Vaneal Ltd

Swimbridge House Nursing Home

Inspection report

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Swimbridge
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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

Overall summary

This inspection was unannounced and took place on 18 and 19 October 2014. There were 20 people living at the service. The inspection was brought forward in response to some information of concern CQC received about the management culture and low staffing numbers for the number and needs of people living at the service. This is the first inspection completed since the providers registered with CQC.

Swimbridge House is registered to provide accommodation for up to 24 people requiring personal and nursing care. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

People told us they were well cared for by a staff group who understood their needs, but could not always meet them in a timely way. Care and support was well planned but there were not enough staff to meet people's needs. People's safety was being compromised in a number of areas. This included how well people were being monitored through busy periods of the day to ensure their safety and wellbeing and how well medicines were being administered.

Staff provided care and support in a kind and respectful way. They showed they understood the needs and wishes of the people they cared for and worked in a way which promoted their independence where possible.

There had been improvements to the way staff received information, including handover time to discuss each person at the start of each shift, monthly team meetings and opportunities for one to one meeting with a senior member of staff. The feedback we received from staff was that the culture of the management team was not always open and inclusive and staff morale was described as low.

The registered manager and provider had needed to discipline a number of staff in order to drive up improvement in practice. People's rights were protected via the Mental Capacity Act 2005. The registered manager had made sure people's capacity to make decisions was assessed for all aspects of their lives.

Staff had received training in understanding the safeguarding processes and were able to describe types of abuse and when they should report their concerns and who to. The registered manager had been proactive in ensuring any concerns about vulnerable adults were detailed to the local safeguarding team and CQC.

There had been a significant investment in training and staff had been asked to complete a training audit so further training could be planned. Steps had been taken to ensure the right equipment was in place to assist staff to meet people's needs, but quality assurance audits were not always in place to monitor that all equipment remained fit for purpose.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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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?

Requires Improvement

The service was not always safe. Staffing levels had not been assessed and monitored to ensure there were sufficient staff to meet people's identified needs at all times.

Medicine administration was not always done in a timely way. There was the potential that people were at risk of not receiving sufficient pain relief when prescribed and needed.

Staff recruitment processes were robust, but some newer staff had started work without full checks being completed.

Is the service effective?

Requires Improvement

The service was not always effective. People were being supported by care staff who understood their needs and had the necessary skills and knowledge to deliver care but not always in a timely way.

Management promoted good practice with training, team meetings and sharing good practice issues. There was a good induction programme in place for new staff. A training audit had been completed to seek the views of staff about their skills and knowledge needs.

People were supported by staff to eat and drink throughout the day; however at lunchtime people had not been offered a choice about what they wanted to eat.

People's health care needs were being met and monitored effectively. Health care professionals were appropriately involved in the care and treatment of people.

Is the service caring?

Good

The service was caring. People were positive about the care they received and this was supported by our observations. Dignity and respect was maintained for people, although at times care staff were rushed and not always able to offer the emotional support some people needed to reassure them.

Nursing staff had received updated training to ensure people's end of life care could be met.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's personal and healthcare needs were met but their emotional needs were not always met in a timely way. People were left with little or no engagement in their surroundings for long periods of the morning. Some people required emotional support to assure and orientate them to time and place, but this support was not always available.

Summary of findings

There were limited activities available for people to participate in during the afternoon. People had not been consulted about the types of activities they wished to participate in. No records were kept about how people who stayed in their room were supported with their emotional and social needs throughout the day, other than being served their meals and drinks.

Complaints and issues of concern had been dealt with comprehensively. People living at the home and relatives said they would feel able to make their concerns known and were confident they would be addressed.

Is the service well-led?

Requires Improvement

The service was not always well led. People were put at risk because systems for monitoring quality were not effective. In addition, there were no systems to assess staffing levels against people's needs, so there were not enough staff on duty at certain times.

Although systems had been put in place for staff to have their views heard, they did not feel listened to or valued and this was impacting on staff morale.

Swimbridge 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 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 18 and 19 October 2014 and was unannounced. It was completed by one inspector who spent time observing care and support from morning through to suppertime.

We looked at the information available to us prior to the inspection visits. These included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law.

During the two days of inspection we spoke with 10 people using the service, four relatives and friends or other visitors and 13 staff. We also used pathway tracking, which meant we met with people and then looked at their care records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at records, including four care plans and risk assessments, three staff training and recruitment files, staff rotas and menu information.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we had received information of concern from two people about low staffing levels and people's care needs not being met. Two healthcare professionals told us although staff were ''knowledgeable and caring'', the bells were ringing constantly and staff appeared "very rushed.'' Since the inspection the provider has provided information to show on average the calls bells were being answered within 1.5 minutes.

