that staff had not been trained in using a syringe driver but that they were looking to see who the training could be provided by. We will review this at the next inspection.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we learned the registered manager was leaving the service. We discussed this with the nominated individual who told us they were planning to recruit a new registered manager and also a new nursing unit manager to try to strengthen the management oversight within the home. We will continue to monitor this as a condition of the registered provider's registration with the CQC is that there is a Registered Manager for the service.

The nominated individual explained they were working with the local authority and the local Clinical Commissioning Group (CCG) and were open to suggestions from them about how the care provided in the home could be improved.

At our last inspection we rated this key question as 'requires improvement' as the provider had not demonstrated consistent and sustainable good practice for long enough to be awarded a 'good' rating.

At this inspection we found issues relating to the safety in the home such as expired PAT testing, entrapment risks and water outlets that posed a scalding risk, as reported in the Safe domain of this report. We also found moving and handling training for some care workers had expired meaning their practices may not have been in line with current guidance. This did not demonstrate that governance systems in place were robust enough to identify issues and to ensure timely action was taken to remedy them to ensure the continued quality and safety of service provided to people.

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

Staff told us they felt able to approach the manager of the home with any issues they had.

Complaints, incidents and accidents were reviewed monthly to identify any actions that were required or any learning that could be taken from them. We saw minutes of staff meetings where issues had been discussed. Where required, notifications had been made to other bodies such as the Care Quality Commission (CQC).

Information about a local advocacy service and contact details for the local authority and CQC were displayed to encourage people to share their views about the service. A box for people to leave comments about the service was in the entrance hallway to the home.

A number of thank you cards and compliments were displayed throughout the home so that people living in the home could more easily see them rather than keeping them on a notice board.

Regular meetings were held with people living in the home and their relatives. The outcomes from previous meetings were displayed on a wall in the home showing what actions had been taken as a result.

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 12 HSCA RA Regulations 2014 Safe care and treatment Portable Appliance Testing (PAT) had expired, unlocked rooms posed an entrapment risk and control measures were not in place to prevent scalding.

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 Governance systems in place were not robust enough to identify issues and ensure timely action was taken to remedy them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Moving and Handling training for some staff had expired. Staff were not trained in the use of suction machines and first aid training requested by staff had not been provided.