Uttoxeter and District Old People's Housing Society Limited

Kirk House Care Home

Inspection report

34 Balance Street
Uttoxeter
Staffordshire
St14 8JE
14 JE
Tel:017889562628

Date of inspection visit: 25 November 2014
Date of publication: 17/04/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected Kirk House Care Home on 25 November 2014. The provider is registered to provide accommodation, personal and nursing care for up to 33 older people who have physical health needs and memory problems. The provider had two intermediate care beds for people who required short-term support before returning home when they left hospital. At the time of our inspection, 33 people used the service.

There was no registered manager in post at the time of the inspection. 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.

The provider was compliant at our last inspection of the service in September 2013.

Summary of findings

Staff did not always recognise and take appropriate action when abuse was suspected. This meant that people were not always protected against potential abuse.

People did not always have risk assessments in place to ensure that they received care that was safe. People's risks were not reviewed regularly to ensure that the care provided was still appropriate for them.

People's care records did not always reflect they care they received. Information about people's care needs were not always available. Care records were not kept securely.

There were not always appropriate numbers of staff to meet people's needs. This meant that people did not always the assistance they required when they needed it.

People did not always receive their prescribed medicines as planned. People on as 'required medications' (PRN) for pain relief did not have care plans in place to guide staff on when these medicines should be administered. Systems for ordering medicines were not effective.

People's liberties were at risk of being restricted inappropriately. The legal requirements of the Mental Capacity Act (MCA) 2005 were not always followed when people were deemed to lack the capacity to make certain decisions relating to their care and treatment. The MCA and Deprivation of Liberties Safeguards (DoLS) set out the requirements that ensure where appropriate; decisions are made in people's best interest.

People on special dietary requirements did not always have appropriate food to ensure that they remained healthy. People's food and drink intake were not always monitored as recommended by other professionals.

People were not always involved in planning their care. People's personal interests and preferences of activities were not always taken into consideration when activities were planned.

The provider did not have effective systems in place to deal with complaints. Records of complaints were not maintained, therefore, the provider could not monitor if they had been acted on effectively.

The provider did not regularly monitor the quality of the service provided. We saw that there were no action plans for recommendations made following recent Inspections of the service.

People who used the service told us that staff understood their care needs and provided care to meet these needs. We saw that staff communicated well with people.

People told us and that they always had a variety of food offered them during meals and enjoyed the food provided. We observed that the atmosphere in the dining area was pleasurable.

People told us that staff were caring. Staff obtained people's views about various aspects of their care before care was provided. We saw that people were happy and were treated with dignity and respect.

The service manager had been in post for just under three months. The provider had employed them to manage the service in the absence of a registered manager. People told us that the manager was approachable and was always available. Staff told us that they felt supported by the manager. The manager told the service faced a number challenges which they were confident will be resolved in due course. The manager told us that they planned to apply to be the registered manager at the end of their probationary period.

We identified that the provider was not meeting some of the Health and Social Care Act 2008 Regulations we inspected against and improvements were required. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were at risk of abuse because staff did not recognise and take appropriate action when abuse was suspected. People did not always have risk assessments in place to ensure that they received care that was safe. People's risks were not reviewed regularly to ensure the care they received was appropriate for their needs. People did not always receive their medicines as prescribed. Staff were not always available to provide people with assistance when they needed it. People's care records did not always reflect the care they received and were not always stored securely.

Inadequate

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

People's liberties were at risk of being restricted unlawfully. The legal requirements of the Mental Capacity Act (2005) were not always followed when people were deemed to not have capacity to make certain decisions. Recommendations made by other professionals were not always followed. People on special diets and dietary requirements were at risk of poor health because they did not always get the appropriate food and drink to remain healthy.

Requires Improvement

Is the service caring?
The service was caring.

We observed that care was rushed. However, people told us that staff were caring and treated people kindly. People told us that they were supported to express their views about the care they received. They told us that the staff knew them well and what their wishes were. People told us and we saw that they were treated with dignity and respect.