People and their relatives told us they were well supported by staff, but said staff were sometimes rushed and people had to wait for longer than they would have liked. One person said, "The staff are all lovely and I try not to call my bell too often, but I need some help to get to the bathroom and sometimes you have to wait a long time". One relative told us they had volunteered to help out in the home one day per week to assist with the laundry and loading the dishwasher as they felt this may help free up staff time, as they were ''run off their feet trying to do everything".

Staffing was not always maintained at safe levels. During the morning, people were left in the main lounge for long periods of up to 30 minutes unsupervised. Some of these people required close supervision to ensure their safety and wellbeing. There were insufficient staff available during the morning to provide consistent monitoring and support to keep people safe. One person got a handling belt out of a drawer and tried to fix it around themselves whilst walking back to their seat. The belt was trailing down and was a trip hazard. The person was unsteady on their feet. Another person was anxious and disorientated to where they were. They cried out and became more distressed and needed regular reassurance which was only available sporadically when staff came into the lounge to bring some one in who they had assisted to get up and dressed.

Incident records completed by the service showed there was an increase of falls in the lounge when people were unsupervised. We observed people were left unsupervised, but have been assured by the provider this is no longer occurring.

Staff said they were very rushed in the mornings. For example, staff were still assisting people to get up at 12.30pm. One staff member said, "We try hard to make sure those who wish to get up early are assisted, but some people do have to wait because most of our residents need two staff to get them up". Staff raised concerns about the lack of time they had to ensure interactions were not just about tasks such as washing and dressing or assisting with meals. On the first day of the inspection there were three care staff who had worked at the home for several years, one care staff member who had worked at the home for one month and one care staff who was on their first day so could not be counted as part of the core care staff team. The registered manager told us two staff had rung in sick that morning. Care staff confirmed this was not unusual, that they had frequently had to cope with only three care staff per shift and this was not sufficient to meet people's needs. One care worker explained ''Most of our residents need two staff to move them, so only three carers per shift is just not enough.'' Management said they always tried to get additional staff in, either their own staff or from agencies, but this was not always achieved.

The registered provider and registered manager did not have a system or a dependency tool to help them assess the appropriate staffing levels for the number and needs of people living at the service. They described the difficulties they had faced in recent months regarding staffing, which included disciplinary issues and maintaining a good skill mix. We were informed 15 staff had left for various reasons since August 2013. This appeared to be a high number for the size of the service and staff commented that there had been a large number of staff leaving.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One nurse had given a double dose of insulin to one person as they had not checked the records to see the night nurse had already administered this. It was not normal practice for the night nurse to administer an 8am medicine, so the day nurse had made the assumption she needed to administer the insulin without first checking the records. The GP and diabetic nurse were called for immediate advice and additional sweet drinks and snacks were given as well as regular monitoring of the blood sugar levels and the person's general wellbeing for that day.

The provider had introduced an electronic system for recording medicine administration because the registered manager told us paper records were not always completed accurately and audits were not robust. However, the electronic system was running in parallel with the medicine administration records (MARs). This was time consuming so nursing staff were struggling to get the morning

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Is the service safe?

medicines administered within a reasonable time frame. On both mornings, the medicine round had not finished before 12.30 pm. We were assured by the nurses involved, they had prioritised people who needed medicines at exact times due to their illness, but this still meant some people received a morning dose of medicine, such as pain relief, much later than prescribed. We fed this back to the registered manager and provider, who said adequate support and training was being given to nurses to assist them to be with being more familiar with the new electronic system.

This is in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The storage and disposal of medicines was in line with the home's stated policy. The stock of medicines tallied with the records and the lead nurse told us she checked stock weekly and ordered medicines as stock as running low.

