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Tordarrach 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**

Summary of findings

Overall summary

The inspection took place on the 26 April 2016 and was unannounced. The last inspection of this service was on 8 May 2014. At that inspection we found the service was meeting all the regulations we assessed.

Tordarrach Nursing Home is registered to provide accommodation for up to 20 older people who require personal care on a daily basis. During the inspection the provider was also providing nursing care to some people. Whilst the provider is registered to provide personal care to people at Tordarrach Nursing Home, it is not registered to provide nursing care. We have asked the provider to apply to the CQC so they can provide nursing care legally to people using the service.
At the time of our inspection, the home was accommodating 13 older people many of whom were living with dementia.

The service has a registered manager in post. 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.

We found several issues of concern about the provision of care at Tordarrach Nursing Home. The provider had trained some staff regarding the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Act helps protects people who are unable to make decisions for themselves. Whilst some staff had an awareness of the Act, they were not always aware of its implications and therefore could be restricting people of their liberty illegally.

The provider did monitor and audit certain aspects of the service. However, there were other areas where this monitoring had not identified shortcomings. For example, the provider did not ensure staff completed certain training designated as mandatory or other training relevant to their roles. They had also not taken adequate measures when a member of staff had not provided a renewed police check. In this way the provider could assure themselves of the continued suitability of a member employed at the service.

We identified three breaches of the Health and Social Care (Regulated Activities) Regulations 2014 during our inspection. You can see what action we told the provider to take at the back of the full version of this report.

We also had concerns that people were not offered a range of social and recreational activities in line with their needs and interests. We have made a recommendation that the provider review the provision of activities in line with guidance from reputable sources in respect of this issue.

People told us they felt safe. Staff we spoke with were knowledgeable about what they needed to do if they suspected someone was at risk of harm. Staffing levels were sufficient to meet people's needs.

People had their health needs met. This included having access to healthcare professionals when they needed them. People's nutritional needs were assessed and monitored. They received a variety of meals according to their needs and wishes. People received their medicines as prescribed to them. The home was able to provide end of life care to people, should it become necessary.

Staff knew people well and could tailor their care accordingly. Care was personalised and staff were able to maintain people's privacy and dignity when providing care. People were encouraged and able to maintain links with their friends and relatives.

People we spoke with were positive about the registered manager who they considered open and approachable. They felt any issues they raised would be taken seriously and acted upon.

Accidents and incidents were recorded and analysed by the registered manager in order to minimise the possibility of re-occurrences. Risk assessments were reviewed regularly so they reflected people's current needs and care was provided on that basis.

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. The provider had carried out appropriate checks when employing new staff, but could not assure themselves of their continued suitability as police checks had not always been renewed according to their own policies and procedures.

Staff knew how to keep people safe. The provider was able to ensure people received their medicines as they had been prescribed. Staffing levels were sufficient to meet people's needs.

Accidents and incidents were recorded and monitored and the registered manager assessed these to ensure action was taken to minimise the risks of re-occurrence.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not have a working knowledge of the requirements of the Mental Capacity Act 2005 to help ensure people's rights were protected.

The provider did not ensure all staff had received training in line with their own guidelines. This meant there was a risk people might receive care that was not in line with best practice.

People received care and support they needed to maintain good health. This included access to healthcare professionals as and when they needed them, and sufficient amounts to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring. Whilst we observed caring attitudes from staff, some of the interactions with people did not always put them at the centre of the care provided.

Staff were familiar about people's needs, and they were able to provide care that ensured people had privacy and dignity. The provider had processes in place to provide appropriate end of life care to people.

People were encouraged to maintain relationships with friends

and relatives.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were not offered a range of activities that met their social and recreational interests. This meant there was a possibility of people's social and recreational needs not being met and becoming socially isolated.

People told us they could raise issues and concerns with the registered manager, and they were able to give us a number of examples where their views had been taken seriously and acted upon.

Care provided at Tordarrach Nursing Home was in general, personalised so it met people's individual needs and it was regularly updated so it reflected current needs and wishes.

Is the service well-led?

Requires Improvement

The service was not always well led. The quality assurance systems within the home were insufficient and shortfalls were not being identified. This could be putting people at risk of unsafe and inappropriate care.

People told us the registered manager was open and approachable. Staff were aware of their roles and responsibilities.

Tordarrach 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 inspection took place on 26 April and was unannounced. The inspection was out of hours and started at 7.15 am. This was because of concerns that had been expressed about the levels of staffing during the night and early hours of the day. The inspection was undertaken by two inspectors.

Prior to the inspection we reviewed information about the service such as notifications they are required to submit to CQC. Notifications contained information about significant events the service is required to inform us about. We also had contact with the local authority safeguarding adult's team and received information from the local Clinical Commissioning Group (CCG).