Requires Improvement

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

People did not always have up-to-date care plans that reflected their individual needs. Activities which took place in the homes were not always activities that people were interested in. The provider did not have effective systems in place for dealing with complaints.

Requires Improvement

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

Requires Improvement

Summary of findings

Quality monitoring checks and audits were not always carried out. People were not actively involved in developing the service because the provider did not always obtain their views about service provision. People who used the service and staff told us that the manager was approachable and always available to deal with their concerns.

Kirk House Care 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.

This inspection took place on 25 and 26 November 2014 and was unannounced and in response to concerns raised by other professionals about the service. Two inspectors and an expert by experience undertook the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.'

We reviewed the information we held about the service. Providers are required to notify us about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We refer to these as notifications. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding team and local commissioners of the service.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

We observed how general care was provided and carried out a lunchtime observation to see how people were supported during meals. We spoke with 11 people who used the service and six relatives. We spoke with two nurses, three care assistants and the service manager. We also spoke with three professionals who went to the home regularly to obtain their views about the care people received.

We looked at eight people's care records to see if their records were accurate and up to date and conducted an audit of five people's medication administration records (MAR). We looked at records relating to the management of the service. 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

One person who had swallowing difficulties was being given inappropriate snacks during visits. The manager expressed concerns that the person was at risk of choking and they had advised they should not have these snacks. The manager said, "I've seen them choking. It's my responsibility to keep them safe". However, the manager had not recognised and reported this as a safeguarding as the risk was still present.

One person with complex needs had not been receiving care as planned. Records showed that the person's family had expressed concerns about their care. A professional told us that a family member had raised concerns about the person's to the manager but this was not reported as a safeguarding. A safeguarding referral aims to notify the local authority's safeguarding team about a concern so that appropriate interventions can be put in place to prevent and to protect people from abuse.

Staff did not always demonstrate a good understanding of procedures for reporting suspected abuse. We saw that information was not available to staff on how to raise safeguarding concerns. All the staff we spoke with told us that they had not had any updates in safeguarding training. A professional we spoke with said they felt that all the staff needed additional training in safeguarding because safeguarding concerns were not being reported. Records on our system showed that recent safeguarding concerns were reported by other professionals who visited the service and not by staff. This meant that people were at risk of abuse because staff did not always report suspected abuse. This constituted a breach for Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person required support with their mobility. We observed two care assistants trying to transfer them from their wheelchair on to a chair. We saw them trying to use a standing hoist but the person could not stand even when being supported by both staff members. One care assistant said, "It's not safe, we'll just park [Person's name] for now". They then left the person sitting in their wheelchair. We checked the person's care records which stated "Risk of falls. [Person's name] can stand and weight-bear to transfer with one carer from chair to chair". The person's needs had changed but their risk assessment and management plans had not been updated.

One person suffered with severe sores on various parts of their body. The person's assessments for pressure sores stated that they were at "Very High Risk" of developing pressure ulcers. There were no risk assessments of how the person's sores will be managed to prevent them from deteriorating. Recent hospital admission records showed that the person's sores were at risk of becoming necrotic. Necrosis is when body tissues die due to not enough blood flowing to the tissue. We saw that the provider had not carried out risk assessments to guide staff on how the person's care will be managed to prevent further deterioration of the sores.

One person was prescribed creams for their legs to protect their skin integrity. The cream was to be applied three times a day. There was no indication on the person's MAR that the cream was being applied. There were no body maps in the person's records of where the cream was to be applied. The nurse told us that the care assistants applied the creams and signed in the person's daily care records. We checked the person's daily care records and saw that it had not been recorded that the cream had been given every day. One entry stated that the cream had been applied but the skin looked sore and was warm to the touch. The staff we spoke with could not confirm if the creams had been applied. We brought it to the attention on the manager for their action.

We saw that people's care records were not always kept securely and could be obtained easily by people not involved in providing care to people because the manager's office door was not locked at all times. There were several boxes on the floor in the manager's office which contained people's care records. There were loose sheets of records relating to various people's care all over on the manager's tables and on another table in the office. We saw that information relating to people's care could easily be read by other people who came into the office and who were not involved in the care of people. This meant that people's confidentiality was not always protected.

