Fewcott Healthcare Limited

Fewcott House Nursing Home

Inspection report

Fritwell Road
Fewcott
Bicester
OX27 7NZ
Tel: 01869 345501
Website: www.fewcott.com

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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

We visited Fewcott House Nursing home on 1 June 2015 It was an unannounced inspection. We previously inspected the service on 7 June 2014. The service was meeting the requirements of the regulations at that time.

The service provides nursing care for up to 40 people over the age of 65. At the time of our inspection 33 people were living there. Some people were living with dementia or had a learning disability.

There was a registered manager at the service. 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.

Summary of findings

People and their relatives were complimentary about the registered manager and provider. The registered manager demonstrated a personalised approach and a commitment to providing good quality care. Since being in post they had made many changes and improvements for people living at the service. However, they required support and development to make further changes to bring the service up to the required standard. Systems were not always effective in monitoring the quality of the service and ensuring people were protected from harm. Some documents relating to the management of the service needed reviewing and updating. People felt able to raise any concerns with the management team and were confident they would be addressed promptly.

Medicines were not always stored in a safe way. Action was not taken to ensure medicines were always stored at the correct temperature and one medicine that could present a risk to people if not taken in the right way was stored within reach of people. People received their medicines as prescribed.

People felt safe and their relatives told us they did not have concerns about people's safety. People were protected from abuse. There were enough care staff to meet people's needs although a shortage of housekeeping staff meant communal lounge areas were not as clean as people would like them to be.

People told us they liked living at the home and were complimentary about staff. People felt they were treated in a caring, patient and friendly way. Whilst we observed many positive and caring interactions we also observed some interactions that meant people were not always supported in a way that was respectful. Staff did not always engage with people unless they were providing a care task. A lack of activity meant some people were bored and lacked stimulation. We have made a recommendation about the provision of activities at the service.

People were offered choice and their preferences were respected. People liked the food and were supported to maintain a healthy diet. People were referred for specialist advice as required.

Staff felt supported. However, gaps in training for both new and existing staff meant they were not always supported to improve the quality of care they delivered through training.

Although risks to people's health were identified and plans were in place to minimise the risks, there was no systems to identify whether pressure relieving mattresses were set correctly. We identified one person with a mattress that was set too high for their weight which may mean they were not protected from developing a pressure ulcer. One person had behaviour that could be described as challenging. Although staff knew the person and understood their needs this information was not recorded in their care record.

The provider, registered manager and staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions or who may be deprived of their liberty for their own safety.

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

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

Improvements were required to ensure people were safe.

Medicines were not always stored in a safe way.

Nursing staff identified and managed the risks of people's care. However, there was not a system in place to ensure pressure relieving mattresses were set correctly which could mean they were not effective.

There were not always enough housekeeping staff on duty to ensure all areas of the home were clean. There were enough care staff to meet people needs.

People felt safe. Staff understood their responsibilities around safeguarding and knew how to raise concerns.

Is the service effective?

Requires Improvement

Improvements were required to ensure the service was effective.

Staff had not always received the training they needed to care for people.

People were involved in the planning of their care and were supported by staff who acted within the requirements of the law.

People were supported to maintain their independence. Other health and social care professionals were involved in supporting people to ensure their needs were met.

Is the service caring?

Requires Improvement

Improvements were required to ensure the service was caring.

People spoke highly of the staff. People were cared and spoken to in a patient and friendly way. However, some interactions with people were not always carried out in a respectful way.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People did not benefit from regular or meaningful activities.

Staff had good knowledge about people's needs in relation to behaviours that may challenge. However, this was not always recorded in their care records.

People were involved in the planning of their care. Care records contained detailed information about people's health needs.

People knew how to make a complaint if required.

Is the service well-led?

Requires Improvement

Some improvements were required to ensure the service was well led.

Summary of findings

Quality assurance systems were in place but had not identified the issues we found during the inspection. Records relating to the management of the service were not always kept. Policies and procedures had not been reviewed or updated.

People, staff and relatives were complimentary about the manager and the improvements they had made since they had been in post.

Fewcott 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 June 2015. This was an unannounced inspection. The inspection team consisted of three inspectors and an expert by experience. 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 the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern. We spoke with local authority safeguarding and contracts teams.

We spoke with 11 people who were living at the service. We also spoke with two people's relatives. 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.

We spoke with seven staff, the registered manager and the provider. We looked around the home and observed the way staff interacted with people.