On the day of the inspection we spoke with four people who lived at the home. As some people in the home were living with dementia we also used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot talk with us. We were also able to speak with three relatives who were visiting on the day of the inspection. We looked at records relating to three people who lived at the home, and three staff files to review the recruitment process.

After the inspection the provider sent us information which was not available to us on the day of the inspection, this included some training records and information relating to staff members' police records checks. We also had telephone contact with two healthcare professionals to get their views of the service.

Requires Improvement

Is the service safe?

Our findings

The provider had not taken reasonable measures to ensure the safety of people living at Tordarrach Nursing Home.

We looked at staff recruitment records to make sure only suitable staff were employed by the service. Amongst the checks completed we saw there were the initial application forms and notes from interviews, proof of identity and criminal records checks. The provider also completed additional checks if a nurse was being recruited.

However, we noted for one person the criminal records check had not been renewed since 2011, and in line with the providers' own policy should have been renewed in 2014. We discussed this issue with the registered manager who later told us that the check had been completed by the provider, but the staff member had not supplied the provider with a copy of the check. In the absence of an up to date criminal records check we were not confident the provider could assure themselves of the continued suitability of staff employed by the service.

The provider had not always ensured that the premises were maintained in a timely manner to make sure they were safe to use for their intended purposes. For example the gas and electrical checks were out of date albeit action was being taken on the day of the inspection to address this issue. Additionally, the service did not have a current Legionella test, which was subsequently sent to the CQC after its completion. Legionella is an organism that can exist in water systems if appropriate precautions are not taken and that can cause severe illness to people.

Relatives told us they considered people living at the home were safe because of the care provided by staff. The provider had taken some measures to ensure people were protected from harm which included staff training. Staff we spoke with were clear about safeguarding adults at risk. We saw that through one to one meetings with their line managers, staff were regularly asked about the signs of abuse and what action they needed to take if they thought someone was at risk of abuse. We saw there were also a number of posters displayed throughout the home reminding staff about their responsibilities to ensure people's safety including if they suspected another staff member was putting people at risk.

We reviewed the staffing levels within the home to ensure people needs were being met. On arrival at the home there was a Registered General Nurse (RGN) and a carer who had been on duty overnight for 13 people. They told us it had been a 'busy night but nothing they could not manage'; they went on to say, nights were variable and often there was not a great deal to do other than routine night checks. We were assured by the RGN that if the numbers of people within the home increased so would the staffing levels. During the day, we saw there were three carers on duty and an RGN who was responsible for managing the shift. In addition, there was the registered manager, a cook and a cleaner; there was also an administrator available on certain days. From our observations we considered there were enough on duty to meet people's needs.

People received their medicines safely. We were told only nurses administered medicines. We checked whether the procedures for the storage, recording and administration of medicines were being followed. Those medicines no longer required were returned to the pharmacist in a timely manner. We checked individual records for medicines and saw there was a front sheet which contained a space for a photograph of each person to help staff identify the person to reduce the risk of medicines being administered incorrectly. We saw the medicines administration records (MAR) were complete with no errors or omissions. We also checked the stock of medicines against the balance which indicated people were receiving their medicines appropriately.

Risk assessments that related to people's care and treatment had been completed and were reviewed regularly. These risk assessments were developed with the aim to maintain people's independence as far as possible. They covered areas such as people's mental health, moving and handling, nutritional screening and risk of falls. These risk assessments were reviewed monthly and more often if required. We saw they were written in a way to prompt and advise staff about action they should take. For example, staff were reminded to get a person consent prior to supporting them with their mobility. There was also a record of all incidents and accidents. In this way the registered manager told us they were prompted to monitor these and to identity any patterns in order to minimise the possibility of re-occurrences and to update risk assessments as required.

Requires Improvement

Is the service effective?

Our findings

People were at risk of receiving care from staff who were not appropriately trained or aware of best practice. This is because staff did not receive all the training they needed to ensure they were appropriately prepared to fulfil their roles and responsibilities. We saw the provider had a computer record which identified when training was completed, if a certificate had been issued and how long the training was valid for. We viewed this information on the day of the inspection and were sent subsequent information. However, we were still unable to ascertain what training if any had been completed by certain members of staff. Training in regards of dementia awareness appeared sporadic, with some staff telling us they had completed dementia awareness training, others they were booked onto a training course later in the month and others staff telling us they had not received any training in this area.

We looked at three records of staff members in detail. The provider had identified manual handling, safeguarding adults at risk and fire safety as amongst the training they considered mandatory. Records showed that one member of staff had not completed any training, another's training had not been refreshed since 2013 and one staff member had completed two out of three training courses within the last year. This meant that out of nine training sessions that should have been completed by three members of staff, only four were documented as completed.

