HC-One Limited

Pytchley Court 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?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection took place on the 2, 3 and 5 February 2016. Pytchley Court Nursing Home provides accommodation for up to 38 people who require nursing or residential care for a range of personal care needs. There were 35 people in residence during this 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 2008 and associated regulations about how the service is run.

The registered manager had been isolated from the support and guidance they had required from the provider. Recent changes had led to some improvements in the governance and support; however, the provider had not identified the issues raised in this inspection. The audits used to monitor safety and quality had not all been effective at identifying areas for improvement or driving forward improvements.

There had not always been enough staff to meet people's assessed needs. This had had a direct impact on people's relationships with staff, the time people waited for care and their ability to attend activities or have the opportunity to socialise.

People did not always have the opportunity to drink sufficient amounts of fluids to help maintain their health and well-being. People who required help to eat their meals did not always receive their meals in a timely way. The registered manager had not ensured that kitchen staff had sufficient information to provide meals that met people's dietary needs or have adapted cutlery for people to eat their meals independently.

There had not always been appropriate arrangements in place for the management of medicines. Staff did not have access to all the relevant information about people's identity and allergies and staff did not always ensure that people took the medicines they had been prescribed.

People received care from staff that were not always supported to carry out their roles as staff did not always feel confident to bring up issues about staffing levels. Staff received training in areas that enabled them to understand how to meet the care needs of each person. Recruitment procedures protected people from receiving unsafe care from care staff unsuited to the job.

People were assessed for their suitability prior to their admission to the home. Staff carried out regular reviews of peoples' assessments and care plans and there was clear communication between staff to update them on any changes in care. People had been involved in planning and reviewing their care when they wanted to.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse. Staff knew their responsibilities as defined by the Mental Capacity Act 2005

(MCA 2005) and Deprivation of Liberty Safeguards (DoLS) and had applied that knowledge appropriately. People were involved in decisions about the way their care was delivered and staff understood the importance of obtaining people's consent when supporting them with their daily living needs.

People's needs were regularly reviewed so that risks were identified and acted upon as their needs changed. People's healthcare needs were met. People had their comments and complaints listened to and acted on.

People who were at risk of falls benefited from an initiative by the whole staff team to help prevent falls by identifying the reasons and mitigating the risks.

Records relating to the day-to-day management and maintenance of the home were kept up-to-date. People's and staff records were securely stored to ensure confidentiality of information.

There were breaches of four of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The service was not always safe.

People had not always been assured that there were sufficient numbers of staff deployed to meet their needs.

People's medicines were not always appropriately managed.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse.

People received care from staff that had been appropriately recruited and had the skills and experience to provide safe care.

Risks were regularly reviewed and, where appropriate, acted upon with the involvement of other professionals so that people were kept safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported to have sufficient to drink to maintain their health and well-being.

People were not always supported by staff that had access to information about their dietary needs or facilitated to eat their meals in a timely way.

People received care from staff that required closer supervision and support to carry out their roles.

People received care from care staff that had the training and acquired skills they needed to meet people's needs.

Care staff knew and acted upon their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported by staff that had the time to build and maintain therapeutic relationships with them.

People's care and support did not always account for their individuality and their diverse needs.

People were not always supported to make choices about their care and staff did not always respect people's preferences.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not always met in line with their individual care plans and assessed needs.

People's needs were assessed prior to admission and subsequently reviewed regularly.

Appropriate and timely action was taken to address people's complaints or dissatisfaction with the service provided.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of systems to identify and monitor the quality and effectiveness of the care that people received.

The manager did not always take action where they had identified issues that affected people's care.

People did not have their feedback about staffing levels responded to.

The provider had not recognised that the registered manager required support and supervision.

There was a Registered Manager.

Pytchley Court 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 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 unannounced inspection was carried out on 2, 3 and 5 February 2016 by two inspectors.

We reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners that help place and monitor the care of people living in the home that have information about the quality of the service.

We undertook general observations in the communal areas of the home, including interactions between staff and people.