We looked at seven people's care records, the medicine administration records for all people living at the service and at a range of records about how the home was managed.

Requires Improvement

Is the service safe?

Our findings

We observed staff administering medicines; staff supported people to take their medicines in line with their prescription. However, people's allergies were not documented with their medicine administration records. This meant that staff might not be aware of people's allergies in relation to the safe administration of medicines.

Medicines were not stored safely. For example, thickening powder that was prescribed to be used as part of the treatment for people with swallowing problems was kept on people's bedside tables. This was not in line with safe storage guidance that had been issued in February 2015 following a national patient safety alert. Staff were not aware of this guidance.

Medicines were not always stored at the correct temperature as recommended by manufacturers. This meant they may not work in the way they were intended. For example, the recorded daily temperatures of the medicines fridge showed it was not working effectively. Staff were not aware of the correct temperature that medicines should be stored at and had not taken action to ensure medicines stored in the fridge were safe to use. A medicines trolley was stored in an area of the service that felt warmer than other areas in the service because of nearby hot water pipes. The temperature of this area was not monitored to ensure medicines were stored in line with manufacturer's guidance.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and supported by staff. One person said, "Of course I feel safe". Another person told us they could not see very well but staff made sure they were safe. They said, "I feel safe in my room. They [staff] come to take me, hold my hand and take me to the lift so that I am not wandering by myself." One person's visitor told us, "The residents are very safe here I have never noticed anything of concern when I am around." A relative said, "I have peace of mind. I am happy he is safe here."

People had risk assessments in a range of areas such as bed rails, falls, and moving and handling. Ways of reducing the risks to people had been documented. Where advice and guidance from other professionals had been sought this was incorporated in people's care plans. For example, one person who mobilised independently but was at high risk of falls wore hip protectors as recommended by the falls team. Staff were aware of the risks to people and used the risk assessments to inform care delivery.

Some people had risk assessments and equipment in relation to preventing a pressure ulcer. However, there was not a system in place to ensure people always had their pressure relieving mattresses set correctly. For example, one person had a specialist pressure relieving mattress in place. The mattress was not set at the correct setting for the person's weight. This meant the person was not fully protected against the risk of developing a pressure ulcer. We discussed this with the registered manager who took immediate action to ensure the mattress was set correctly.

Equipment used to support people's care, for example, hoists were clean and had been serviced in line with national recommendations. The service had adequate stocks of personal protective equipment and staff used them as appropriate to prevent the spread of infection. Bathrooms, the kitchen and dining areas appeared clean. However, some people and relatives told us the service was not as clean as they would like it to be. On the day of the inspection some people's bedrooms and communal lounge areas had not been cleaned. There was one housekeeper on duty and we were told they were working in the laundry during the morning so were not available for cleaning duties at that time. We discussed this with the provider who told us they were in the process of recruiting additional housekeeping assistants.

People told us there were enough care staff to meet their needs. The provider calculated staffing levels according to people's dependency. Call bells were answered promptly and people were assisted in a timely way.

People were supported by staff who were knowledgeable about the procedures in place to keep them safe from abuse. For example, staff had attended training in safeguarding people and had good knowledge of the provider's whistleblowing and safeguarding procedures. They knew how to report any safeguarding concerns to the manager or provider. Staff also knew how to protect people in the event of a suspicion or allegation of abuse, which included notifying the local authority and Care Quality Commission (CQC).

Requires Improvement

Is the service safe?

Safe recruitment procedures were followed before new staff were appointed to work with people. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role.

Requires Improvement

Is the service effective?

Our findings

People were not always cared for by suitably skilled staff who had been kept up to date with current best practice. When we last inspected the service in April 2014, we found some staff members had not completed training in working with people living with dementia, health and safety, and food safety. We were told this training was being planned. However, at this inspection we identified continued gaps in this and other training. For example, half of the nursing and care staff had not attended training in working with people living with dementia, training in food safety or nutrition training. Many staff had also not attended training in health and safety or fire training.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We discussed this with the registered manager and provider who showed us evidence that they had recently purchased a training package from a training provider and were in the process of arranging training dates.

People were supported to eat and drink at mealtimes. However, during the morning we did not see people in the lounge being encouraged or supported to drink. People told us they enjoyed the food. A person said "I have a treat, when I have a full English breakfast." A visitor told us their relative liked the food and "Had put on weight since being admitted." People were given a choice of what to eat and people who needed assistance to eat were given the support they needed. People choose where they wanted to sit during mealtimes and the mealtime was a relaxed and sociable event.

