Rockley Dene Homes Limited

Cherry Hinton Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this home on 19 August 2016. At this inspection we found a breach of the legal requirements. This was because the provider could not assure us that people's prescribed medicines were being safely managed. We found that detailed records to prompt staff about how, and when, to administer people's 'as required' medicine were not always in place. Staff did not always follow the provider's policy of recording people's medicine administration at the time of the person taking it. The reason why covert medicines (medicines disguised in food or drinks) were to be given was not always formally documented within people's care records.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the management of medicines. We undertook this focused inspection to check that the provider had followed their plan and to confirm that they now met legal requirements. This inspection was also prompted in part by notification of an incident following which a person who lived at the home died. Information shared with the Care Quality Commission (CQC) about the incident indicated potential concerns about the management of falls. This inspection examined those risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Cherry Hinton Nursing Home' on our website at www.cqc.org.uk.

Cherry Hinton Nursing Home is registered to provide accommodation, nursing, and personal care, for up to 60 people. At the time of our inspection there were 42 older adults, including adults living with dementia living at the home. At this inspection there was an embargo from the local authority in regards to new placements. This embargo was in place due to on-going concerns found at the home.

At the time of this inspection there was no registered manager in post. A new manager was working at the home and they were currently applying to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At our focused inspection on 7 December 2016, we found the provider had followed their plan, and was now meeting the legal requirement around the safe management of people's medicines.

Whilst improvements had been made we have not revised the rating for the key question 'is the service safe?' To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating at the next comprehensive inspection.

We looked at how risks to people's safety and welfare were managed and found people who lived at the home were not protected from harm. This was because the local authority had not been made aware of all safeguarding incidents and medicine errors that had taken place within the home as per safeguarding

protocols.

People were not always safeguarded against the risk of having their freedom restricted in an unlawful manner. The provider had not made sure that applications to the local authority to lawfully restrict a person's liberty had been made when they had been assessed as lacking capacity.

The Care Quality Commission had not been notified by the provider of all safeguarding and medicine errors that they were legally obliged to inform us about.

The provider did not have systems in place to assess and monitor the quality of the service provided at the home. They had had failed to review and investigate incidents that had occurred at the home which had compromised people's safety. The provider had not made sure prompt action was taken to remedy incidents such as, recurrent falls and behavioural issues. Referrals to external specialist health care professionals such as the falls team and the mental health team had not always been made in a timely manner. Prompt referrals would have helped to reduce the risk of further incidents.

A complaints procedure was in place, and we saw evidence that actions were taken to try to resolve complaints. However, we found there was not always documented evidence to show that all complainants were responded to.

We saw that there were sufficient numbers of staff to meet the needs of people living at the home.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations (Part 4). You can see what action we told the provider to take at the back of the full version of the report.

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

We found action had been taken to improve the safe storage, disposal and management of people's prescribed medicines.

People were not protected from harm because incidents of physical abuse had not been reported to the local authority safeguarding team to investigate.

People were not always protected from unlawful restrictions. Applications had not been made to lawfully restrict people's liberty when they were assessed as lacking capacity.

Risks to people's safety were not being managed. Referrals to external healthcare professionals were not always made in a timely manner.

There was enough staff to provide the necessary support and care for people.

Whilst the provider has taken action to make improvements to the management of medicines, further improvements are required to ensure people received safe care and treatment. We could not improve the rating for safe because to do so requires consistent good practice over time.

We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a system in place to receive and manage people's compliments or complaints. However, there was a lack of documented evidence to demonstrate that complainants were always responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in place.

The provider did not have effective systems in place to assess and monitor the quality of the service. They had failed to identify the improvements needed to ensure people received safe care and treatment.

The provider had not notified the Care Quality Commission of all of the incidents they were legally obliged to inform us about.

Cherry Hinton Nursing Home

Detailed findings

Background to this inspection

We undertook a focused inspection of Cherry Hinton Nursing Home on 7 December 2016. This inspection was undertaken to check that improvements, to meet legal requirements planned by the provider after our comprehensive inspection on 19 August 2016, had been made.

We inspected the service against three of the five questions we ask about services: is the service safe? Is the service responsive? Is the service well-led? This was because the service required improvement under these questions.

The inspection was undertaken by two inspectors. Before our inspection we reviewed the information we held about the service. This included the provider's action plan, which set out the action they would take to meet legal requirements by the 30 November 2016.

We also looked at information that we held about the service including information received and notifications. Notifications are information on important events that happen in the service that the provider is required to notify us about by law. We received feedback about the quality of the service provided at a local authority multi-disciplinary team meeting. This meeting was held with the provider due to on-going concerns about the service provided at the home. We used this information as part of our inspection planning.

