Mr Alan Hannon

Threen House Nursing Home

Inspection report

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Date of inspection visit:
16 November 2016

Date of publication:
07 December 2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 16 November 2016 and was unannounced. Following our last inspection in July 2016 we issued the provider with a Warning Notice that required them to improve risk management, staff training and the ways staff supported people with moving and handling. The provider sent us an action plan on 8 September 2016 telling us about the actions they had taken. Although they were not able to say when they would achieve compliance with the Warning Notice, the provider had made contact with the Clinical Commissioning Group (CCG) to request assessments of people's care needs and arranged training for staff. We carried out this inspection to check whether the provider had addressed the issues highlighted in the Warning Notice and made the required improvements to the way people were cared for and supported. We found that the provider had made some progress to address the concerns we raised but further action was needed to ensure people were cared for safely.

Threen House is a registered care home for older people who require nursing or personal care, some of whom are living with the experience of dementia. The service can accommodate up to 26 older people, in single or shared rooms. At the time of this inspection, 16 people were using the service. The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous registered manager left the service in May 2016. The provider appointed a new manager in June 2016 but they left the service in July 2016. The provider then appointed the current manager in August 2016. The manager told us they were waiting for their Disclosure and Barring Service (DBS) check to enable them to register with the Care Quality Commission.

We found the provider had made some improvements to the way they assessed and managed risks to people using the service but this was not consistent. Some risk assessments provided clear information and guidance for staff but others were not completed correctly and did not reflect people's care and support needs.

We found a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider and manager did not ensure they followed the service's policy for risk assessment, risk management and care planning and failed to carry out audits of completed risk assessments and care plans to ensure these were completed correctly.

There were sufficient staff to meet people's care needs and the provider had carried out checks on new staff to make sure they were suitable to work with people using the service.

The provider and manager had arranged for an external trainer to provide moving and handling training for all nurses and care staff and had obtained some new equipment. The provider was also trialling other

equipment on loan from the local Clinical Commissioning Group (CCG) to address the specific moving and handling needs of one person. During the inspection we saw staff supported people in a safe and caring way when they helped them to move around the service. Occupational therapy staff from the CCG had assessed the mobility, moving and handling support needs of each person using the service.

There were enough staff to care for and support people and we saw they did this in a caring and professional way. The provider worked regularly in the service as a care assistant.

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

Some aspects of the service were not safe.

The provider had improved the way they assessed some risks to people using the service but they did not do this consistently.

There were sufficient staff to meet people's care needs and the provider had carried out checks on new staff to make sure they were suitable to work with people using the service.

There were enough staff to care for and support people and we saw they did this in a caring and professional way. However, we did note that the provider also worked extended periods in the service as a care assistant, without sufficient breaks.

Threen 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 took place on 16 November 2016 and was unannounced. One inspector and a Specialist Professional Advisor (SPA) carried out the inspection. The SPA for this inspection was a qualified nurse.

Following our last inspection in July 2016 we issued the provider with a Warning Notice that required them to improve risk management, staff training and the ways staff supported people with moving and handling. We carried out this inspection to check whether the provider had addressed the issues highlighted in the Warning Notice and made the required improvements to the way people were cared for and supported.

Before the inspection we reviewed the information we held about the provider and the location. This included the last inspection report, the action plan the provider sent to us following that inspection and statutory notifications the provider sent us about significant incidents and events that affected people using the service.

During the inspection we spoke with eight people using the service and five members of staff, including the provider, the manager, nurses and care staff. We also spoke with staff from the local Clinical Commissioning Group (CCG) who were assessing the mobility, moving and handling needs of people using the service. We reviewed the care records for four people, including their care plans and risk assessments, three staff recruitment and training records and the staffing rota.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2016 we found people using the service were not always safe as the provider did not produce risk management plans to mitigate risks to people and staff did not have guidance on how to manage risks in the service. We also found people were at risk because staff did not follow manual handling assessments or guidance and people were not always transferred safely, for example from an armchair to a wheelchair. The provider sent us an action plan on 8 September 2016 and told us they had introduced "a new format of detailed risk assessment on all service users regarding moving and handling."

During this inspection we looked at the care records for four people and found the manager had completed new moving and handling risk assessments for each person. The assessments included information about people's ability to move independently and any support they needed from care staff. The manager had transferred information from the risk assessments into people's care plans where we saw they gave staff guidance on the level of support each person needed. The manager told us they were incorporating advice, from the Clinical Commissioning Group's (CCG's) occupational therapists who had visited the service to assess each person, into their care plans.

We also saw the provider had purchased some new moving and handling equipment and was working with the CCG to trial other equipment to assess its suitability for use with people using the service. Individual items of equipment, such as wheelchairs and hoists, were clean and in good working order. Staff reported that they checked and cleaned mattresses and bedrails regularly. The occupational therapists assessing people's care and support needs told us two people received all of their personal care in bed and the service needed to provide height-adjustable beds to enable care staff to provide this care safely. We discussed this with the provider and manager who told us they would arrange for the beds to be provided.