Staff confirmed they knew about the safeguarding policy and procedure and most knew where to locate it if needed. They demonstrated a good understanding of what might constitute abuse and knew where they should go to report any concerns they might have. The registered manager had sent us a number of notifications about areas of risk and possible abuse, which demonstrated she had acted swiftly to fully protect people. The registered manager had taken action where staff had placed people at risk, including reporting them to the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were effective recruitment and selection processes in place. Three staff files showed completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers, health screening and the DBS. Some newer staff had started work before their DBS checks had been completed. This had been risk assessed to say the new staff member should not be left unsupervised. Staff confirmed this was difficult to ensure throughout the working day. This left people in the home vulnerable as full checks had not been completed and returned to ensure newer staff were suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Staff received on-going training and support to do their job. The registered manager explained they had invested heavily in ensuring staff had the right skills, with regular training sessions and monthly discussions in team meetings about good practice issues. The induction included details of national good practice, guidance in induction standards and tested staff knowledge in key areas. New staff were expected to answer questions about key topic areas such as their understanding of respect and dignity, safeguarding processes and working with people living with dementia. The registered manager had asked all staff to complete a training audit and to say what they felt their training needs were. This was also being looked at as part of regular one to one supervision with the matron or the registered manager. Supervision involves looking at support and review of work practices.

A nurse educator (employed by the local NHS community nursing service) said the service had made good use of the free training they provided and staff had been engaged and keen to learn with staff turn out for the courses being well attended.

Staff said they had received training in key areas such as moving and handling, basic food hygiene, Deprivation of Liberty Safeguards (DoLS) and safeguarding processes. The matron explained that nurses had also received training in syringe drivers to ensure they could provide good pain relief for people who may be terminally ill. The matron also said she had updated nursing staff on using dressing packs and had replenished their stock with sterile dressing packs. She had also ensured the blood monitoring equipment was calibrated regularly to ensure they were effective. This had not previously been done and she had found some blood monitoring machines were not in working order. Where people had pressure relieving mattresses care plan information did not include what setting these should be set to, to ensure people are fully protected. We fed this back to the registered manager who agreed she would ensure this information was recorded within people's care files.

Staff said the provider had been proactive in ensuring they had the right equipment to do their job effectively. This had included replacing or purchasing more hoists and standing aids, handing belts and slide sheets.

Staff demonstrated a basic understanding of the Mental Capacity Act (2005). They were able to give examples of how they gained people's consent. Our observations of care and support being delivered supported this approach. For example, staff asked people if they were ready and wanted to be assisted to move from the lounge area to the dining area using equipment such as hoists and handling belts. Staff explained each step of what they were doing and checked people were ready, comfortable and consented to the support being offered. Mental capacity assessments were in place which detailed the specific area the capacity assessment had been completed for. For example, the use of bed rails to protect people from falling out of the bed.

Staff said they had received some training in DoLS and understood they should not deprive people of their liberty. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. The registered manager explained they were in the process of making applications to the DoLS assessors for specific people to ensure they were providing the right care and support in the least restrictive way. There was one person who was subject to this type of safeguard.

People who had swallowing, drinking or eating difficulties had been assessed by the speech and language therapist team. The team had given advice on specific diets, such as food being pureed or thickened. We spoke with the chef who knew which people needed a soft or pureed diet. He also had lists of people's likes and dislikes and catered for special diets such as gluten free.

Where people had been identified as being at risk of being nutritionally compromised, people had been referred to their GP for supplementary drinks and were being offered extra snacks and drinks. The amounts people ate was monitored and records kept in the kitchen. These records were reviewed by the registered manager on a weekly basis. Where people had reduced intake of food and fluid, the registered manager discussed this with the nursing and care team and if needed a referral was made to their GP.

People were supported to eat and drink and maintain a balanced diet at lunch and teatime, but this was more sporadic at breakfast time due to lack of staff being available in the dining area. Staff assisted people with their meals, and encouraged others to eat in a kind and

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Is the service effective?

respectful way. People were offered seconds, but it was unclear whether they had been offered any choice at lunchtime. There was only one option for the main meal and this was not displayed or discussed with people prior to the meal being served. The provider informed us there as an alternative choice offered and people had menus in their rooms. The chef told us they would provide an alternative for them as needed. The registered manager told us they were in the process of devising a four week menu which could be printed and shared with people and their families to help them make choices about their daily diet. People told us they enjoyed the meals offered to them. One person said ''I love the meals here, they are very good.''

People were able to see appropriate health and social care professionals when needed to meet their healthcare needs. Health and social care professionals were involved on an on-going and timely basis. For example, GP, speech and language therapist and mental health practitioner. Staff discussed daily monitoring of people's general health and emotional well-being as part of daily handover and daily records showed this was being monitored and actioned when needed.

Good

Is the service caring?

Our findings

People said staff were caring and kind towards them. One person told us, ‘‘I would recommend it here, I couldn’t ask for better. They (staff) are all lovely. You only have to ask and they will get you what you need.’’ Another person told us, “We are very well cared for, if I had a problem I would soon tell them.”