We found that people's records were not up to date and confidential information about people could easily be seen by people not involved in their care. This was a breach of

Inadequate

Is the service safe?

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that they had not slept well for the past few nights because they had not been given their prescribed sleeping tablets for over two days. They told us that they had never missed their medication for over 17 years. We brought this to the attention of the manager, who said, "That was my fault, I didn't order it". The manager told us that as soon as they had realised this, they placed an order for the medicine to be supplied. This meant the person's welfare had not been maintained because the person's medicines had not been managed effectively.

One person had been prescribed a variety of medications for their pain. These some of these medicines were to be given on 'as required' (PRN) basis. The person could not always communicate that they needed PRN pain killers. This person could not walk without assistance and chose to remain in their bedroom most of the time. This meant that the person had to sometimes shout out loudly to alert staff they were in pain. We heard the person shouting sometimes. Staff told us that this was usually when they were in pain or needed the attention of staff. A nurse told us that the person was given one of their PRN medicines before they had their wound dressings changed because this was when they were most in pain. The person's MAR did not indicate when or how other pain relief medications were to be given. Pain management records were not maintained to monitor the person's pain and take appropriate action before they experienced pain. This person's pain was at risk of not being managed effectively.

The provider had not ensured that people's medicines were always managed effectively. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(f)&(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were not always available when they needed assistance. One person said, "We shout for ages sometimes, which is really annoying if you need to go". It had been brought to our attention by other professionals that many staff had left the service and there were not enough staff to meet people's needs and staff we spoke with confirmed this. We saw that people were left unattended for long periods when staff were supporting other people especially during the morning period. Some people needed assistance to go to the toilet but staff were not always around to offer them support when they needed it. The registered manager said "recruitment is the biggest challenge now".

Requires Improvement

Is the service effective?

Our findings

People were not always given food to meet their dietary requirements. We saw that one person who had to have only diabetic meals was offered a non-diabetic dessert. This person had a disability that meant they could not always see what had been given them. We brought this to the attention of the manager and the food was removed from the person's room. The manager told us that kitchen staff had a list of all those who required special diets and this should not have happened. This meant that the person had been at risk of eating food not recommended for their health condition.

We saw that a relative had left a notice in their relative's bedroom reminding staff to administer regular oral care to their relative and for water to be given regularly. The person had to have food and drink through a soft plastic tube that was put into their stomach. This is known as percutaneous endoscopic gastrostomy (PEG) feeding. This person could not communicate and relied on staff of all aspects of their care. A staff we spoke with expressed concerns about how the person was cared for. We spoke with a professional about the care the person received and they told us that staff needed training in how to support the person with their PEG feed. They told us they were concerned about the person's care and that the person's family had to regularly prompt staff about how to care for the person. Staff told us that they had not had updates in training which they felt would enable them to provide effective care. We asked the manager how they ensured that staff were up to date with their knowledge and skills. The manager said, "Training needs analysis has not yet been done. I haven't had chance to have a look to see what who's done and when". This person had been at risk of poor health due to staff not always following the appropriate PEG feeding requirements. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) agreement in place. The person had been assessed as having fluctuating capacity. This meant that the persons sometimes had the capacity to make certain decisions and sometimes, they didn't. The form stated that the person often changed their mind about this decision and the decision had to be reviewed regularly. We saw that the review had not taken place when it was due. A DNACPR is an agreed decision that the person will not receive cardiac pulmonary resuscitation (CPR) in the event of a medical emergency or heart attack. The provider had not taken appropriate steps to ensure that the person's consent to the DNACPR agreements was valid.