During this inspection we spoke with nine people who used the service and four relatives. We looked at the care records of 14 people. We spoke with the registered manager, and six staff including care and support staff. We looked at six records in relation to staff recruitment and training as well as records related to quality monitoring of the service by the provider and registered manager.

Requires Improvement

Is the service safe?

Our findings

People's assessed needs had not always been safely met by sufficient numbers of experienced staff on duty. People had told us there were not always enough staff and gave examples of how this had impacted on their care. At time of our inspection 23 of the 35 people living at the home required two members of staff to provide personal care; this was not always safely achieved. The staff rota showed that at times there were three members of staff allocated at night, staff told us "most of the people on the ground floor need two staff for personal care, when we are helping them it leaves no-one on the rest of the floor to provide care for anyone else." We saw that people who required help to eat their meals had to wait for staff to be available. For example there were two members of staff to help seven people; people watched others eat whilst they waited for assistance. We observed people in communal areas with no staff to supervise them; we were concerned as some of these people had been identified as at risk of falls. We found examples of people not attending activities or having the opportunity to socialise as there were not enough staff to facilitate them to move to the relevant lounge area.

The number of staff on each shift was set by the provider. They used a system to calculate the number of staff required according to people's category such as nursing or dementia, there was no system in place to account for people's individual or changing needs such as a change in their dependency levels. The staff rota showed that staff had not been allocated to every shift to the levels set by the provider; the manager told us they did not have enough staff to allocate to every shift. Although some shifts had been covered with the use of regular agency staff, the manager had not used agency to cover all shifts; they described how challenging it was to cover all shifts as the process of booking agency staff through the provider was difficult.

This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We provided detailed feedback to the Registered Manager and the provider's operations manager on 3 February 2016, on how the staffing levels had had a negative impact on people's care and experiences. We saw that the provider began to take a range of actions to improve the staffing arrangements in the home, however the effectiveness and sustainability of these changes have not yet been assessed.

Improvements were required to the arrangements in place for the management of medicines. Although staff had received training in the safe administration, storage and disposal of medicines, we saw that people had not always received all of their medicines as prescribed. Staff had not always observed that people had taken their medicines which had meant that in the past some people had been found with tablets in their clothing or in medicines in pots on their tables after the medicines round had finished. There was a risk that people living with dementia could take the medicines that were not prescribed for them, as we observed some people wandering in and out of people's rooms. People's information about their allergies and their photographs for identification were not always present, this was important for staff to identify people correctly. We brought this to the attention of the Registered Manager who immediately updated people's photographs and allergies on the medicines records and provided supervision for staff administering

medicines.

Most people who could communicate verbally told us they felt safe and they felt confident that they could raise their concerns directly with staff. Relatives told us they were confident that people were safe, one relative told us "I come in at all different times of the day and I've got no worries about the care." Staff had received training on safeguarding vulnerable adults and demonstrated they understood their responsibilities. One member of staff told us "the training explained all the different types of abuse and what to look out for." The safeguarding and whistle blowing policies were readily available to staff, however, they did not include all of the information staff would require to contact the local safeguarding team should they need to raise a safeguarding alert. We brought this to the attention of the Registered Manager; they immediately took action to rectify this. Where staff had identified areas of concern, they had notified the manager who had raised safeguarding alerts. Where the local safeguarding team had asked the manager to investigate any concerns, the manager had completed the investigation and used the learning from the incident to improve care, for example being more vigilant of people mobilising at night.

People could be assured that prior to commencing employment in the home, all staff applied, and were interviewed through a recruitment process; records confirmed that this included checks for criminal convictions and relevant references. Nursing staff were registered through their professional body and there were systems in place to ensure that their registrations were updated.

People's needs were regularly reviewed so that risks were identified and acted upon as their needs changed. People's risk assessments were included in their care plan and were updated to reflect changes and the resulting actions that needed to be taken by staff to ensure people's continued safety. For example, where people were identified as being at risk of pressure ulcers, the risk assessments and care plans were updated to reflect that the pressure relieving equipment used and the frequency people were helped to move their position.