Additionally, information from the CCG confirmed that staff from the home had not attended two recent courses arranged by them in relation to improving their skills and knowledge in caring for and treating people who use the service. The registered manager told us they had not attended this training as they similar courses with the NHS.

People living at Tordarrach Nursing Home were therefore at risk of receiving inappropriate or unsafe care.

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

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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider had made two applications to the local authority to deprive people of their liberty and these

had been granted. Staff received training in MCA and DoLS. However, in our discussions with staff some were unable to show they had a working knowledge of what MCA and DoLS meant for people living at the home. For example staff were unaware that if they wanted to prevent a person who might be at risk from leaving the home, then there needed to be an authorisation under DoLS in place. This meant there was a risk that people may be deprived of their liberty illegally. This is not acting in people's best interests and in accordance with the MCA 2005.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We heard staff seek people's consent prior to them providing care, for example, one member of staff was heard to ask "Can I help you with that?" Staff were also prompted in written documentation to seek consent before offering support to people.

Staff received supervision and were appropriately supported by their line managers in their roles. There were various forums for staff to talk about their work, professional development and share information. We saw staff received one to one supervision with their line manager every three months. There were also monthly staff meetings in which information was shared regarding the provision of the service to people. We saw there were staff annual appraisals which helped staff to consider their professional development and their overall performance within the home.

We saw people were encouraged to eat and drink sufficient amounts to maintain their health and well-being. People appeared to enjoy the food; one person told us "Food's nice, very good." Staff were observed asking people if they wanted any more to eat or drink, and waiting for a reply before responding. We saw records showed people were weighed monthly. If there were any significant changes in their weight it was identified quickly and appropriate action taken. We saw the provider had made referrals to speech and language therapists (SaLT), where people were not able to eat their meals properly because of the risk of choking and advice provided by them regarding supporting people to eat was in people's care plans.

People had access to healthcare services as and when they needed them. The home routinely completed weight and blood pressure checks on people to alert them to any significant changes in people's well-being which they could then refer to healthcare professionals. The home had regular contact with a range of professionals, this included the community GP's, tissue viability nurses and SaLT. There was also evidence that people saw opticians and dentists when required.

Requires Improvement

Is the service caring?

Our findings

We received positive comments from relatives about the care provided. One person told us, "They are all very, very caring" and another relative said "always very nice and [mother] is very happy". One person living at the home also told us, "It's good in here."

Whilst the comments we received from people were positive about the care provided by staff at Tordarrach Nursing Home. We observed a number of interactions which did not put people at the centre of the care provided. For example a person was poorly positioned by staff whilst they were being supported with their meal, so that they had to lean forward which resulted in them being uncomfortable, after a few minutes they were repositioned. On arrival at the home at 7.15 am most people were still asleep in their bedrooms; however, a member of staff still let doors slam and switched on a bedroom light, and had to be reminded it was still early in the morning. A further example was a member of staff putting on 1940's without consulting people, while the television which was still on and resulted in the lounge being very noisy. People in the lounge had previously said they wanted the music turned off.

We raised these issues with the registered manager who was unable to give explanations about why they had occurred. The registered manager agreed to observe care and if it became necessary provide additional training to staff about person centred care.

Staff were able to tell us how they provided care, including personal care, that ensured people had privacy and dignity. We saw staff were knowledgeable about people's preferences and were able to provide care on that basis, for example one person enjoyed porridge and a banana for breakfast and the home provided this. Staff's knowledge was supported by information contained in people's care plans. We saw there was documentation developed by the Alzheimer Society called 'This is me', which contained information about a person's life history, and their likes and dislikes. Additionally, there was information for staff about communication methods for people who may have limited verbal communication. In one example we looked there was advice about using written communication for someone receiving respite care. This ensured people had the relevant information to be able to make decisions about their care and daily life.

People were supported to maintain relationships with friends and relatives. Relatives said there were no restrictions on when they could visit the home and they always considered they were welcome. we saw a number of relatives visit the home on the day of the inspection.

We saw there was a range of information available to people in the foyer area, this included information about dementia and funding of care services, as well as the provider's complaints policy.

The provider had the necessary arrangements to provide end of life care to people should it become necessary. We saw the staff had recorded people's wishes for their care and in some instances a 'Do not attempt resuscitation' form had been completed which recorded people's wishes about being resuscitated should they become unwell and stop breathing. The home also had a document from the local hospice entitled 'Looking Ahead' for those people who were nearing the end of their life. This document was

appropriately completed and contained information about the person's preferences for end of life care and wish for funeral arrangements

Requires Improvement

Is the service responsive?

