Waverley Care Homes Limited

Autumn House Nursing Home

Inspection report

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Staffordshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 10 March 2016 and was unannounced. At our previous inspection in August 2015 we found that people did not or were not supported to consent to their care, treatment and support, we had issued the provider with a requirement action and asked them to improve. At this inspection we found that no improvements had been made in this area and people were still not being supported to consent to their care. We found that there were insufficient staff to keep people safe, care being delivered was not always safe and the systems the provider had in place to monitor the quality of the service were ineffective. The overall rating for this service is Inadequate which means it has been placed into 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.

Autumn House Nursing home provides accommodation, personal and nursing care for up to 67 people. The service had recently been placed into administration.

There was a new manager in post who was in the process of applying for their registration with us. 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so and the DoLS ensures that people are not unlawfully restricted. We found that no improvements had been made since our last inspection and people could not be assured that decisions were being made in their best interests when they were unable

to make decisions for themselves.

There were insufficient staff to keep people safe and meet people's care needs in a timely manner.

Systems to manage people's medicines were not safe. People were at risk of not receiving their medicine as prescribed.

People did not always receive care that reflected their preferences. Care records were not up to date and did not contain accurate information.

People's privacy and dignity was not always respected. Staff did not always knock before entering people's bedrooms and were not always able to respond to people's request for help.

Systems in place to monitor the quality of the service were ineffective. People knew how to complain but complaints were not always acted upon.

People's nutritional needs were met, however some people experienced delays in receiving their food and drink due to insufficient staff.

People had access to a range of health care professionals when they needed it, however people's individual assessed needs were not always met and people were put at risk of further harm due to their being insufficient staff.

There were opportunities for people to engage in hobbies and interests of their choice, however staff did not have time to spend talking to people.

People who used the service were safe from abuse or the risk of abuse. Staff we spoke to all knew what constituted abuse and told us they would report it if they suspected abuse had taken place.

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 consistently safe. There were insufficient staff to meet people's needs and keep them safe. People did not always have the equipment they needed to be kept safe.
People's medicines were not managed safely.
People were protected from abuse as the staff and manager knew what to do if they suspected someone had been abused.
New staff had been recruited through safe recruitment procedures.

Is the service effective?

Inadequate

The service was not consistently effective. The principles of the MCA were not being followed to ensure that people consented to their care, treatment and support.
People's nutritional needs were met, however not always in a timely manner. People's health care needs were not always met due to insufficient staffing levels. Staff felt supported, however some staff practise was not always effective.

Is the service caring?

Requires Improvement

The service was not consistently caring. People's privacy and dignity was not always respected.
People were encouraged to be as independent as they were able to be.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Some people did not receive care that met their individual preferences. People's care was not regularly reviewed.
People knew how to complain, however complaints were not always acted upon. People were offered opportunities to engage in hobbies and activities of their choice.

Is the service well-led?

Inadequate

The service was not well led. The provider had not made any improvements to the quality of the service since our last inspection. The quality assurance systems the provider had in place were ineffective.

Autumn House 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. We looked to see if improvements had been made since our last inspection in August 2015.

This inspection took place on 10 March 2016 and was unannounced. It was undertaken by two inspectors.

We spoke with eight people who used the service and three relatives. We observed people's care in the communal areas. We spoke with the manager, five members of staff and the local authority quality monitoring officer.

We looked at four people's care records, staff rosters and the provider's quality monitoring systems. These records helped us understand how the provider responded and acted on issues related to the care and welfare of people, and monitored the quality of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection we had concerns that there were not enough staff to keep people safe. The acting manager at the time told us they would be increasing the staffing hours to ensure people received safe care. At this inspection we saw that there was still insufficient staff to keep people safe specifically on the nursing unit. We saw there were two nurses, one of which was an agency nurse and six care staff to 30 people. We saw two care staff were responsible for caring for 10 people. Most of the people required two staff to support them with their mobility, in getting out of bed and with personal care. This meant that no staff were available to support other people if they required help whilst the two staff were busy. One person was at high risk of falls and although they had a falls sensor in place to alert staff to them moving, staff explained that they could not always get to the person in a timely manner as they may be supporting someone else who they could not leave. We saw this person had recently fallen when unsupervised and had seriously injured themselves.

During the morning we heard call bells ringing and people asking for support to get up and have a drink. Staff were unable to attend to their needs in a timely manner. Two people who shared a room were still in bed at 10.45am and had not received personal care. A visitor told us: "You can see the staff have not been in yet as the curtains are still closed". We saw that one of the two people had been heavily incontinent. To ensure their welfare we alerted the staff and they came to support the person with their personal care. This person was assessed as being at high risk of damage to their skin, being left in a wet bed would potentially cause damage to the person's skin. We saw that this person's relative had recently complained to the manager that they had found their relative still in bed and unwashed at 12.30pm.

We heard another person, who was unable to get out of bed alone, was asked to wait to get up on several occasions and was finally supported out of bed at 11.00am, they told us: "I wish they would come [the staff], I want to have my breakfast". This meant that this person was not receiving care in a way that met their needs and kept them safe.