During the inspection we spoke with one person who lived at the home. We also spoke with two relatives of people living at the home. We spoke with the home manager, a unit manager, the admin manager, two registered nurses, two care workers and an agency staff member. We used observations to help us understand the care provided to people who had limited communication skills.

We looked at accident and incident records from January 2016 to November 2016 and four care records for people living at the home.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection the CQC received information that risks to people's safety were not always being managed by staff at the home. At this inspection we looked at how staff supported people deemed to be at risk of falling or behaviour that challenged themselves and others. We looked at incident and accident records dating from January 2016 to November 2016. Although we saw there were records in place documenting these incidents, we found that there were a number of people at the home who had a high number of falls. Care records prompted staff to, 'be aware of factors that increase the risk of falls.' However, we noted that six people had fallen between nine and 17 times during the time period we looked at. Whilst we saw actions had been taken by staff to attempt to reduce the risk of falls, we found no documented evidence that referrals had been made to the external falls team (specialist team) for advice and guidance on how to reduce the person's risk of falling. This was not in line with the providers falls prevention policy which stated, 'if there has been a change in the frequency of falls. The resident should be referred to the falls clinic.'

One relative told us, "My [family member's] health is deteriorating and they can be quite aggressive towards me. When this happens, it upsets me and the staff care for me, they are really good, they support me, ask me if I am alright and get me a coffee. There are some people living here whose behaviours can be quite challenging to others and the staff, however staff manage this well and I feel my [family member] is safe."

Records we looked at showed that there were reoccurring incidents of people with behaviour that challenged themselves or others. This behaviour sometimes resulted in physical harm to others. Records were being used by staff to document incidents of this nature within a person's care record for long term observations on a routine basis. However, these documents are designed to be used to assess and monitor a person's behaviour over a short time period. We saw that incident forms for one person who experienced regular increased anxiety, documented that that the person, 'would benefit from a referral to the community psychiatric nurse (CPN).' However, we found that although regular incidents dated from April 2016, a referral to the CPN had only recently been made.

We observed there were a high number of bed rails in use, by people living at the home. Bed rails are used to reduce the risk of people falling out of bed. People should only use bed rails where they have been assessed as being at risk of falling from their bed. However, we saw three incidents recorded where people were at risk of injury from bedrails. The home manager told us they were aware they needed to ensure people with bed rails in place were properly risk assessed and only those deemed as needing them for their safety to have them in situ.

This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Staff demonstrated to us an understanding of their duty to report any suspicions of harm or poor care. However, having reviewed accidents and incidents forms we found the provider had failed to notify the local authority of all safeguarding incidents and medicine errors that had occurred in the home between January

2016 and November 2016.

This was a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People were not always safeguarded against the risk of having their liberty unlawfully restricted. We found that no application had been made to the local authority for a person who had been assessed as lacking capacity to make decisions about staff administering their medicines covertly (disguised within food or drink) and the use of bedrails which restricted their movement out of bed. We spoke to the home manager about this and they made an immediate Deprivation of Liberty safeguards (DoLS) application to the local authority.

At our comprehensive inspection of Cherry Hinton Nursing Home on 19 August 2016, we found we could not be assured that people's prescribed medicines were managed safely. During this inspection on 7 December 2016 we found that the provider had made the necessary improvements.

People living at the home and their relatives said they were happy with how medicines were managed by staff. A relative told us due to the care their family member received at the home, there had been a reduction in the medicines they had to now take. They said, "Staff have been fantastic about managing [family members] mental health illness, their medication has now been reduced which is very positive." One person told us, "I have no concerns around [my] medication; I have never had any medication run out."

Arrangements were in place to ensure medication was stored safely and securely and that the medicine trolleys were kept locked. Our observations during this inspection showed people were supported by the nurse to take their prescribed medicines in a kind and patient manner. We saw the nurse explained what the medicine was for and stayed until the person had taken their medicine in full and as prescribed. After each person had taken their medicine, we observed the nurse documented this on the Medicine Administration Records (MAR). We also noted the nurse washed their hands to prevent cross contamination.

Medicines were stored at the appropriate temperature and disposed of safely. We were told by nurses that it was only the nursing staff that administered people's medicines and that they had received training to do this and had their competencies checked. Records we looked at confirmed this. We saw there were clear and detailed instructions on either pharmacy printed MARs charts and/or protocols for staff in respect of how and when people's medicines were to be administered safely. This included those to be given 'when required.' We also noted there were risk assessments in place for people who took their medicines covertly (disguised in drinks or food). These risk assessments documented the reason why the person was taking their medication covertly and the discussion held with the family member / advocate, GP and pharmacist as guidance for staff. This assured us that people's prescribed medicines were being managed in a safe manner.

