Quality Care Management Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**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 15 and 19 May 2015. Breaches of Regulation 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found. Following this inspection we served warning notices on the registered provider of the service requiring them to be compliant with the Regulations by 7 August 2015.

We undertook this follow up inspection on the 30 December 2015 to check the registered provider had met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Quality Care Management t/a Aquarius Nursing Home on our website at www.cqc.org.uk

Quality Care Management t/a Aquarius Nursing Home is a nursing home where personal and nursing care is provided for up to 38 older people, most of whom live with dementia. The home consists of three Victorian houses linked by a corridor. During our inspection 37 people were living at the home.

A registered manager was in place. 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.

At this inspection we found the service had not met all the requirements of the Regulations to meet the fundamental standards.

Risks associated with people's specific care needs had not been assessed. Plans of care did not identify how risks to people could be reduced.

Medicines were not always administered in a way which ensured the safety and welfare of people.

Systems were in place to reduce the risk of cross infection as the registered manager had implemented a robust system of audit and review for this.

Staff had not always accessed or completed training to ensure they had the appropriate skills to meet the needs of people.

Whilst the registered provider had systems in place to review the quality of the service they provided and ensure their service met the needs of people, these were not always fully implemented.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of this 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?

Inadequate

The service was not safe.

Risks associated with people's specific care needs had not been assessed and plans of care in place for people did not reflect these risks or how they could be reduced.

Medicines were not always administered in a way which ensured the safety and welfare of people.

Systems were in place to reduce the risk of cross infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Whilst training was available for staff they had not always completed this. Staff did not always have the skills and knowledge to meet the needs of people safely and effectively.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems in place to review the quality of service provided for people to ensure their safety and welfare were not always effective.

People had the opportunity to feedback to the registered provider about the quality of the service they received at the home.

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Detailed findings

Background to this inspection

We carried out this follow up 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, and to look at the overall quality of the service.

We undertook an unannounced follow up inspection of Quality Care Management t/a Aquarius Nursing Home on 30 December 2015. This inspection was completed to check that improvements to meet legal requirements had been completed by the registered provider after our comprehensive inspection of the service in May 2015. The service was inspected against three of the five questions we ask about services: Is the service safe, is the service effective and is the service well led? This is because the service was not meeting some legal requirements.

The inspection team consisted of an inspector, a specialist advisor in the care of frail older people, especially people living with dementia, and an expert by experience in the care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and the warning notices served on the registered provider. We reviewed notifications of incidents the registered manager had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with six people who lived at the home and four relatives to gain their views of the home. We observed care and support being delivered by staff in all areas of the home. We spoke with the registered manager and a senior manager for the registered provider. We spoke with seven members of staff, including two registered nurses, care staff and ancillary staff.

We looked at the care plans and associated records for six people who lived at the home. We looked at records relating to the management of the service including records of accidents and incidents, audits, staff supervision records, staff training records and quality assurance documents.

Inadequate

Is the service safe?

Our findings

At our inspection on 15 and 19 May 2015 we found there was a lack of timely, thorough and accessible risk assessments in place to ensure the safety and welfare of people. Medicines were not always recorded appropriately to ensure the safety and welfare of people and infection control procedures were not always followed. This was a breach in Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We issued a warning notice to the registered provider requiring them to be compliant with this Regulation by 7 August 2015.

We found at this inspection, whilst some steps had been taken to address these breaches of the Regulation, the registered provider had not taken sufficient action to achieve full compliance in all aspects of this legal requirement.

Risk Assessments had not been completed to reflect the risks associated with the care people required and received. The safety and welfare of people who lived at the home had not always been reviewed and plans of care adjusted to reduce or mitigate these risks.

One person had returned to the home following a fall, serious injury and subsequent surgical treatment in hospital. Risk assessments and plans of care to meet their complex health and social needs on return from hospital had not been completed. Care records did not identify how this person's needs had changed. The risks associated with their care including the high risk of falls, the risks associated with reduced mobility and with a surgical wound had not been identified or assessed and plans of care were not in place to mitigate these risks. Care records demonstrated this person's condition had deteriorated; they were drowsy which may have been an indication of ill health and was not usual for them. They required extensive support to maintain their safety and welfare. We spoke with the registered manager and nominated individual for the service about the lack of risk assessments and appropriate plans of care for this person. They told us this person would be reviewed as a matter of urgency. We referred this person to the local safeguarding authority as we were concerned for their safety and welfare. None of the risks associated with this person's care had been identified by staff as a cause for concern.

Risk assessments in place for people who were at risk of choking or had difficulties with swallowing had not always been updated to reflect the information available from external health professionals who had assessed their needs. A care plan in place for one person identified the person should only be supported by senior care staff or nurses to manage their dietary intake. There was no information in this care plan or risk assessment to identify why this was required and how senior staff or nursing staff should support the person. Two registered nurses told us that it was only the senior care staff or registered nurses who may recognise when the person was having difficulty swallowing when they were feeding the person. However risk assessments in place did not reflect the risks associated with the care this person required.

