

P M Tripp

Kestrel Grove 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 effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

This inspection was carried out on 6 October 2015 and was unannounced.

Kestrel Grove Nursing Home provides accommodation and personal care for up to 57 older people, some of who live with dementia. There were 55 people living at the service on the day of our inspection. There was a registered manager in post. 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.

When we last inspected the service on 26 November 2013 we found them not to be meeting the required standards in relation to their management of medicines. At this inspection we found that they had addressed the shortfalls identified previously, however, there were areas that required improvement. These areas related to the

Summary of findings

security of the home, pressure care equipment, moving and handling, infection control and the recording and storage of medicines. In addition, there were areas in relation to relationships between people and staff.

CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had been made to the local authority and authorised in relation to people who lived at the service. Staff were not clear of their role in relation to MCA and DoLS and required further support to improve their understanding. This included assessing people's capacity to ensure they were decision specific to promote people's autonomy.

People received care that met their needs and care plans included up to date information. People were positive about the staff and how they were supported, however, at times support was task orientated and lost the personal, holistic approach. Activities were limited and required some improvement to reflect people's individual strengths, hobbies and interests.

There was a variety of food and people enjoyed their meals. There was appropriate support for people to eat and drink sufficient amounts. People had access to health and social care professionals.

People knew how to make a complaint and these were acted on appropriately. Feedback was sought through meetings and surveys. There were systems in place to enable the manager to identify and address any issues. People, their relatives and staff were positive about the management team.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

The building was not secure during the day.

People did not always have their pressure relieving and moving and handling equipment used correctly.

Individual risks were assessed and reviewed.

Management of medicines required improvement.

Requires improvement



Is the service effective?

The service was not always effective.

People were supported by staff who were appropriately trained and supported. However, staff did not always work in accordance with their training.

People's mental capacity was assessed. However, this was done in its entirety increasing the possibility of decisions being taken out of people's hands.

The food was varied and enjoyed. People received appropriate support to eat and drink.

There was access to health and social care professionals as needed.

Requires improvement



Is the service caring?

The service was not always caring.

People were positive about staff. However, we observed only limited meaningful interaction between staff and people.

People were involved in the planning of their care.

Privacy was promoted.

Requires improvement



Is the service responsive?

The service was not always responsive.

People mostly received care that met their needs. However, assessed moving and handling techniques were not always used.

Activities were provided but work was needed to reflect people's individual strengths, hobbies and interests.

People knew how to make complaints and these were responded to appropriately.

People's feedback was sought through meetings and surveys.

Requires improvement



Summary of findings

Is the service well-led?

The service was not always well led.

People were positive about the manager and the provider.

There were systems in place to identify and address any issues.

The management team were looking at ways to drive improvement through the service.

Requires improvement



Kestrel Grove 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This visit took place on 6 October 2015 and was carried out by an inspection team which was formed of two inspectors. The visit was unannounced. Before our inspection we

reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with seven people who lived at the service, four relatives and visitors, 10 members of staff, the registered manager and we met the provider. We received feedback from health and social care professionals. We viewed four people's support plans and three staff files. 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 due to complex health needs.

Is the service safe?

Our findings

When we inspected the service on 26 November 2013, we found them not to be meeting the standards in relation to the management of medicines. At this inspection we found that they were now meeting the standards, however, there were still areas that required improvement.

When we arrived at the service we found both medicines trolleys that were in use, open, unattended and accessible to people, staff and workman in the area. The nurses were in bedrooms administering medicines. We also found two of the eight medicines we counted had a discrepancy in the quantity recorded and the amount held in stock. Further investigation showed that this was a counting and recording error as opposed to an administration error but this, in conjunction with the unlocked and unsupervised trolleys required improvement. However, we saw that medicines charts were generally completed clearly and handwritten charts were countersigned. We saw open medicines were dated and nurses followed safe working practice when dispensing and administering medicines. This helped to ensure that people received their medicines in accordance with the prescriber's instructions.

People told us they felt safe at Kestrel Grove. One person said, "I feel safe here they [staff] look after me well." However, staff were not clear on how they reported concerns externally and some staff were unable to describe what abuse was and we were unable to ascertain if they were aware of the need to report unexplained bruising due to them not understanding what we asked them. Also, there was no information displayed through the home about safeguarding people from abuse or informing staff on how to whistleblow should they be concerned about a person's safety or welfare. We asked the manager if they reported any unexplained bruises or injuries and they told us they had not needed to but would if the situation arose. However, we were not confident that staff would identify unexplained bruises as a possibility of abuse and therefore the manager would not be able to investigate appropriately.