One person often asked to go out but staff told us they could not let them go out on their own because it was not safe to do so. The person could only access the local community when supported by staff or a relative. Their records stated that they lacked capacity to make certain decisions due to their deteriorating mental health but there was no capacity assessment to identify which decisions could be made in their best interest. No application had been made by the provider for the person's liberty to be restricted. The Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements that ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. Staff had not identified that the person was unlawfully restricted, in order for appropriate action to be taken. Staff did not have a good understanding of the principles of the MCA (2005) and DoLS and had not had training in these. The concerns above showed that there had been a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulations 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person said, "You can get a doctor, it depends how busy staff are. They [staff] do try to get you in that day". A relative expressed concerns that their relative was not supported to see a health professional in a timely manner. Health and social care professionals told us that staff did not always follow recommendations made by them. A professional told us that they had requested on three separate occasions for staff to monitor specific aspects of a person's care but it wasn't done. They said, "That's my problem with them [staff]. When I ask them to do things, it doesn't get done".

We observed that people in communal areas were offered adequate amounts of food and drinks. We also carried out observations in the dining area at during breakfast and at

Requires Improvement

Is the service effective?

lunch time and people told us that they enjoyed the food. The atmosphere in the dining area was pleasant. We saw that people were offered a choice during lunch. One person said, “The foods gorgeous; all home-made”.

Requires Improvement

Is the service caring?

Our findings

We saw that care was rushed. One person was cared for mainly on their bed as a result of their illness and another person chose to remain in their bedroom due to their physical disability. We noted that staff did not always sit and talk with them. We saw that the main interaction these people had with staff was when care was being provided or when they were being supported with their eating, drinking or with their personal hygiene. This meant that the care provided to these people was task-led.

People told us that staff were caring and treated people kindly. One person said, "The staff fall over backward to help". We observed a care assistant supporting a person who was visually impaired during lunch. The member of staff guided the person to their table and also guided them to where their spoon and fork were. Another member of staff put the person's hand around their cup so that they knew where it was to pick it up. The person told us, "I feel as if I can trust them [staff]. They make sure they don't move me until I am steady". This meant that staff had demonstrated kindness and attention to this person.

People told us that staff always spent time chatting with them. One person said, "I'm one of those who likes a bit of a joke with the staff". Another person said, "I like a bit of a laugh and a joke with them". A relative said, "The staff are lovely, they've always got a smile on their faces". We observed jovial conversations between people who used the service and staff. There was 'old time music' playing and we saw that the people and staff were having a sing-along to some of the songs.

People told us that their faith beliefs were supported. A staff member said, "We have a church service every month". Staff told us a choir from the local church came to sing at the service and people enjoyed this.

People told us that they were supported to express their views about the care they received. Most of the people we spoke with told us that the staff knew them well and what their wishes were. One person said, "They get to know you, our routines and what we need". A relative said, "They look after [Person's name] tremendously well. You can't knock them". We saw that that staff took time to seek people's opinion and explain things to them in a way that they understood before engaging in any activities. A staff member told us, "You ask what they want and they tell you. Their care plan has what they dislike. [Person's name] doesn't like tomatoes but they like eggs and sandwiches". One person said, "If we want to be quiet, they leave us alone".

People told us that they were treated with dignity and respect. One person said, "That is one thing that's very nice. If they know you're in the toilet, they knock on the door and ask if you are alright". Another person said, "The carers don't make you feel embarrassed". We saw that staff knocked on people's door and waited before going in to provide care. We saw that people's bedroom doors or bathrooms were shut when care was being provided. We saw that staff maintained people's dignity when they were being assisted to transfer from one place to another with the use of a hoist. We observed that staff explained to people what they were about to do before people were moved with a hoist. We saw that people's legs were covered with a blanket so as to prevent their legs or other parts of their bodies from being exposed when they were being lifted with a hoist.

Requires Improvement

Is the service responsive?

Our findings

Peoples care plans were either not in place or had not been updated to reflect how they wished to receive care and support. Staff told us that they had worked for the provider for a long time and knew most people's individual care needs. The manager told us that they were reviewing people's care plans so that they could be more person centred. They said, "Care plans are not as person centred as they should be".

We saw that activities which took place in the home were not always activities that people were interested in. We observed a staff member engaging in quiz game in one of the lounges and saw that very few were involved in the game and others were dozing on and off or looked uninterested. The manager said, "I'm not happy with activities at all. I'm trying to encourage the activities coordinator to have a wide range of activities".