During the inspection we observed staff on a number of occasions when they supported people with transfers from their armchairs to wheelchairs and when they moved around the service. We saw they did this in a calm, caring, safe and professional way at all times. Staff were professional and appropriately safe in explaining how they were going to help the person to move to go to the toilet. Throughout the inspection, staff communication with people using the service was warm and friendly, showing caring attitudes whether conversations were outwardly meaningful or not. Relationships were good between team members. Individuals were courteous, quiet mannered and friendly. People enjoyed talking to staff and all staff appeared to be enjoying their work.

Staff were able to describe appropriate moving and handling techniques they used when transferring people who were in wheel chairs and they told us they worked in pairs, as required. Staff confirmed they were trained and updated yearly with moving and handling training. Their comments included, "We should always transfer in two's and we get training to do this. We maintain dignity in moving.'' Floor areas were generally uncluttered with space for manoeuvring wheelchairs. However, there was limited storage space for equipment, and these were kept in bathrooms, on corridors or in the lounge area. Staff told us, "We get help from the occupational therapists and have an assessment process which identifies manual handling tasks and residents for which mechanical aids should be used. We have slide sheets, stand-aid hoists and

adjustable height beds and chairs."

However, some people may have been at risk of unsafe care or treatment as other risk assessments the manager and staff had completed did not always accurately reflect the level of risk to people using the service. For example, we saw pressure care risk assessments for three people where staff had not totalled the scores correctly and the assessments showed a lower level of risk than the assessment indicated. One person's falls risk assessment indicated they were at medium risk of falling but there was no guidance for staff on how to mitigate the risk. Staff had not scored another person's falls risk assessment correctly and this showed a lower level of risk than the assessment indicated. This assessment was also not dated and it was not possible to see if staff were reviewing the person's care needs regularly. The bed rails risk assessment for this person was dated 30 June 2015 and there was no record that staff had reviewed or updated this.

Where risk assessments recognised risks to people using the service, there was not always a detailed risk management plan with guidance for nurses and care staff on how to lessen the risk. For example, where people were at risk of falling, there was partial guidance for nurses and care staff on how to decrease the risk but this lacked detail. Some care plans were also inconsistent and did not take on board other evidence in the notes. Some written information was unclear and ambiguous. For example, a care plan for continence assessment said, "No issue with mental state." However, elsewhere on the person's notes it said that, "Sometimes she presents with agitation during personal care…and can be confused and disorientated. This can make her restless. She also has a diagnosis of depression and is on an antidepressant." This may have resulted in staff not fully understanding the person's care needs in a way that would enable them to support and care for them appropriately.

Another care plan did not detail how nurses and care staff should support the person concerned if they became upset or distressed. For example, the plan said this person "grabs staff hands and has scratched people" but there was no information or guidance on what actions staff should undertake or what they should look out for to minimise this. As the service had recently appointed a number of new nursing and care staff, people's care plans needed more detail to ensure staff had the information they needed to care for and support people safely.

This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider and manager did not ensure they followed the service's policy for risk assessment, risk management and care planning and failed to carry out audits of completed risk assessments and care plans to ensure these were completed correctly.

Risk assessments for other people were completed correctly and we saw evidence staff had taken appropriate action based on the assessment. For example, one person's nutrition risk assessment showed they were at high risk. The provider referred the person to the dietician who gave staff a fortified meal plan. Another person's moving and handling assessment included a safer handling plan that gave staff some guidance on how to support the person safely. This person's care records also included a skin integrity care plan that included clear guidance for staff on the prevention of pressure sores.

At our last inspection we found people may have been at risk of unsafe care as the provider did not always carry out pre-employment checks before staff started to work in the service. At this inspection the staff recruitment records we reviewed included application forms, references from previous employers, proof of identity and the right to work in the United Kingdom and Disclosure and Barring Service criminal record checks.

Also at our last inspection we could not be sure that staff supporting people had the correct skills as the provider did not follow systems to assess their understanding of the training they completed or their competence. We asked the manager for the service's training record and this showed that most staff had completed video based training modules in areas the provider considered mandatory. This included food hygiene, infection control, safeguarding and health and safety. The manager told us they had ensured people completed workbooks following the video training and they would review these as part of each member of staff's supervision.

The provider had also arranged for an external trainer to provide moving and handling training for all nurses and care staff working in the service. The training took place on 9 September 2016 and a total of 18 staff completed the training. The manager showed us the slides the trainer had used to explain the theory of safe moving and handling and confirmed the session had also included the correct use of equipment used in the home, including hoists and wheelchairs. One member of staff told us, "We have all of the equipment we need, but I have been away for a bit and I have not had my re-training as yet." This member of staff was not able to explain how to use the new equipment, but said, "Training was coming up soon."

We did note that the provider worked as a care assistant in the service and was included on the rota as a member of staff on shift on the days they worked. However, we did not see the provider's name on the training record or the attendance record for the manual handling training. As we could not evidence that the provider had completed the training they needed we discussed this with them during the inspection and they confirmed they had completed all of the training.

We also noted that the staff rota showed the provider worked as a care assistant in the service and was due to work 14 days without a break between 6 and 19 November 2016. We discussed this with the provider who agreed that staff working extended periods without adequate time of may be less effective or more likely to make mistakes. The provider and manager agreed they would not expect another member of staff to work extended periods without a day off. Following the inspection the manager confirmed they had updated the training records to include the provider and that the provider would, in future, take a day off each week.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users as the registered person did not assess the risks to the health and safety of service users. Regulation 12 (2) (a)