Risk assessments in place relating to the management of wounds and skin integrity lacked clarity and often were not completed. The registered manager told us one person at the home had a wound which required

nursing intervention and monitoring. Care records showed three people had pressure injuries and one had a facial injury. None of these care records held appropriate risk assessments and related care plans about these injuries.

One person who was sat in a communal area of the home called out for help and support in a distressed way regularly during our inspection. Other people were clearly agitated and disturbed by this behaviour. We reviewed this person's care records and saw that this was recognised by staff as a behaviour the person frequently displayed. People and their visitors told us this occurred regularly. We looked at their care plan for risk assessments, behaviour monitoring and support plans and found there were none. We spoke with the registered manager about this person as we could not locate a referral to a health care professional in relation to this behaviour, the risk it posed to the person and others who were clearly agitated by this behaviour. The registered manager told us, "There is none [referral] but it's a good idea". Risks associated with this person's behaviour and plans of care to meet this identified need had not been completed.

For another person, staff had identified they required one to one support at all times to ensure their safety and welfare. We saw that this person received this support however risk assessments and care plans had not been updated to reflect this need.

At our inspection in May 2015, the registered provider had used a computerised system of care planning and risk assessment to review the risks and subsequently plan care for people. At this inspection a new system of paper records had been introduced to support staff in reviewing risks associated with people's care and implementing plans of care from these. This system was not effective and paper records lacked appropriate detail on the risks associated with people's care and plans of care were not informed from these. Registered nurses were unclear as to how they were required to update risk assessments and care plans to reflect new risks. There was no clear guidance available for registered nurses on how these documents should be completed.

The lack of assessments of the risks associated with people's care together with the lack of clear plans of care in place to mitigate these risks was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines which had been prescribed as required (PRN) were not always administered and monitored in a way which was effective and ensured the safety and welfare of the person.

One person had been prescribed a medicine for severe agitation. Whilst a PRN protocol and a plan of care were in place for the administration of this medicine, there were no supporting records to show the required actions were taken prior to and following the administration of this medicine. Medicine administration records (MAR) were not clear and did not show appropriate actions had been taken in the administration of this medicine.

For this person, a medicines care plan told staff to monitor for the side effects of their medicines such as low blood pressure. There was no evidence this action had been taken to ensure the safety and welfare of the service user.

For a second person, information from a health care professional identified staff were to monitor their blood glucose levels three times per day on discharge from hospital as their medicines had been changed. There were no records to demonstrate this action had been completed for the first six days following the person's discharge from hospital. This person was at risk of unsafe administration of medicines as staff had not taken all the necessary actions to ensure their safety.

This person had been prescribed a medicine for thinning of the blood. There were no risk assessments or plans of care in place to identify the risks associated with the administration of this medicine.

A topical medicines administration chart (TMAR) was available for use when people had medicines such as creams and lotions to be applied. However these records were incomplete and did not reflect the medicines had been administered as prescribed. For six people who required these medicines to be applied by staff, the care records in their rooms did not demonstrate regular or consistent application of these medicines.

Policies and procedures in place in relation to the administration and management of medicines related to the 2010 Regulations of the Health and Social Care Act 2008. These were replaced by the 2014 Regulations which came into force in April 2015; whilst the medicines policies were dated April 2015 they had not been updated to reflect current legal requirements. Guidance available for staff on the administration and management of medicines did not reflect current guidelines and information.

Medicines were administered by registered nurses who had received updated training on this skill. They interacted with people kindly and calmly to encourage them to take their medicines, informing them what they were for and ensuring medicines were taken before going on to the next person. The registered provider had systems in place to ensure staff were provided time to administer medicines without being distracted and taken away from this task. However staff did not always use this system. We saw two registered nurses did not utilise the red 'Do not Disturb' tabard system which was in place to identify they were administering medicines and should not be interrupted. The registered nurses were frequently interrupted by others during the medicines round. This increased the length of time the medicines round took to complete and could increase the risk of misadministration of medicines.

The lack of clear systems, accurate records and associated medicines care plans and risk assessments in place to ensure the safety and welfare of people during the administration of medicines was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had implemented robust schedules for cleaning and the maintenance of infection control procedures at the home. All areas of the home were clean although some areas required maintenance which was being attended to on the day of our visit. People and their visitors told us they found the home to be very clean and hygienic. One visitor said the home was clean and well lit. Another told us they always found the home to be clean and tidy. Staff had access to personal protective equipment such as gloves and aprons. Alcohol gel pumps and soap dispensers were provided throughout the home and equipment such as hoists, slings, commodes and bed tables were clean. Domestic staff had a clear schedule of cleaning activities to perform throughout their duties and this was clearly audited and monitored by the registered manager.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 15 and 19 May 2015 we found staff did not receive regular formal supervision or adequate training to ensure they could safely meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the registered provider requiring them to be compliant with this Regulation by 7 August 2015.