Relatives expressed a high level of satisfaction with the care their family member received. One family member told us, ‘’You can’t fault the care staff, there just needs to be more of them.’’

People’s choice about whether they wished to have their personal care delivered by a male or a female was recorded and respected as far as possible. One person said, ‘‘I like the male carer and don’t mind him bringing my drinks, but I don’t want him to help wash me and they stick to this.’’

Staff encouraged people to be as independent as possible, assisting them to use their walking aids appropriately. Where people had a hearing difficultly, staff got down to their level and talked to them in a slightly louder voice maintaining eye contact and ensuring people had time to respond.

Staff offered support in a discrete way to ensure people’s privacy and dignity was upheld. For example, when asking if people needed assistance to use the bathroom, this was done in a way so other people could not hear. When people were being supported to move using hoisting equipment, this was done in a relaxed and unhurried way, explaining each step of the process to put people at ease. Blankets were used to ensure people’s dignity when they were in the hoist sling.

Staff told us how they maintained people’s privacy and dignity when assisting with personal care, for example gaining consent before providing care. We saw examples of where staff supported people who were distressed or anxious in ways which reassured them. We observed staff checking with people whether they wanted support to move or change to a more comfortable position. When staff needed to support people in tasks such as eating and drinking, they made sure the person was happy and ready to receive the support before giving it. For example, one member of staff said, ‘’Do you want me to help you with your drink, is it warm enough, I can go and get a fresh one for you?’’

We heard staff refer to people by their preferred name and the interactions we observed showed staff were inclusive and good humoured. At lunchtime and tea time people were asked if they needed any support and if they had enough to eat and drink. People were offered the choice of where they would like to sit after mealtimes. Most people chose a particular area of the lounge although some people preferred to go back to their rooms. Staff respected people’s choices and preferences.

Nursing staff had received updated training to ensure they could meet the clinical needs of people who were at the end of their life. Previously this had been highlighted as an issue as one person who needed pain relief for end of life care, had needed to move to the hospice as nursing staff were not trained to deliver pain relief via a syringe driver.

Requires Improvement

Is the service responsive?

Our findings

Some people were left with little or no engagement for periods of up to 30 minutes during the morning. Some people required emotional support to assure and orientate them to time and place, but this support was not always available. For example, one person was restless and wanted to get up and move around, however was unsafe to do this without risk of falling. Staff had placed a pressure mat next to the person's seat to ensure they would be alerted to the fact they had got up, but the person needed more closely monitoring, due to the risk of them falling. This had been identified in their care plan and risk assessment. We observed three people sitting in wheelchairs at the dining table for most of the morning period. Two of these people were in wheelchairs which were not designed to sit in for long periods. We fed this back to the registered manager who agreed to check why people had been sitting in wheelchairs for long periods.

Another person became increasingly anxious and confused and needed a lot of emotional support. Staff reassured them every time they went into the lounge, but this did not provide the person with enough reassurance as they continued to show signs of distress by calling out for help. At breakfast time there were some people in the dining area who needed staff to prompt them to eat and drink. This did not always happen, because staff were too busy.

Care and support was well planned. Care files included people's preferred routines for getting up and going to bed, what they had enjoyed doing in the past, work and social life and people who were and remained important to them. The care plans and risk assessments were reviewed monthly and where changes in need were identified, the plans were changed to reflect their increased needs. Staff confirmed they were not always able to keep to people's preferred routines due to the complex needs of people and not always having the right levels of staffing available to meet their identified needs and wishes.

People's care plans included information relating to their physical and mental health, mobility, skin care, personal care, communication and eating and drinking. They were written with clear instructions for staff about how care should be delivered. Staff were expected to sign to say they had read and agreed the plan. Staff were able to demonstrate they had read plans and understood people's needs. Some plans had been reviewed with the person and their family whilst others did not show this had occurred. One relative said she had been asked for detailed information about their relative's past and the things which were most important to them.

Care staff completed 'This is me' documents for each person. These are plans developed by the Alzheimer's Society to assist care staff understand the person and their dementia care needs. Within this plan was a section about people's religious beliefs. The service had regular contact with the local clergy and a service was held monthly for people to attend. The registered manager said that to date this appeared to be sufficient to meet people's needs, but they would be happy to explore other faiths and cultures as needed.