People's specific dietary needs were met, for example, people had softened foods or thickened fluids where choking was a risk. Where some people had lost weight there was a plan in place to manage the weight loss, food and fluid charts were maintained, people had been reviewed by the GP and referred for specialist advice if required.

People had regular access to other healthcare professionals such as, chiropodists, opticians and dentists. One person told us, "I see the Chiropodist" and another said, "The Optician and the dentist have been". People were referred for other specialist advice for example, from the speech and language therapist (SALT) if they were thought to be at risk of choking, or the care home support service if they were identified as being at risk of falling. We saw evidence specialist advice was followed.

Staff felt supported by the registered manager and provider. Staff were supported to improve the quality of care they delivered to people through the supervision process. Supervision gave staff the opportunity to discuss areas of practice. Any performance issues were discussed and actions were set and followed up at subsequent supervisions.

Staff understood their responsibilities under the Mental Capacity Act 2005. People were asked to give their consent to their care, treatment and support. Where people lacked capacity to make certain decisions, records identified the decisions where staff would need to consider using the best interest process. For example, one person's care record stated they were able to "make simple decisions" but "not able to make decisions about or manage finances".

The provider understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be restricted of their liberty for their own safety. The provider had previously made DoLS applications, was aware of the outline of the supreme court judgement and had sought advice and support to identify people whose situations might now be brought into the widened definition of deprivation of liberty.

Requires Improvement

Is the service caring?

Our findings

People did not always experience care that was respectful. For example, we spent time in the communal areas of the home and observed staff only entered the lounge if they were directly involved in delivering a care task. Although staff interacted with the person they were supporting, they did not always interact with other people in the lounge.

Some people were sitting in the lounge watching the television. The television was on but no sound was playing. Staff did not check if people wanted the sound up or wanted to watch a different programme. The television remained without sound until the registered manager entered the lounge an hour later and turned the sound on.

We observed one person being assisted to move using the hoist. One staff member spoke with the person in a caring way. However, another member of staff stood out of sight behind the person. The staff member put their hand on the person's forehead to pull their head back to prevent it banging on the hoist. They did not speak with the person or tell them what they were going to do.

During the lunchtime meal we observed a person who required assistance to eat. The staff member assisting the person stood over them and placed the food to their mouth without speaking with them. Although the staff member spoke with other people in the dining room there was no interaction with the person they were supporting.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that staff were kind and caring. Comments from people included, "Staff are nice, very caring", "The staff here are all very good" and "I think they're very kind." A relative said, "The carers are wonderful. He's comfortable here and likes it. Staff are good to him".

The atmosphere in the home was calm and when staff interacted with people they were spoken to in a friendly and respectful way. One person told us staff "Talk to us nicely." One person did not speak English as their first language. Staff used communication cards to ensure this person was able to make their needs and preferences known. Staff were aware of how some people communicated using body language. For example, by facial expressions to agree to care. Staff were patient with people and responded promptly when people asked for help. One person told us "If I want something, I just ring the bell, and they come."

People were supported with their personal care discretely and in ways which upheld and promoted their privacy and dignity. Staff knocked on people's doors, waited to be invited in before entering and addressed people using their preferred name. People told us they were offered a choice of how they would like their personal care delivered and their preferences were respected. For example, one person preferred a bath rather than a shower. Care records and the person confirmed they were supported to have a bath at a time they chose. Another person said, "We get asked if you would like this or that?" People were clean, well kempt and dressed appropriately for the weather.

People were supported to be independent and were encouraged to do as much for themselves as possible. What people were able to do themselves was documented in their care plans and staff used these to inform how people were supported. Staff ensured people had equipment when they needed it and encouraged people to use it. For example, one person's care record stated 'able to walk short distances with a Zimmer (walking frame)'. We observed staff ensure this person had their frame and encouraged them to use it.

People told us they were supported to express their spiritual needs. For example one person told us staff made sure they "always had their bible close by."

People had been involved in decisions about their care and what information could be shared with relatives to ensure they were kept informed of any changes to people's health.

Requires Improvement

Is the service responsive?