People had their individual risks assessed and reviewed. We saw that there was clear, accessible information available to staff to enable them to support people safely. However, we observed that all of the pressure relieving mattresses we checked were set to the wrong weight for people and one person assessed as at high risk of

developing a pressure ulcer was not sitting on a pressure relieving cushion, or indeed any type of cushion. Therefore this increased the risk of people developing a pressure ulcer. We brought this to the manager's attention who immediately instructed a nurse to check and appropriately set the mattresses and the deputy manager developed and implemented a daily mattress audit to reduce the risk of a reoccurrence. We also observed poor moving and handling techniques. In one instance a person had the hoist footplate pulled away from their feet briskly with no support to their legs and feet, and another a person was lifted under their arms and quickly spun round from their wheelchair to the armchair. Staff spoken with told us that they understood that they must use the hoist for people who required it. We saw that this person was assessed as needing the hoist for transfers. We brought this to the manager's attention at the time of the incident.

Slings used for transferring people with the hoist were not for individual use. Staff told us that only people with MRSA would have their own sling, otherwise three or four people would use the same sling. We brought this to the manager's attention who told us that slings were available but staff were, "Cutting corners." This increased the risk of cross infection as people were hoisted for personal care and when using toilet facilities. We also saw that there were cleaning chemicals accessible throughout the home, in corridors and bathrooms. The manager told us that they had a COSHH risk assessment and these chemicals being left out did not pose a risk to anyone as there was no one living at the home who was at risk of ingesting them. However, we noted that over half the people living at the home had a diagnosis of dementia and this increased the risk of chemicals being mistaken for a drink.

On arrival at the home we were able to walk directly into the building as the door was unlocked. We were able to access people's bedrooms, the medicines trolleys and all areas of the building without challenge from staff. We asked staff about this who told us they unlock the door in the morning. We spoke with the manager about this who told us, "We operate an open door policy here." We raised concerns regarding the safety implications of everyone being able to access people's home without restriction and recommended that this was addressed to ensure people were kept safe.

Due to the concerns in relation to security of the building, pressure equipment not being used correctly, medicines

Is the service safe?

not being correctly recorded and being accessible, communal use of slings and the lack of staff knowledge in relation to safeguarding people from the risk of abuse, this was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

Accidents were recorded in detail and each month the manager completed an accident audit which looked for trends and themes. They also checked to ensure all remedial action had been completed. This helped to reduce the risk of a reoccurrence.

People gave mixed views about whether they were supported by appropriate numbers of staff to meet their needs. One person told us, "If I ring my bell sometimes when it is a busy time I have to for a wait long time." Another person said, "They [staff] take a long time to answer the bell and this is all the time. It seems that there are not enough of them." We saw that on most occasions call bells were responded to quickly and people received the support they requested. However, on one occasion we saw that it took ten minutes for a person who was in need of assistance to use the toilet to have their bell answered. We noted that the nursing staff also got involved in

providing care to help ensure people's needs were met. Staff told us that sometimes they were busy. One staff member said, "Staffing can be short at times but when we are full staff is ok. In the holiday periods we cannot cover all the shifts." The manager told us they did not use agency staff as they had their own bank staff. they also said that they could manage to meet people's needs even if up to two staff did not work their shifts, due to the support in numbers of nurses on duty and 'tray staff' who ensured people had food and drink. We saw from the rota that staffing levels were set as we observed on the day of inspection and confirmed that staff absence was not covered as explained by the manager. The manager told us if people's dependency changed then this would be reviewed and staffing levels adjusted accordingly.

People were supported by staff who had been through a robust recruitment process. Staff files included the appropriate pre-employment checks which included verified references, criminal records checks and proof of identity. This helped to ensure that staff employed were fit to work with vulnerable people.

Is the service effective?

Our findings

People felt that they were supported by staff who were appropriately trained. One person said, “Staff are very knowledgeable; they know how to look after me.”

Staff told us that they received regular training. One staff member said, “We have good training here, I do enjoy training. We had, infection control, Manual handling. I did NVQ2.” We saw from records that training was up to date. However, although this training was up to date, it was not always effective as we saw poor practice in relation to moving and handling and infection control.

Staff received regular one to one supervision and annual appraisal. We saw that these meetings gave opportunity for staff and management to discuss things and plan any further training requirements. Staff told us they felt supported. The manager was in the process of implementing a more in-depth appraisal form to ensure that all aspects of the staff member's role was covered.

People had their ability make decisions assessed. However, we noted that mental capacity assessments stated that people lacked capacity as a whole and not in specific areas. For example, in relation to financial decisions. As a result, at times we saw that people living with dementia, or those being cared for in bed, had day to day decisions taken away from them. For example, in relation to what they wanted to watch on television. We also saw from survey results that people had identified the lack of involvement in decisions as an issue. Issues detailed were in relation to if a person being able to choose if they wanted their curtains opened and one person complained of being told what to do. Staff knowledge around this area was limited. Although tasks appeared to be being completed in a

person's best interests, there were no documented best interest decisions and staff did not grasp the concept of people's individual abilities. One staff member described what the mental capacity Act 2005 meant to them, they told us, “If a person cannot take decisions on their own and they need help or somebody to take decisions for them.” Another staff member said, “[Direct quote] Mental from residents if they are ok or they have dementia.” This demonstrated a blanket approach and did not reflect people's individual strengths in relation to making their own decisions.