This showed that there were insufficient staff to meet people's needs in a timely and safe way. These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have the equipment they needed to keep them safe. During the morning before people were out of bed we saw a member of staff collecting people's mobility slings from their individual bedrooms. The member of staff told us they were going to be laundered. We asked how people would be supported to get out of bed if their sling was in the laundry and the staff member told us that they would all be back in an hour and some people had two slings. However we saw one person who was assessed to use a 'small grey full sling' was supported to get up with a 'large blue full sling'. We asked the staff member who was supporting the person about this and they told us they couldn't find the person's own sling so they were using the blue one instead. This put the person at risk due to the use of equipment not assessed for the individual person.

We looked at the way people's medicines were managed. We saw that one person's medication records did not correspond with the medication that the nurse was administering. The nurse explained that the person's medicine had recently changed but the records had not. There was regular use of agency nurses who may not have known the person's recent change to their medication and the incorrect records meant that the person was at risk of having medicines that they were not prescribed for. One person's medicine records stated that they were prescribed cream to maintain their skin integrity and stated that care staff were administering the cream and signing on a separate record. We found there was no separate record and care staff did not know to apply the cream.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were safe from abuse or the risk of abuse. One person said: "I feel safe". Staff we spoke with all knew what constituted abuse and told us they would report it if they suspected abuse had taken place. One member of staff told us: "If I see something untoward, I would report it to the manager or the safeguarding team". The manager gave us two examples of suspected abuse that they had reported to the local authority for investigation.

Pre-employment checks on potential new staff were made to ensure that they were safe and appropriate to work with people. Staff we spoke with confirmed that references and disclosure and barring checks had been in place before they commenced their employment at the service.

Inadequate

Is the service effective?

Our findings

At our previous inspection we found that one person had been stopped from managing their own money as it had been assessed as a risk, as it may get mislaid. The unit manager and a relative had discussed and made this decision although the person wanted to retain responsibility for their own money. The unit manager told us that they were unsure as to whether the person had the capacity to look after the money for themselves or not as they had not had their mental capacity assessed. The provider was not following the principles of The Mental Capacity Act 2005 (MCA) and ensuring people consented to their care. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At this inspection we saw that a mental capacity assessment had still not been completed for this person and they were still being stopped from handling their own money.

The same person had a Do Not Attempt Resuscitation order (DNAR) put in place since our last inspection. It stated that the person did not have capacity to consent to this decision and the GP had signed the order. No mental capacity assessment had taken place to demonstrate whether the person could consent to the order and the person's relatives or representatives had not been involved in the decision making process. We saw DNAR's for a further two people which had did not make reference to any discussion about the decision with the person themselves, a relative or representative. All three people's 'consent to care' care plans stated that they had the capacity to consent to their care, treatment and support.

Another person was being cared for in bed. We saw that it had been discussed and agreed by a nurse and a relative that this was in the person's best interest due to the fact they were unable to sit up right. The person's mental capacity had not been assessed and the other available options which may have been less restrictive had not been explored. For example, purchasing a chair that would support the person to sit upright and safely. This meant that the provider had not followed the principles of the MCA and ensured that any decisions were being made in people's best interests and demonstrated that this was the least restrictive practice.

These issues constitute a continued breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training and support was on-going and although some staff training was out of date there was a plan to make sure all staff had their training refreshed, however we saw staff using incorrect equipment with one person, which put them at risk of harm. Staff we spoke with told us they felt supported to fulfil their role. One staff member told us: "It's been a difficult twelve months and we are doing our best to keep things going and make sure people get good care". Senior staff and nursing staff had received supervision from the new manager. There had been several staff meetings since the new manager had been in place to discuss the changes and ideas for improvement.

Some people experienced delays in receiving their food and drink due to there being insufficient staff to support people in a timely manner. Some people were being offered breakfast shortly prior to being offered their lunch and then not wanting their lunch. If someone required a specific diet such as soft diet or a fortified diet this was available to them. The catering staff knew people's needs and responded to any changes in people's needs. People had three choices of main meals including a salad every day. We saw that people who required it were weighed regularly and the appropriate action was taken if there was any significant weight loss. Some people required feeding through a tube, this is called PEG feeding. We saw comprehensive information available to staff about the PEG and we saw several people receiving their nutrition through a PEG in a safe manner.

When people required specific health care support it was sourced for them, however staff were not always able to meet people's individual needs in a timely manner due to there being insufficient staff. For example, we saw one person who was at risk of pressure ulcers was lying in a wet bed, which would have increased the risk of sore skin. Referrals were made to community and district nurses, speech and language therapists and other agencies. We saw that people saw their GP when they needed to and regular health observations such as people's blood pressure and weight were monitored.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us that the staff were kind to them. One person said: "The staff are lovely, they do their best, there is just not enough of them". Most of our observations were that staff interacted with people in a caring manner. However, we saw one person was sitting uncomfortably in a chair, in their bedroom with the door open and they were compromising their dignity. We alerted staff to this person, who instead of making the person comfortable in their chair put the person into bed. We saw other people had to wait for support with their care even though they were asking for help. One person was found to be in a bed that was wet as their incontinence needs had not been met. They told us: "They're is not much care here".

