Care Quality Commission

Embrace (South West) Limited

Dunollie Nursing Home

Inspection report

31 Filey Road
Scarborough
North Yorkshire
YO11 2TP
Tel: 01723 372836
Website: www.embracegroup.co.uk

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 19 February 2015. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 22 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now meet 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 Dunollie Nursing Home on our website at www.cqc.org.uk.

Dunollie Nursing Home is a 58 bedded nursing home. It is operated by European Care (SW) Limited as part of the Embrace Group. The service is located in the South Cliff area of Scarborough. It can provide nursing care for up to 50 older people who may have a dementia or physical disability in an adapted and extended building and personal care and support for another eight people in a separate detached building. On the day of the inspection there were 50 people using the service.

During this visit we found that the service was not safe because staffing levels were still not sufficient. We found that the provider had not made the changes they told us they would following our last inspection. This put the people living at Dunollie Nursing home at risk as there were not always enough staff on duty to meet their needs. There was a continuing breach and we issued a warning notice to the provider and to the registered manager.

Summary of findings

At our last inspection we had made a recommendation that the provider look at current good practice around dementia friendly environments. We had seen that the service did not follow their own policy relating to caring for people living with dementia. We checked at this inspection to see if progress had being made. We found that the provider had made no changes to the environment which would support people living with dementia and was still not applying the company policy.

The numbers of people living with dementia had risen to more than 25 per cent of the people who used the service. Seven people were nursed in bed which meant that eight people were living in an environment that was not suitable to meet their access needs. In addition there were insufficient staff to provide consistent care and support to those people as no action had been taken to address this issue. These failures by management to address shortfalls which they had identified in order to improve the quality of the service and to mitigate risks to the health, safety and welfare of service users was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) 2014. We issued a warning notice to the provider.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

This service was not safe.

We found that action had not been taken to improve safety at the service.

The service used a tool to determine the levels of staffing needed to meet people's needs safely but they consistently fell below that level.

Staffing levels were not safe for people living at Dunollie because of the size and layout of the building and the variety of needs of people who used the service.

Is the service well-led?

Requires improvement

This service was not consistently well led.

Following our previous inspection the provider had sent us an action plan to let us know how they would improve. None of the actions had been completed to improve the quality of the service or mitigate risks to the health, safety and welfare of people who used the service.

Policies and procedures had not been implemented properly which impacted on the quality of care and accessibility for some people who used the service.

Dunollie 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. We undertook an unannounced focused inspection of Dunollie Nursing Home on 27 August 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 19 February 2015 inspection had been made.

The team inspected the service against two of the five questions we ask about services: Is the service safe? And Is the service well led? This was because the service was not meeting some legal requirements. We had also made a recommendation that the provider look at current good practice guidance around dementia friendly environments in line with their own service policies.

The inspection was undertaken by two adult social care inspectors.

During our inspection we spoke with the registered manager, the operations manager, two registered nurses and five care workers. We also spoke with seven people who used the service, one visiting professional and two relatives. We looked around the service and visited the bedrooms of ten people living with dementia.

We reviewed the policies and procedures relating to staffing and care of people with dementia, inspected staff rotas and the tool used by the service to determine what staff they needed each day. Where appropriate we checked details in people's care and support files.

Following the inspection the registered manager sent us an up to date copy of the staffing tool for August 2015.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection on 19 February 2015 we found that staffing levels were not consistent and had not been sustained to a satisfactory level at night.

This was a breach of Regulation 22 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following this inspection, the provider sent us an action plan telling us how they intended to meet the shortfalls in relation to the requirements of Regulation 18. They had told us that "Staffing levels will be maintained consistently in conjunction with the dependency tool" and that "The service is establishing a bank staff who will be available to provide cover at short notice if it is required or we can access agency staff if we are unable to recruit a full staff team."

At our focused inspection on 27 August 2015 we found that the provider had not followed the action plan they had sent us.

People who lived at Dunollie Nursing Home told us that staff were "Really helpful" and "Do the best they can." One person said that there were "Definitely not enough staff." Other comments included "I don't think there are enough staff for the amount of patients" and they "Always seem rushed." A visiting relative said "They don't seem to have enough staff; I have rung the bell sometimes when Mums needed it and have had to go looking for carers." On the day of our visit we saw that staff did respond promptly to people's call bells but staff told us they were often short staffed which meant that they had to rush. One member of staff said "I don't know much about people because we don't have time to find out. We are just in and out trying to get everything done." Another said "I don't feel that there are enough staff. I am just running around". One member of staff told us "I am not going to be able to give people baths today, because I am on my own. They [other staff] help me, but it is hard to do everything."