At this inspection we found the registered provider had not taken sufficient action to achieve compliance with this legal requirement as training records identified staff had not received all the training they required to meet the needs of people.

The registered provider had employed the services of an external training organisation to ensure staff had access to all the training they required to meet the needs of people. However, records of training provided for, and completed by nursing and care staff, showed significant numbers of staff had not received training in line with the needs, or to maintain the safety and welfare, of people.

For example, of 30 care staff, records showed only four members of staff had completed training on infection control, 18 members of care staff had not received moving and handling training and 12 had not received training about safeguarding adults. Records showed staff had not always received the training they required to ensure the safety and welfare of people.

Of eight registered nurses five had not completed infection control training, seven had not completed training on safeguarding adults and six had not completed training on the Mental Capacity Act 2005.

Staff told us they had access to training, some of which could be completed on line and that more training was planned in the near future. They were unable to remember what training was planned, however staff told us they discussed and prioritised their training needs at their supervision sessions with the registered manager and registered nurses.

The registered manager identified a significant amount of time and effort had been invested in ensuring staff had access to the training they needed to meet the needs of people in the home and that this was continuing at the time of our inspection. However, we were not assured staff had received the appropriate training required to ensure the safety and welfare of people.

The lack of training completed by staff to ensure they were able to meet the needs of people was a continued breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager showed us the records maintained of supervision sessions held for nursing and care staff. Staff confirmed they had received supervision and found this time helpful for identifying any training needs they may have or for raising any concerns they may have. They felt the registered manager supported them to use these sessions positively to develop their role in the home.

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 15 and 19 May 2015 we found there was a lack of a robust quality assurance system in place. This was a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We issued a warning notice to the registered provider requiring them to be compliant with this Regulation by 7 August 2015.

We found at this inspection, whilst the registered provider had taken some steps to address these breaches of the Regulation, this legal requirement had not been fully met.

Systems in place to review and audit the quality of the service provided for people were not always adequate or effective. Whilst audits of medicines and care plans had identified some concerns which we had raised at this inspection, there were no actions planned to address these. Audits of medicines and care plans which showed areas of discrepancies did not contain any information on how these should be addressed. Whilst areas of concern may have been identified, no action was identified to ensure this was addressed and monitored.

The registered manager told us they had identified to the registered provider their concerns about care plans and the quality of the information in these. A head of care, who was not available on the day of our visit, was responsible for the management of care plans and the auditing of these. They had completed a "Care Audit and Action Plan" document for each person who lived at the home at the beginning of December 2015. These documents rated the information in a care plan on a scale of one to five in accordance with the information provided in the care record. A rating of one showed, "Many significant shortcomings" and a rating of five showed, "No significant shortcomings".

We reviewed seven of these care plan audit records. Each of these records identified the care records held some information which had, "Many significant shortcomings." Of 203 entries across the seven audits, 29 of these rated the information provided in the care record as one, showing many significant shortcomings. There was no supporting information in the record to identify why this was the case and how this should be addressed. Each had an entry to state the information required action by 31 December 2015; however there was no information to identify what action was required, by whom and to confirm any action had been taken. Whilst systems were in place to monitor the quality of the service provided these were not used to ensure the safety and welfare of people.

The lack of adherence with systems and processes in place to assess, monitor and improve the quality of service provided for people was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager met with or spoke in a telephone conference with the registered provider weekly. This ensured they were able to discuss any ongoing issues, concerns, audits and information about the service. The registered manager told us this was very supportive of their role. They had a system of reports they provided for the registered provider weekly.

Incidents and accidents were logged, reviewed by the registered manager monthly and then forwarded to the registered provider. A system in place identified any trends in these occurrences and information in people's care records reflected these incidents and the actions taken to prevent their recurrence.

Audits had been completed on infection control practices and identified significant improvements in the management of cross infection since our inspection in May 2015. This included an outbreak of an infectious disease which was well documented and had been managed effectively by the home.

The provider had sought feedback in the past six months from people who lived at the home and their relatives. The feedback from these questionnaires showed people were very happy with the quality of service they and their loved ones received at the home. The registered provider had tried to engage with health and social care professionals who visited the home through a questionnaire but had received no feedback.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1)(2)(a)(b)(g) Care and treatment was not always provided in a safe way for people. Risks associated with people's care were not always assessed and appropriate actions taken to mitigate these risks. Medicines were not always administered in a safe and effective way.

The enforcement action we took:

Imposed condition to prevent admission to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1)(2)(a)(b) Systems or processes were not established or operating effectively to assess, monitor and improve the quality of the services people received. Risks associated with people's care were not assessed, monitored and actions were not taken to mitigate these risks.

The enforcement action we took:

Imposed condition to prevent admissions to 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 18 HSCA RA Regulations 2014 Staffing Regulation 18(2)(a) The provider had filed to ensure person's employed in the service had received appropriate training to carry out the duties required of the to meet the needs of people.

The enforcement action we took:

Imposed a condition to prevent admissions to the service.