We saw another person who was living with dementia sitting in their bedroom in their nightdress and bare feet. We were told they had been awake most of the night. We spoke to the person who was distressed and they told us they were cold. We alerted the staff and they told us and we saw that they were busy meeting other people's needs. They had not been able to support this person with personal care and to dress due to there being insufficient staff available.

We observed two members of staff walk directly into people's bedrooms without knocking and waiting for a response. This meant people's right to privacy was not always respected.

Staff we spoke with told us they wished they had more time to sit and talk to people. One staff member said: "[Person's name] just wants five minutes of our time and we just don't have it.

People were free to come and go around the service. We saw people wandered around from area to area with no restrictions. People were as independent as they were able to be. Most people had their own ensuite facilities. We saw two people shared a room and there was a privacy curtain available to maintain people's privacy.

There had been several meetings for people who used the service and their relatives to inform them of the changes to the management of the service. Visitors were free to visit when they wished, and we saw lots of visitors coming and going freely.

Requires Improvement

Is the service responsive?

Our findings

Some people did not have care that met their individual preferences as they had to wait to have their care needs met due to lack of staff. Several people had to wait to get up in the morning and some people were not able to have their breakfast until near lunchtime. A visitor told us: "My friend sometimes doesn't get breakfast until 11.30 and then it's lunch at 12pm, so they don't want it then". We heard other people asking to get up and they were being asked to wait until staff had time to get around to them.

People's care records were not up to date and reflective of their current care needs. Care plans were not being regularly reviewed to ensure they were still relevant. Staff told us that they did not have time to read the care plans but relied on daily handovers for information to be passed onto them about any changing needs. This put people at risk of receiving care that was not appropriate.

There was a complaints procedure and people knew how to use it. The complaints procedure was visible on the wall in the reception. A member of staff told us they would follow the complaints procedure if someone complained to them. We saw that two verbal complaints had been made to the manager and they had been recorded as a formal complaint. However one of the complaints that had been made was still evident of the day of our inspection. A relative had complained about their relative still being in bed at 12.30pm and their personal care needs had not been met. We saw that the manager had said they would investigate their concerns. We found that this person was still in bed at 10.45am in need of their personal care needs being met. This meant that the complaint had not been acted upon.

A relative told us: "The staff inform me if there is anything I need to know. My relative had a fall and they rang me to tell me they were at the hospital". Resident and relatives meetings took place and we saw that the new manager had introduced themselves in a meeting and through written communication with people.

There were opportunities for people to engage in activities, however if people chose not to this was respected. There was a wide range of entertainment and hobbies that met people's individual preferences. We saw that some people were enjoying a quiz. A designated activity person asked people throughout the service if they wished to attend, some chose to and others declined. Some people chose to stay in the room, watching TV, listening to music or enjoying a hobby of their choice such as a jigsaw.

Inadequate

Is the service well-led?

Our findings

There was a new manager in post; they had been in post for two months. They were responsible for managing Autumn House and the sister home Manor House. Since their appointment the provider had gone into administration and they told us they were keeping people, staff and relatives informed of what was happening through regular meetings to try and alleviate any worries.

No improvements had been made in relation to our previous inspection. The previous manager had submitted an action plan following our inspection however we found the provider continued to not follow the guidelines of the MCA 2005 by ensuring that people consented to or were supported to consent to their care, treatment and support. Staffing levels had not been increased and people were still having to wait for care and support.

At our previous inspection we found that people's care records and risk assessments were disorganised and it was not easy to find information in them. Some people did not have care plans and risk assessments which would have supported staff to meet people's needs in a consistent way. At this inspection we saw that there had been no improvement in this area. We saw that there was a regular use of agency nurses and care staff and the plans not being up to date and organised left people at risk of not receiving the care they required in a safe way .The manager told us that they recognised that the care records were disorganised and was looking into a new format to implement.

Accidents and incidents were analysed including falls. However one person had been found to be falling on a regular basis due to their dementia and their needs during the night. The manager told us that they had recognised this but had not actioned or agreed extra staffing to support the person until we discussed this with them on the day of the inspection.

Complaints were not always managed and used as a tool to improve. We saw one person was still receiving a delay in their care following a recent complaint from a relative. Record showed that the manager and nurse had investigated the complaint, however no improvement in this person's care was evident on the day of the inspection.

The provider had quality monitoring systems in place. However they were not up to date as the manager told us they were prioritising recruiting new staff and had been left to deal with issues relating to the service going into administration such as non-payment of bills and the cancellation of essential services.

These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive care that was safe.

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 11 HSCA RA Regulations 2014 Need for consent People did not always consent or were supported to consent to their care, treatment and support.

The enforcement action we took:

We issued the provider with a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to monitor the quality of the service were ineffective.

The enforcement action we took:

We issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to keep people safe.

The enforcement action we took:

We issued the provider with a warning notice.