We looked at how the service worked out the number of staff needed and we reviewed staff rotas for August. We found that staffing levels had not been sustained and regularly fell below the level the registered manager told us was needed.

The service used a system called the Rhys Hearn tool to work out how many staff were needed to support the people who lived at Dunollie Nursing Home. This tool assessed the number of staff needed to provide care in line with the number of people using the service and their need for assistance. We found that this tool had not been updated following two recent admissions. This meant that the provider could not be certain that staffing levels were sufficient to meet the needs of all the people who lived at the home. This has since been updated by the manager, who told us that normal staffing during the day in the main building is two nurses and six care assistants on duty. We found that the number of nursing staff was being sustained with an agency nurse used to cover gaps in the rota.

However, we found that there were not enough care assistants on seven days out of twenty seven in August. We also found that on nine occasions in August the person who organises activities within the home was used to cover care assistant's shifts. They had been appropriately trained to do this; however, this left the people who lived at Dunollie Nursing Home without an activity coordinator on those nine days. Staff confirmed that the activities organiser often worked as a care worker when they were short of staff, so activities were not always arranged. On the week of our visit, staff also told us that activities were not being organised in the home. The activities organiser was on leave and this absence had not been covered which meant that peoples social and spiritual needs were not being met.

The registered manager told us that normal staffing at night in the main building was one nurse and three care assistants. We found that on at least eleven occasions in August there was one nurse and only two care assistants on duty. Staff confirmed that there had been occasions when staffing was below the level needed and that absences were not always covered.

We considered that on the occasions where staffing levels were reduced it was unsafe for people who used the service. This was because of the size and layout of the building as well as the range of needs of the people living at Dunollie Nursing Home. We found that staffing levels were inconsistent and had not being sustained during the day or at night which meant that people's needs were not always met in a timely manner.

Requires improvement

Is the service safe?

This means that this is a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection on 19 February 2015 we found some positive features of the management of the service but some policies and procedures had not been implemented properly. We made a recommendation that the provider look at current good practice around dementia friendly environments because they had not implemented their policy relating to this subject.

At our focused inspection of 27 August 2015 there remained some positive features of management and the policies had been updated. However, these had not always been implemented appropriately. This impacted on the quality of care and accessibility of the service for some people.

For instance we saw that the policy on 'Care of People Living with Dementia' was issued on 6 January 2014 and due to expire two years later so was in date. However it stated, "The Embrace approach to dementia care is consistent with the National Dementia strategy and National Institute for Health and Care Excellence (NICE) quality standard 'Recognising quality outcomes for people with dementia; building on the work of the National dementia strategy." When we looked at the NICE quality standard we saw that in relation to environment the service was only meeting three out of twelve of the suggested changes to the environment to help meet the needs of people living with dementia.

When we spoke to the nursing staff they could tell us what was meant by a 'dementia friendly' environment and agreed that the service was not currently 'dementia friendly'. However the care workers were not able to describe any features of the environment that you would expect to see in a service which supported people living with dementia.

The quality standard goes on to describe how organisations providing care and support ensure people with dementia are enabled to take part in leisure activities based on individual choice and interest. There were no activities taking place on the day of inspection and staff told us that there would be nothing organised for two weeks because the person employed to organise activities was on leave. Although areas for improvement had been identified to support people living with dementia, there had been a failure to take appropriate action.

The registered manager was spending only two days a week at the service because they were overseeing another service in the organisation that was without a manager. In the absence of the registered manager any shortfalls in standards were not always consistently monitored and recommendations made at our last inspection had not being implemented.

At the comprehensive inspection on 19 February 2015 we found that appropriate staffing levels were not sustained. At the focused inspection on 27 August 2015 we found that this situation had not improved.

The registered manager told us that due to staff leaving and problems recruiting new staff they had not been able to create a bank of staff to cover short-term gaps in the rota as they had indicated they would on the action plan they sent to CQC. They told us they were currently recruiting using a variety of advertising methods and had already introduced additional pay incentives to encourage staff to cover shifts. They had unsuccessfully tried to use agency staff to cover care workers shifts. The methods they had employed to improve staffing had not been successful and they did not identify any further plans to resolve the issue. This meant that the staffing issues identified were likely to be on-going with no clear plan in place for a resolution of the situation which in turn presented a potential risk for people who used this service. This meant that although the registered manager had identified where quality and/or safety were being compromised they had not taken the necessary action to make improvements.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance No actions taken to improve quality and/or safety following recommendation by CQC

The enforcement action we took:
We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing levels were inconsistent and not sustained. This was an on going breach of regulation.

The enforcement action we took:
We issued a warning notice