People were assured that regular maintenance safety checks were made on all areas of the home including safety equipment, water supplies and the fire alarm. There was a business continuity plan in place which explained the actions that staff would take in the event of anything disrupting the service, such as a failure of the power supplies. Staff were mindful of the need to ensure that the premises were kept appropriately maintained to keep people safe. There was a system in place for ensuring that the front door was secure to minimise the likelihood of uninvited visitors entering the premises without staff knowledge or people's agreement.

Requires Improvement

Is the service effective?

Our findings

People were at risk of not receiving enough to drink to maintain their health and well-being. We observed that around half of people relied on staff to provide them with a drink and assist them with drinking. People did not have the opportunity to drink regularly as not everyone had water or juice available to them at all times; we saw that there were jugs of juice in the communal areas, but these were out of people's reach. Where staff did help people to drink, we observed that staff did not provide people with enough time to drink all of their drinks. Where people were provided with tea or coffee, we saw that the cups were half full, and people complained that they were too cold to drink, and did not drink their tea or coffee. One person told us that the drinks were 'barely lukewarm'. We observed that the nurse administering the medicines had to find people drinks, as people did not have their own, so they could take their medication. Staff could not tell us how much people received to drink in a day as they did not record what people drank.

We were concerned because there was no system in place to ensure people who were identified as prone to urinary tract infections had enough to drink to help prevent further infections. Their infection control audits had identified that there was a higher incidence of urinary tract infections in November and December 2015 than at any other time in the last year. Staff had not received guidance as to how much people required to drink every day to help prevent infections, and there was no record kept of what people drank. We brought our concerns to the attention of the manager during our inspection.

By the third day of our inspection we saw that people were receiving hot drinks, but not all people were being prompted or assisted to drink where required, the jugs of juice remained out of people's reach and staff were not recording what people had drank. People were not being provided with the opportunities to drink sufficient amounts of fluids to help prevent urinary tract infections, or maintain their health and well-being.

People's information about their dietary needs were not always available to the chef or kitchen staff. The chef told us they relied on staff telling them if people were on a diabetic diet; they did not have any documentation that identified everyone's dietary needs. There was a risk that people were not having their dietary needs met as the staff that prepared their meals did not have enough information to prepare meals that met their needs.

There had been regular monthly audits of the dining experience, where it had been identified that there was no adapted cutlery available for people who could be more independent by using these; we found that there was no adapted cutlery available. We brought this to the attention of the Registered Manager.

Staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). However staff had not interpreted the instructions on the MUST tool the same way which had led to people's scores to not always reflecting their risk. We brought this to the attention of the Registered Manager so that they could re-train staff in the use of the MUST tool.

This is a breach of Regulation 14 (4a and 4d) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. Meeting nutritional and hydration needs.

We brought this to the attention of the Registered Manager who supplied a complete list of everyone's dietary needs to the staff in the kitchen, however we have not assessed it's accuracy with people's care records.

People were cared for by staff that were not always supported to carry out their roles. Although staff received supervision and had their appraisals, and they held regular staff meetings, staff told us that these were used primarily to give them information and did not always feel confident to bring up any issues. Where staff had brought up concerns about the lack of staff previously, they had not seen any improvement in the numbers of staff.

People received care and support from staff that had completed an induction that orientated staff to the service. Staff received training in areas that enabled them to understand and meet the care needs of each person they cared for and records showed that staff training was regularly updated and staff skills were refreshed. Most of the training was provided via the computer, we identified that some staff required further assistance with their skills as the computer training had not suited their learning needs. We discussed this with the Registered Manager who recognised that some staff required further assistance with their training to attain competence.

People were involved in decisions about the way their care was delivered and staff understood the importance of obtaining people's consent when supporting them with their daily living needs. We observed staff communicating effectively with people using a variety of means to help them understand what people needed; for example where people could not communicate verbally, staff looked out for signs of agreement or disagreement with the care that was offered.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
People's care plans contained assessments of their capacity to make decisions for themselves and consent to their care. There was recorded evidence of how decisions had been reached through best interest meetings. Care staff had received the training and guidance they needed in caring for people that may lack capacity to make some decisions for themselves. The registered manager and care staff were aware of, and understood their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately.