This was a breach regulation 11 of the Health and Social Care Act (Regulated Activities) 2014.

People told us that they enjoyed the food and there was plenty of choice. One person said, “The food is nice and if I don't like something I can always ask for something else.” We saw that people were suitably supported to eat and drink sufficient amounts. This was monitored and recorded where needed. We also saw that appropriate referrals were made to health care professionals where needed. There was a colour coded tray system in place to alert staff to the individual needs of people. For example, if they were able to eat independently, if they required supervision and if they needed full assistance to eat. People who required supervision or assistance were allocated to a staff member each day to ensure they received the appropriate support.

There was regular access to health care professionals. We saw that where a GP was needed, they were called. One person told us, “I can have the GP when I need it.” we saw that there were also visiting opticians, chiropodist and a hairdresser. One of these visiting professionals told us, “I love it here, I worked in other homes as well but they were nothing like this.”

Is the service caring?

Our findings

People told us their privacy and dignity was respected. One person said, “Staff are caring, respectful and they have patience.” Another person said, “I feel that staff looks after my privacy and dignity.” We saw that staff explained to people what they were doing while they supported them. However, on two occasions, we saw they carried out tasks very quickly without giving the people time to respond and walked away quickly afterwards. One relative told us that they worried staff might not notice that their relative might be cold or need a drink as they often rushed around. We saw that staff knocked on doors before entering, however, most doors were open for the duration of the inspection and it was not documented if this was practice or common practice. One person told us, “I always leave my door open day and night.”

People who lived at the home and their relatives were positive about the staff that supported them. One person said, “I have seen other homes as well but this place is very good, they are all kind and caring.” A relative told us, “Staff are very welcoming and very nice.” Another told us, “I can recommend this place to anybody. I cannot fault the care.” However, we did not observe many examples of established relationships. We saw one staff member sitting and chatting with a person while they ate their lunch and an activities organiser laughing and chatting while playing bingo. Other than that we did not see staff engage in

meaningful interaction with people. While staff were supporting people to eat in the lounge, they chatted amongst themselves, talking across the room rather than talking with the person they were supporting. We did not hear laughter or ‘chat’ and people spent long periods of time on their own. We saw from care plans that this was people’s choice in some cases. However, we noted that staff who were delivering trays, snacks and drinks were in a good role to spend time chatting with people but all staff rushed in and out of rooms, often without passing the time of day. We saw lots of compliments recorded about staff, including one which stated ‘even the little things were done like applying lipstick’ about a person’s relative who had recently passed away but unfortunately were unable to observe these practices during our inspection.

People were involved in the planning and reviewing of their care where able. At times, their relatives, where appropriate, were involved and signed on their behalf. However, when asked people were not clear on what their care plan was and the amount of involvement they had had. One person said, “I am not aware that I have a care plan.” A relative told us, “I am not involved in [their] care planning; staff didn’t mention it and I didn’t ask.” We did note that on one care plan we saw there was a person’s signature and one relative told us, “I know about the care plan I am involved.” The manager told us that people were invited to read and sign their care plan when it had been written to ensure they were happy with the content.

Is the service responsive?

Our findings

People told us they had their care needs met. One person told us, “They always try their best to help me.” A relative told us, “I am very happy with the care my relative receives.” We saw that people were supported to be well presented and their health needs were met. Care plans were clear and easily accessible. Staff carried a mobile device that enabled them to look and see what support people needed and documented what care and support had been provided. We saw staff updating each person’s care notes straight after supporting them. The system flagged up when previously programmed care needs, such as using the toilet or a position change, had not been completed or input into the notes. This helped ensure that people received the care they were assessed for, when they needed it. However, we saw staff using moving and handling techniques that contradicted people’s care plans.

People gave mixed views about activities provided in the home. Comments included, “I always have something to do which keeps me occupied in this place.”, “The activities are not really suitable. Just a few people attend. The external entertainer in good.”, and “Sometimes I go to the lounge especially when the entertainment is on. Other times people just sit and watch TV so I am not interested.”