Our findings

There was a limited range of activities available to people at Tordarrach Nursing Home and met their individual needs. There was an activity timetable which suggested that singing and bingo would be taking place during our inspection, but neither activity took place. There were newspapers available which some people read, but these were out of date; A member of staff told some people to write their name and age on a piece of paper, however they offered no explanation about the purpose of this; There were two televisions on in the lounge area but generally they were not being watched. From our observations some people sat in the lounge for long periods with little stimulation and with their meals being served to them where they sat. this meant that some people were not able to sit in the dining area with other people to eat their meals and those who required support had little opportunity to move around the home.

We raised this with the registered manager who told us that three times a week, two volunteers from the local high school came to the home to play games and chat with people. whilst it was good to see that the provider had made this arrangement, there was an over reliance on students volunteers from the local school who were only able to visit the home during term time to engage and stimulate people living at the home. There was support for people with their spiritual needs through weekly visits from a local priest and a fortnightly religious service held at the home.

We did observe from time to time staff sitting with people and engaging with them. There was also a steady flow of relatives throughout the day and one person was able to tell us how their visitor had taken them out for a pub lunch the previous day.

Throughout the day we heard and observed people were given choices about what they wanted to eat and wear. One person told us about being asked about what they wanted for lunch, "They [staff member] asked about chicken, but I'm not a great lover of chicken. So I asked for jacket potato with some beans, you can ask for what you want." We heard people were also asked what they wanted to drink and what they wanted for dessert. There was also information contained in people's care plans which prompted staff to discuss with people what they wanted to wear.

We saw a timetable throughout the home which seemed to indicate a task orientated approach to the day including a 6.30 pm bedtime. We discussed this with a number of people who told us it was their choice. We raised this with the registered manager who assured us that people only went to bed at this time if they requested it. We were told some people did chose to go to bed in the early evening and watch television in their own bedrooms.

The provider ensured people's needs were assessed before they were admitted to the home, to make sure their needs would be met in the home. Before admission the registered manager gathered information from a variety of sources including from other social and healthcare professionals. care plans we looked at showed that people's needs had been appropriately assessed and their preferences, likes and dislikes were recorded. We saw information in the care plans was regularly reviewed and updated so it reflected people's current needs.

There were systems in place to address complaints. We saw the provider had a complaints policy which was available in the communal areas. People told us, they had no hesitation in approaching the registered manager or other staff if they had any issues or concerns. They were able to give us a number of examples were issues had been raised and subsequently resolved.

We recommend that the provider review the provision of activities in the home according to guidance from reputable sources, including the social care institute of excellence (SCIE) guidance called, "Activity provision: benchmarking good practice in care homes."

Requires Improvement

Is the service well-led?

Our findings

We found the provider did not have an effective governance system to enable them to routinely and proactively monitor the quality of the service to ensure the safety and welfare of people. For example with regard to staff training, the provider had not demonstrated they were monitoring the training delivered to staff to ensure they were developing their skills and knowledge to care for and treat people appropriately.

In another example, the provider had not assured themselves of the continued suitability of a member of staff, as they had identified the need for a renewal of a criminal record checks, but had then not examined it for the two years since it had been completed. Additionally, some premises safety checks were currently out of date and although they were being completed this was being done retrospectively.

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

Notwithstanding the above information regarding effective governance, we did see some evidence the provider sought the views of people, so that improvements could be made regarding the quality of care. On the day of the inspection the registered manager was only able to show us evidence of completed questionnaires from 2014 and two visitor's questionnaires, one completed in January and one in April 2016. However, after the inspection, the provider supplied us with a copy of an annual assessment completed 2015 for Tordarrach. We also did see evidence of medicines being routinely checked and audited including the monitoring of controlled drugs.

Relatives and staff told us the registered manager was open and approachable. People told us they felt comfortable raising any issues and that they would be listened to and their concerns addressed.

Tordarrach Nursing Home was using the 'Red Bag' initiative which was instigated by the CCG for care homes to implement. The aim is to improve the processes of admissions of people to hospitals and their discharges back into the care homes. In this way the home was co-operating with other agencies to help provide seamless care for people.

Staff were aware of their roles and responsibilities within the home and said the registered manager made sure they were clear of these. Staff told us the registered manager was open and approachable. We saw evidence of this through supervision meetings with staff, and during staff meeting where there were discussions about the direction of the home and issues relating to good practice.

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	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not act in accordance with the Mental Capacity Act 2005 and people were at risk of being deprived of their liberty unlawfully. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess and monitor the quality and safety of services provided, including the experience of people receiving the service to identify any areas for improvement so these could be addressed. Regulation 17 (2)(a)(b)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not take all measures to ensure staff were appropriately trained to undertake their roles and responsibilities. Regulation 18 (2)(a)