People's healthcare needs were met. People told us that if they needed to see the doctor they told a member of staff and this was arranged for them. Staff maintained records of when healthcare appointments were due and carried out, such as GP review of medicines, eye tests, dentist and the chiropodist. Nursing staff monitored people's well-being by taking their clinical observations regularly, such as blood pressure. One relative told us "[staff] make sure [name] gets to their hospital appointments"

Requires Improvement

Is the service caring?

Our findings

People's relationships with staff were variable, there were times when staff communicated well with people, however, we saw that the consistency and quality of people's care suffered when there was not enough staff on duty. People spoke about how the staff knew them well and could have conversations easily about their interests. One person told us "staff know me very well, they are always nice to me, they are very good". However, people also told us that the home was short of staff now and this had had an effect on their relationships as staff did not have time to talk. Staff told us it was hard to build and maintain relationships with people as they were so short of staff, one member of staff told us "we are so short of time we do not have time to chat."

One person told us that staff were very busy and this had affected the way staff talked to them, they told us "In the last two years the caring has gone down a lot, staff don't always listen. They were quite cross with me this morning as when they got to me it was too late, but they took over 45 minutes to answer the call bell and I was desperate. The staff told me they were busy getting people up, but that's not the point I needed them" they went on to say "Most of the time staff are nice, but staff are pushed, but they shouldn't come in here and take it out on me." We brought this to the attention of the manager who took appropriate action regarding the member of staff involved.

The manager had identified that staff attitude was not always appropriate. In the team meeting records of December 2015, the manager reminded staff that they were working in people's own home, and that arrangements for breaks should not take priority over people's needs. One member of staff told us that staff were stressed and at times argued with each other, which had a detrimental effect on people's care. One member of staff told us "It's a lovely home, it just needs more staff."

People were not always helped to integrate with each other. We saw that some people on the ground floor could communicate effectively but they had not had the opportunity to get to know other people within the home as staff did not have time to take them to the lounge where people were meeting. One person told us "it's not what I expected, there is no-one to converse with." We brought this to the attention of the manager who arranged for the person to move their room to another floor so that they could integrate with other people.

Staff had not taken the time to ensure people were able to reach their belongings, for example, staff had left one person's trolley with their TV remote control, water and glasses out of reach. The person had used their call bell to ask for the trolley to be moved closer, but the staff took over 20 minutes to reply. We observed that staff did not know people's likes and dislikes, for example people had been given drinks that they did not like, and staff had not listened to their protest. We heard one person calling out to staff to change their drink for over 20 minutes.

People were encouraged to take part in activities by a member of staff dedicated to arranging and facilitating activities that interested people, such as music, crafts or trips out to local areas. However the activities staff was also called upon to escort people to appointments which meant they were not always

available to provide activities. They told us "people don't always get the stimulation they need, there are not enough staff to assist people into their wheelchairs and transport them upstairs; people can't always get to the activities or they are so late they are positioned in the back of the room and can't see." One person told us "I like to go to the activities, but I can't always get there as I have to wait for staff to hoist me." We brought this to the attention of the manager who took steps to address the staffing levels within the home.

This is a breach of two Regulations:
Regulation 10 (1 and 2b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect

And

Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

Staff took care of people's clothes; people were appropriately dressed in clean clothes. People spoke highly of the quality of the laundry service. One person told us "my clothes come back lovely."

Requires Improvement

Is the service responsive?

Our findings

People's needs were not always met in line with their care plans and assessed needs. Staff carried out regular reviews of peoples' assessments and care plans and there was clear communication between staff to update them on any changes in care. However, people had not always received care that corresponded to their detailed care plans such as receiving drinks and receiving regular personal care as there had not been enough staff to provide all of the planned care.

Where people had been identified as at risk of falls, staff had indicated that some people required regular observations every 15 or 30 minutes. We saw that people were not being observed at these intervals and records showed that these were not recorded. Staff told us and we observed that due to the lack of staffing, these planned observations had not always taken place.