The activity schedule included general activities such as bingo, listening to music and an entertainer that visited on a Wednesday. These were advertised in the weekly newsletter, which included quizzes and puzzles and a reminiscence of the dates that week, and discussed in meetings. We observed a quiz going on for some of the afternoon, followed by bingo on the day of the inspection. Many people were sitting in their bedrooms, some expressed this was their preference. However, one person said, “I cannot attend activities. I don’t have anybody to take me there.” There were no examples of specific activities provided bespoke to people’s individual hobbies and interests, or examples of one to one activities, other than chatting, for people who liked to stay in their rooms, or those who were cared for in bed. There were limited items of interest around the home to invoke conversation, reminiscence and stimulation even though the home supported people who were living with dementia. Research shows that stimulating the brain and keeping the mind active can help slow the progression of the disease. The manager told us they had recently completed a

self-assessment in relation to the dementia care they provided. We saw the assessment and the home had scored as good. However, we found that this was an area, along with the provision of varied and personalised activities, which required improvement.

People were not aware of meetings organised for them. However, we saw meeting notes in the manager’s office that demonstrated the meetings had been held and a number of people, and their relatives, had attended. The manager told us they did not circulate the meeting notes unless they were asked for due to confidentiality. We noted that this may be a contributing factor to people not being aware or remembering that meetings had been held. We saw, however, that the dates of the meetings were detailed in the newsletter that was given out by the activities organiser. We saw where issues were raised at meetings, there was an action recorded to address them. For example, where staffing in the lounge areas was raised as a concern at particular time of day, the manager explained they had tried to address the issue by changing the way handover was done and invited relatives to become involved in monitoring the situation for improvement.

People told us they would raise concerns with the management and were confident that they will be listened to. One person said, “I am confident in raising anything with [provider] and [manager], they are very kind.”

The manager recorded all complaints and action taken to resolve them. This included interviewing staff where needed. There were no recent complaints and no outstanding actions. However, we noted that there was no information displayed on how to make a complaint except in the service user guide that was given to people when they moved into the home. we also noted that there were no easy read format of the service user guide to support people who may find it difficult to read the general complaints policy. We were also told by the manager that they had a ‘grumbles’ book where they recorded any little issues, such as lost laundry or cold meal. They told us these grumbles develop into complaints as they were dealt with straight away. We saw a record of meetings held with kitchen staff and the deputy manager told us that the provider replaced lost clothing at no cost to the person. One relative told us, “Managers are very proactive and they listen to our grumbles.”

There was a survey system in place to seek people’s feedback. One person told us, “The manager deals with

Is the service responsive?

everything we ask and generally is very good.” We saw surveys were completed annually and an action plan devised for any suggestions made or complaints raised. For example, meeting with the kitchen staff to discuss menu

choices and arranging for a new chair for another person. The manager told us that they had recently had a external association carry out a survey and they were awaiting the results.

Is the service well-led?

Our findings

People were all positive about the manager. Comments included, “I like this home, management is good and they listen to us.”, “I know the manager and they are very pleasant and efficient.”, and, “The manager is very nice [they] always explains things to me.”

The nurses on the floors along with the deputy managers were responsible for leading the staff. However, the manager was a visible presence and had introduced coffee mornings with staff to encourage an open door approach to promote effective communication. The manager told us, “Staff are more likely to talk to you informally over a coffee than they are to come into the office.” Staff were positive about the manager. One staff member said, “This is a well-run home.” another staff member said, “Management is very good, they give advice, they listen and they try to sort things out.”

Concerns, issues and incidents were discussed as they happened. We saw that when an individual staff member had a concern or something had been raised, this was addressed and recorded in a prompt and clear way. We also saw that lessons learned were also discussed at team meetings, handovers and supervisions. For example, promoting choice and seeing the person. The deputy manager gave an example of how a person had not liked having their room number on a clothes label and staff did not all understand why. The nurse in charge got the team together and discussed how they would feel if they were to

start being addressed by their payroll number rather than their name. This was addressed as it came up and was a lesson from an actual event and by doing so helped to instil in staff what the home’s values were.

The manager and deputy manager told us that they had identified some of the issues we had found on inspection and as a result they had developed a programme of workshops. These were workshops were to be delivered in half an hour intervals covering several areas of the home. These included monitoring vital signs, person centred care, dementia and infection control. They told us it was their aim to develop the staff team to provide a consistent and high standard of care for people. Some of the workshops had started and the others were scheduled in.

There were systems in place to monitor the quality of the service. Audits covered areas such as medicines, health and safety and infection control. The manager had recently completed a self-assessment in infection control to ensure they were doing all they should be. The manager had also completed a gold framework dementia self-assessment and told us, “While I think we are doing it well, I know there are things we still need to work on and I am in discussions with [provider] to decide how we will do this.” They went on to tell us that they had plans to improve the environment for people living with dementia.

People had access to community links and the home was supported by two volunteers who visited regularly. There were also church services and opportunity to visit the local shops. There had recently been a change to the amount of people who went out at the same time. Feedback was positive and this meant there was more time for individuals to spend time doing what they wanted while they were out.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The service did not ensure that people's needs were safely.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

The service did not work in accordance with the Mental Capacity Act 2005.