Our findings

People were supported to maintain links with their family and friends and there were no restrictions on when people could visit. However, on the day of the inspection we did not see any activities taking place. There was a lack of stimulation for people especially those living with dementia or people who had a learning disability. People were sat with nothing to do for long periods of time and appeared bored or withdrawn. We asked why there were no activities and were told that the activity coordinator had recently left the service. Although actions were being taken to recruit another activity coordinator, no staff member had been made responsible for planning or engaging in activities in the meantime. Staff did not see planning and carrying out activities as part of their role. People told us they would have liked there to be more activities. One person told us there were "No Activities." Another person said there was "Not a lot to do really I mostly just watch TV." Previous activity records showed people had been supported to attend an organised activity usually once a week and one record stated 'spent break with him [service user] as in room'. However, an activity record for one person living with dementia documented 'spent the day in the lounge'.

Before people came to live at the home their needs had been assessed to ensure their needs could be met. People and their families confirmed they were involved in the planning and review of their care. Care plans contained detailed information about people's needs. They reflected how each person wished to receive their care and support and gave guidance to staff on how best to support people. People's care plans and risk assessments were regularly reviewed to respond to people's changing needs. Staff were made aware of any changes through a detailed handover at the start of each shift. However, one person had behaviour that could be described as challenging. A GP assessment filed in their care record identified the person's behaviour might be 'a potential risk to co residents'. Staff demonstrated a good understanding of this person's needs and how best to work with them. This information was not reflected in the persons care plan or risk assessments. This meant support may not be consistent, and care staff who were less familiar with this person would not have the information required to meet the persons' needs

People and their relatives knew how to provide feedback on the quality of the service or to make a complaint. People told us, "She [registered manager] has an open door policy" and "You can say whatever you want". Any concerns received about the quality of care were investigated thoroughly and recorded. The registered manager discussed concerns with staff individually in supervisions, this ensured there was learning to prevent similar incidences occurring. One person told us, "They never sweep anything under the carpet." Another person said, "She [registered manager] always sorts things out."

We recommend that the service seek advice and guidance from a reputable source about the provision of activities and social stimulation for people living with dementia and for people living with a learning disability.

Requires Improvement

Is the service well-led?

Our findings

There were a range of quality monitoring systems in place to review the care and treatment offered to people living at the home. These included a range of clinical and health and safety audits. Where any shortfalls had been identified there was an action plan in place to address them. However, not all of the issues we found during our inspection had been identified.

There was no system in place to ensure important information such as patient safety alerts were notified to staff so that swift action could be taken to keep people safe.

Records in relation to managing the regulated activity were not always maintained. For example, The service did not have current policies and procedures in place to inform safe and effective care. All of the homes policies were dated 2007 and had not been reviewed or updated since this time. Minutes of some meetings such as team meetings were not always kept which meant staff would not be able to read about the issues that were discussed during the meeting if they had not been able to attend. This also meant there was no record of any identified actions that needed to be carried out and followed up at subsequent meetings.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was led by the provider and 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 registered manager was approachable and open and showed a good level of care and understanding for the people within the service. However, we observed that whilst the registered manager was leading the day to day running of the service, the provider was not always giving the registered manager the support or training to develop and improve the quality of the service. For example, the registered manager had not received formal supervision or an appraisal since being employed at the service. The registered manager had not received training in conducting appraisals which in turn meant no appraisals had taken place with staff. The registered manager and provider told us they communicated well with each other and spoke on a daily basis.

People and their relatives were complimentary about the management team and the improvements that had been made since the registered manager had been in post. One person said, "The home is well managed now. There have been many changes." The registered manager worked some clinical shifts as well as office based hours to undertake management responsibilities. People and their relatives told us the manager and provider were frequently visible around the service and they stopped to chat with people and check all was well. One person said "The manager is good; she always comes to see how I am getting on." Another person said, "Oh they [the management team] are good. The Owner always stops to say hi to me, he is a great guy."

Staff spoke positively about the team and the leadership. They described the provider and registered manager as being supportive and approachable. Staff described a culture that was open with good communication systems in place. The registered manager ensured staff were aware of their responsibilities and accountability through regular supervision and staff meetings .

There was a clear procedure for recording incidents and accidents. Any accidents or incidents relating to people who used the service were documented and actions were recorded. Incident forms were checked to identify any risks or what changes might be required to make improvements for people who used the service.

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	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Appropriate arrangements were not always in place for the safe storage of medicines. Regulation 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by receiving appropriate training and professional development. Regulation 18(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person did not make suitable arrangements to ensure people were always treated with respect. Regulation 10(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to maintain records in relation to the management of the service, monitor the quality of the service delivery or to always identify and manage risks. Regulation 17(2)(a)(b)(d).