This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

People had been involved in planning and reviewing their care when they wanted to. People's care and support needs were accurately recorded and their views of how they wished to be cared for were known, for example the time they wished to get up in the morning. However, we saw that some people were assisted to go to bed early in the evening instead of the time they preferred due to staff shortages. Staff told us they needed to get people to bed early as the numbers of staff at night could not cope with helping all people go to bed.

Staff did not always know people's likes and dislikes, or ensure that they had asked; we saw that people were given drinks that they did not like. We saw that people tried to tell staff that they did not like the drinks provided, but they were ignored.

This is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect

We brought these matters is to the attention of the manager, we saw that the provider had ensured that staff had the information they needed to provide people with food and drink that they liked, however the effectiveness and sustainability of these changes have not yet been assessed.

People were assessed for their suitability prior to their admission to the home. Staff told us that they did not know people's needs when they arrived at the home as there had not been any prior discussion about their needs. We brought this to the attention of the manager who immediately changed their practices for new admissions. As a result when one person was admitted to the home on the last day of our inspection, we observed that staff were well informed of their needs. Although we saw an improvement, we have been unable to assess the consistency of this practice.

People's care plans were individualised and contained information that was relevant to them including their

life histories, interests and activities. One person told us "I love writing poems on my laptop" we saw that they had involved the staff in their writing.

People had their comments and complaints listened to and acted on. People had the option to complain in person at care reviews or at residents meetings, or in writing. One relative told us that when they had raised questions or concerns they felt they were responded to effectively and they were happy with the action that had been taken. The manager demonstrated how actions had been taken to rectify situations to prevent them happening again. A complaints procedure was available for people who used the service explaining how they could make a complaint; however, the manager was prompted during the inspection to update the guidance to include information on what to do if their complaint was not satisfactorily resolved. People said they were provided with the information they needed about what do if they had a complaint.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post since November 2014. Although the registered manager had extensive knowledge and experience to manage the service, they had been isolated from support and guidance they required. Changes to the provider's regional management had led to some improvements in the governance and support; however, the provider had not identified the issues raised in this inspection.

The manager recognised that the home required more staff and was in the process of recruiting care staff, but they had not taken enough action to ensure that every shift had been covered in the meantime by other staff, such as agency staff. The manager described how the system of getting agreement from the provider for agency staff was very difficult; the manager told us they had felt demoralised by the lack of support they were receiving from the provider with this issue. We raised our concerns to the provider during our inspection; we saw that by 5 February 2016 the provider had put in place the systems to provide agency staff until the recruitment of permanent staff could be completed.

There was a failure by the provider and the manager to ensure that effective systems were in place to monitor the quality and effectiveness of the care provided and take action where issues had been identified.

There was no system in place to monitor the effectiveness of staffing levels on the quality of care. People told us they had to wait for a long time to have their call bell answered, some for as long as 45 minutes. One person told us "I have to wait a long time to go to the toilet as staff don't answer the call bell for over half an hour, it is very upsetting." We saw records of residents meetings where people had previously raised their concerns about the lack of staff, for example on 31 December 2015; one person had told the manager that on occasions they had telephoned the home to ask them to answer their call bell as staff had not responded. Staff told us they did not always respond to the call bells promptly because they were so busy providing care that they could not get to answer the call bells. We observed that people were using their call bell but were kept waiting for long periods; over 20 minutes. The registered manager had been made aware of the impact on people's care as a result of low staffing levels by staff and people using the service, but they had not taken effective action to rectify the issue.

There was no system in place to identify that people were waiting for care as there was no monitoring of the call bell system. The manager told us they recently had a call bell system upgraded to pagers, but did not have any system of monitoring the calls. After we informed the manager of our observations and people's feedback; the provider arranged for installation of software to monitor the call bell system. The manager's response to the monitoring of the call bell system has not been assessed for its effectiveness.

There was no system in place to identify that people were at risk of not drinking enough to maintain their health and well-being. Although the manager was aware that some people were at risk of urinary tract infections they had not ensured that these people had enough to drink to help prevent further infections. The manager had not identified people who drank very small amounts due to conditions such as dementia or depression, or taken any action to ensure that these people were kept well hydrated to maintain their health and well-being. There was no system in place to measure how much people were drinking as there

no records of what people drank. Staff did not have any instructions or guidance to understand how much each person required to drink every day to maintain their health and well-being.