People told us that they would speak to the manager or to any member of staff if they had concerns. A relative had made a complaint about the care of their relative but this had not been recorded as a formal complaint. The manager told us, "People come and have a chat with me and we sort it out". They told us that they did not have a system in place for recording and monitoring complaints. No information had been made available to people of how to raise concerns about the service. This showed that the provider did not have effective systems in place for dealing with complaints or concerns made about the service.

People told us that they were sometimes supported to go into the shops in town and to keep in touch with the local community and people from the local community came to the hope to engage in activities. The manager told us "One of the resident's family members is trying to organise an open evening at the home".

Requires Improvement

Is the service well-led?

Our findings

We saw that the provider had received recent fire and rescue, infection control and hygiene and health and safety inspections. Several concerns had been identified during these inspections and recommendations had been made. However, we saw that the provider did not have robust action plans to deal with concerns identified. The manager told us they had arranged for an agency to visit the service to do carry out a complete fire checks and train staff. They told us that a health and safety agency was going review the health and safety inspection report, carry out an assessment of the service and then device an action plan. Another agency was to review and advise them on an infection control and hygiene action plan. The manager said, "I tend to bring people in to do the action plan". There were no records of the manager's plans to identify how they intended to deal with concerns about the service.

We found gaps in a sample of MAR which we inspected. These gaps had not been identified by staff. We asked the manager if MAR audits were carried out and they said, "Nothing much, I have to confess, the [Name of chemist] are coming to do a complete medicines audit for me". We checked to see if the provider carried out quality audits and checks and found that no audits were carried out. Records of previous quality checks could not be located so the provider could not check if previous concerns had been acted on. We asked how the manager monitored that concerns were acted on and they said, "It's all in my head".

The provider did not maintain records of people had personal emergency evacuation plans (PEEPs). These plans identify the level of support people required in the event of an emergency evacuation. We saw that some people required some support with their mobility and all the people we spoke with told us they had fallen at least once whilst in the home. Some people were cared for permanently in bed. Care was provided across three floors and an extension to the building at back. Concerns had been identified regarding emergency evacuation procedures during a recent fire and rescue inspection but actions had not been put in place to deal with the concerns. The manager told "I plan to get them [PEEPS] up and running". This meant that in the event of an emergency evacuation, people would not have readily available information about the assistance they require to be moved safely.

The issues above constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us that meetings sometimes took place at the home, where people's views about the service were obtained. Some people were aware of these meetings whilst most could not recall when a meeting last took place. One person said, "They do have them but I don't go to them". A relative said, "Apparently, they do hold meetings but I don't know how often. Maybe once a year". Another relative we spoke with told us meeting had not been held for a while. Staff we spoke with told us that meetings had not taken place for a while to obtain people's views about the service and we saw there were no records to demonstrate that the provider regularly obtained people's views about the service.

People told us that they knew who the manager was and felt comfortable approaching them if they had any concerns. One person said, "They [The manager] are very nice to us all. They come round and have a chat with us all". Another person said, "They come in and ask if I'm alright". Staff told us that the manager was supportive. A staff member said, "We now have four weeks rota so that we can plan what we are doing; that is nice". They said the manager usually acted on their concerns. The manager said, "I have built a good relationship with the resident's. I aim to build a cohesive team whose focus is resident care. I'm sharing reports now with them so they know why I'm telling them to do things". This showed that the manager promoted an open culture.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to identify, assess and manage risks to protect people against the risks of receiving inappropriate or unsafe care. The provider did not regularly assess and monitor the quality of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were at risk of harm because staff did not identify and report abuse when it was suspected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not always protected against the risks associated with unsafe use and management of medicines, by means of making appropriate arrangements for the obtaining, recording and safe administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were at risk or poor health because they were not always monitored to ensure that they received adequate nutrition and hydration.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment they received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected against the risks of unsafe care because the provider did not keep accurate records in relation to people's care and treatment.