Our observations showed there were sufficient staff on duty to meet people's assessed needs. We saw staff supporting people and were available when needed. Staff were busy, but they did not hurry people, and supported people at their own pace. One person said, "I feel that there are enough staff. I only have to wait a couple of minutes only [for staff to help]." A relative told us, "I am here every day, and family visit frequently upstairs [dementia floor] can be difficult, but staff manage excellently… I vary rarely use the bell to summon help for [family member], however when I do the staff have come very promptly."

Care records showed people had their dependency levels assessed to ascertain whether they needed support from either one or two staff members. A staff member said, "Staffing is okay; sickness is an issue at

times, but the nurse's step up to help when there are staff shortages. Five new staff have been recruited. All the new staff are very good, staff work as a team. Staff are allocated to corridors to ensure call bells are responded too. Staffing numbers have increased recently. We have one extra person on each shift across the day time hours. At night we have three care staff and one nurse that works across both floors. Both floors are quite settled at night at present." Another staff member told us, "I think there are enough staff, there are normally two staff nurses and four care staff. There should have been five care staff today, but two phoned in sick, one has been covered, but potentially having more staff would mean we would be more able to monitor people when mobilising." This indicated to us that there was a process in place to make sure there was sufficient staff on duty to meet people's assessed needs.

Requires Improvement

Is the service responsive?

Our findings

Prior to this inspection concerns were raised with CQC that complainants who had raised concerns with the provider about the service were not always responded to by the provider.

Records looked at showed the provider had received compliments about the quality of the care provided. People who lived at the home and their relatives had positive opinions on whether they felt listened to if they raised a suggestion or complaint. One relative told us, "If I was unhappy I would have moved my [family member] by now. I am aware of and would use the complaints procedure. I and my family have no worries in any quarter, they [staff] are absolutely marvellous, I need them." A person said, "[There was a] residents meeting a couple of weeks ago, where you can voice any complaints. My meals were always served lukewarm. Since I raised this, the chef came round [to speak to me] and my meals are now hot."

However, we saw that one complaint had been raised by a relative and was investigated as a safeguarding concern. Whilst records we looked at showed the action taken by the manager was to escalate this concern as a safeguarding incident. There was no record that the complainant had been responded to by the provider. This was not in line with the provider's complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

We found that systems and processes were not in place that enabled the provider to identify where quality and safety was being compromised and to take appropriate action without delay.

We looked at how incidents and accidents were managed and responded to. We found that falls, behavioural issues, missing medicines and risks associated with bed rails had been recorded on incident and accident records. However, there was no robust system in place to analyse the information to identify where action was needed to prevent incidents happening again. For example, although a record of the number of falls had been recorded for each month, there was failure by the provider to link recurrent falls, or to link continued episodes of physical harm between people living at the home.

A falls working group was set up and the first and only meeting to date occurred on the 8 June 2016. This showed that all falls from January to June 2016, were looked at, but it was noted there were no noticeable patterns to these falls. However, specific individuals had been identified as high risk, but the only action taken was to, 'ensure all teams are aware of need for close monitoring and timely response to any evidence of individual consistent falling pattern – care plans updated as appropriate.'

The provider's falls prevention policy stated, 'if there has been a change in the frequency of falls. The resident should be referred to the falls clinic.' The failure to have systems and processes in place to identify any continued trends in individuals falling meant they were not referred to specialist external health care professionals, as per the falls policy. This meant that there was a failure by the provider to assess and analyse information gathered to identify where action was required to reduce the risk of incidents reoccurring.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

At this inspection we found CQC had not been notified by the provider of all of the safeguarding incidents and medicine errors they were legally obliged to notify us about in a timely manner. We spoke to the home manager during this inspection and they told us that they would make the necessary improvements.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

There was no registered manager in place. A new home manager was in place and they told us that they were currently applying to the Care Quality Commission to become the registered manager. The manager was supported by care staff and non-care staff. Staff spoke highly of the new home manager and their colleagues. A staff member said, "Good team work, nice staff to work with. I have worked in other nursing homes, but Cherry Hinton [Nursing Home] has a homely feel. The environment and atmosphere is very good."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (1) (2) (e) Care Quality Commission (Registration) Regulations (Part 4): There was a failure by the provider notify the Care Quality Commission without delay of all incidents that they are legally obliged to do so whilst carrying out the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) HSCA RA Regulations 2014 Safe care and treatment: People were placed at risk of avoidable harm or risk of harm. This was because risks to people's health and safety had not been properly assessed and actions identified to mitigate such risks. There was a failure to report internally and to relevant external authorities of incidents that affect the health, safety and welfare of a person using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) HSCA RA Regulations 2014 Safeguarding service users from abuse and proper treatment: The provider had failed to notify the local authority as per safeguarding protocols, of all

safeguarding incidents and medicine errors that had happened at the home in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good Governance: There was a failure by the provider to have systems and processes in place that enabled the provider to identify where quality and safety was being compromised and to respond appropriately and without delay.
Treatment of disease, disorder or injury	