There was no system in place to ensure that the kitchen staff had information about people's dietary needs. The manager had not identified that the kitchen staff did not have all of the information they would require to prepare suitable meals. Where audits had been carried out we saw that the manager had identified areas for improvement, but the actions had not always been carried out to resolve the identified issues, for example in the dining room experience audit, they had identified that there was no adapted cutlery available for over three months and there was no evidence of the cutlery being ordered. After we informed the manager of our findings, they ensured that the kitchen staff had all the information they required.

The systems to monitor the management of medicines were not effective. Although there had been regular medicines audits and some actions had been taken to improve practice, the audits had not identified poor practice. For example the audits had not identified that there was poor practice in the administration of the medicines, there was a lack of photographs to identify people and a lack of information about people's allergies. After we informed the manager of our findings they took action to provide the training and the information required.

There was no reliable system in place to monitor people's health and well-being for a period of time after each accident or incident. There was a risk that people could be injured following an accident or injury and not receive prompt medical attention as there was no reliable system in place for staff to check people at intervals of time after their incident. We brought this to the attention of the manager who demonstrated how they were going to follow up people's health after an accident or incident. We have not been able to assess the effectiveness of the proposed system.

Staff told us that they did not always feel confident to bring up any issues during team meetings or during supervision. Staff described the meetings as being primarily for information giving and where staff had brought up concerns such as the lack of staff previously, they had not seen any improvements made as a result.

There was no system in place to ensure that all the staff guidance was up to date and contained all the relevant information. Policies and procedures to guide staff were in place but had not always been updated to include contacts for local authorities and ombudsman, for example the safeguarding, whistle blowing and complaints policies and guidance all required more information, which was rectified during the inspection.

This is a breach of Regulation 17 (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

The manager had begun to put in place initiatives that involved staff to help provide solutions to issues they had recognised.

The manager had recognised that people who were at risk of falls required a holistic approach to preventing further falls. The manager had set up a panel of staff including maintenance, nursing and care staff to look at all the areas of the home that could have an influence on people falling, such as the lighting. The panel had looked at the previous falls, where and when they occurred and identified common themes; the panel recommended interventions for people to help prevent future falls.

The Registered Manager was pro-active in ensuring staff enhanced their skills and learning by ensuring they

were involved in further learning where they wanted to. Two care staff were receiving training to become nursing assistants; the training included learning basic nursing skill such as taking blood. In addition one nurse was undertaking extensive training with the local authority to become a trainer within the home. The impact of their training was being measured to establish whether the knowledge and skills of staff improved the number of infections, falls and hospital admissions. The outcome of this will not be known for another nine months.

The manager had recently appointed a deputy manager who had extensive nursing experience and planned to ensure they received further managerial training and visit other homes in their network to gain practical managerial experience.

The activities staff member told us they were due to retire soon, but they were proud to show us the volunteer programme they were helping to set up to provide a team of people who wanted to be involved in improving people's well-being in the home. The manager was very keen to ensure that the volunteer programme was instigated as they told us they could see the benefit of involving people in the community and developing the range of interaction and activities available to people.

Records relating to the day-to-day management and maintenance of the home were kept up-to-date. People were able to rely upon timely repairs being made to the premises and scheduled servicing of equipment. Records were kept of maintenance issues and the action taken to rectify faults.

People's care records had been reviewed on a regular basis and records relating to staff recruitment and training were fit for purpose. Records were securely stored to ensure confidentiality of information.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that service users were always treated with dignity and respect.

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	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The provider did not ensure that people had enough to drink to maintain their health and well-being. Regulation 14 (4a)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have suitable systems in place to assess, monitor and improve the safety of service users; or the risks relating to the health and safety of service users. Regulation 17 (2a and b)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider did not ensure there were sufficient numbers of staff deployed to meet people's assessed needs. Regulation 18 (1)

The enforcement action we took:

Warning notice