Activities were planned after lunch, which care staff fitted in with their care and support tasks. The activities included flower arranging, cake decorating, music and games. There was no indication that people had been consulted about what activities they wanted to participate in. It was unclear how the needs of people who stayed in their room were being monitored or whether consideration had been given to their social needs. We were informed there were ten visits to these people to ensure their safety and offer food and drinks throughout the day.

The complaint's policy set out the procedure to be followed by the registered provider and included

details of the provider and the Care Quality Commission. Where complaints had been made, these had been appropriately followed up and actions taken to resolve the issues. For example, giving keyworkers responsibility to ensure people's laundry was put away in a reasonable way so clothes were not creased.

People we spoke with and their relatives said they were confident their concerns or complaints would be addressed and responded to appropriately. We saw people had also sent in compliments to the service to thank them for the care and support offered. Comments included, "So many thanks for all the wonderful care and affection you have shown to mum over the years and particularly in the past few weeks. We have always felt so happy and reassured that she was in such a homely and friendly environment with such caring staff.''

Requires Improvement

Is the service well-led?

Our findings

The registered manager managed the service day to day, and they were supported by the registered provider.

The registered manager does not hold a nursing qualification, so they had employed a part time matron and had a lead nurse to look at some of the clinical audits and training.

There were systems in place to monitor quality, but they had not been used effectively and this had placed people at potential risk. For example, where audits of medication records had identified gaps, this had not been followed up with individual staff for additional training and/or closer monitoring of their competencies. The registered provider had introduced a new electronic system for recording medicine administration, but had not accounted for the impact of nurse time in completing two sets of records. This had led to people receiving their medicines later than prescribed.

There was no system in place for ensuring the right level of staffing was in place for the number and needs of people living at the home. Although incident and accident records were monitored, they had not been fully audited to check whether there was a pattern or trend to such accidents. On checking care files, it became clear many of the falls had occurred in the lounge when there was no staff member available. This had not been fully analysed and acted upon to protect people from future occurrences.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager and provider had set up ways of improving communication for staff, including having monthly staff meetings and one to one supervision sessions. However, staff felt their views were not always listened to and that the management approach was not always open and inclusive. Staff gave examples of how they were told their break times were being altered so they would only have a 20 minute lunch break in a 12 hour shift. Staff said this was brought in without any consultation with them. The provider stated that in line with legal requirements, there were always 3 breaks (totalling 50 minutes) in a 12 hour shift. The format for individual lengths of these breaks were based on staff suggestions. Additionally, staff were always consulted on changes affecting them and these are discussed during staff meetings. Staff described the registered manager as ‘‘caring toward the residents, but abrupt towards staff members.’’ This had impacted on staff morale.

When we fed this back to the registered provider and registered manager, they explained how they had needed to raise standards within the home. They had needed to discipline some staff for their attitudes and ways of working which did not show respect to the people who lived there. The registered manager said they had looked at ways to improve staff morale by introducing an employee of the month award. They had also rewarded staff who picked up extra shifts to help out when there was sickness. The registered manager had organised a BBQ as a way of team building and saying thank you for their hard work.

People and their relatives were encouraged to complete satisfaction surveys. These had recently been sent out and the registered manager said they would be collating the results to see if any improvements could be made. People, relatives and healthcare professionals we spoke with said they had confidence in the registered manager and provider. They said their views and opinions were listened to and acted upon.

The registered manager worked with health and social care professionals to ensure people’s needs were met. For example in planning for end of life care, making sure nursing staff had up to date skills. The registered manager notified the local authority and Care Quality Commission of various issues in a timely way and with comprehensive information.

The registered manager was introducing competency checks for staff to ensure their performance was in line with agreed learning goals. This was new and some staff felt this was an unfair process and said they had not been given enough information about the process to help them understand what this meant and how it would improve their learning. The registered manager said that she would ensure staff had detailed information to assist them in their learning goals.

When we fed back our findings the registered provider and registered manager understood the issues we had identified and had already begun to put some actions in place to address issues. For example, they were in the process of recruiting more care and nursing staff as well as

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an administrator to assist with some of the auditing processes. They both said they wished to work with CQC and commissioners to move the home forward so it provided the 'best quality care' for people.

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 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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The registered person had not taken steps to ensure the health and safety of service users as there were not always sufficient numbers of suitably, skilled and experienced persons employed for the purpose of carrying out the regulated activity. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The registered person had not protected services users against the risk of unsafe use and management of medicines. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: The registered person had not protected service users as there was no system in place to identify assess and manage risks relating to the health, welfare and safety. Regulation 10 (1) (b)