C M B Wharton

Tyndale Nursing Home

Inspection report

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Date of inspection visit: 9 and 10 December 2014
Date of publication: 04/06/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

Tyndale nursing home was last inspected on 9 September 2013. The home was found to be non-compliant in relation to the provision of care and welfare, assessing the quality of the service and staff support.

When we visited there had not been a registered manager in post for the last four months. 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.

Tyndale Nursing home provides nursing care and support for up to 27 older people. At the time of the inspection there were 19 people living at the home.

The lack of registered manager impacted on the support and guidance to staff. There were no effective systems to improve the standards in the home which meant that it was failing to meet the expected standards of care.

Staff lacked the guidance and support to be able to give medicines safely and in accordance with the relevant legislation. This put people at risk of receiving medicines inappropriately.

Summary of findings

Some people told us that the staff met their care needs but this is not what we found. There was insufficient evidence to say that people were involved in the planning of their care. Records relating to people's care and support needs did not always give staff the information they required to keep people safe. They failed to plan and assess people's needs in order to ensure they were met in a consistent manner.

The provider was not meeting the requirements of the Mental Capacity Act 2005 and assessments of people's capacity had not consistently been made. The staff at the home, whilst understanding some of the concepts of the Act, such as allowing people to make decisions for themselves, did not demonstrate that they could implement this.

The staff demonstrated a degree of caring and compassion to people living at the home but did not understand how to meet all the needs of those people with enduring mental health illness such as dementia. People were not consistently offered choices at mealtimes such as where to sit and what to eat. One person who required staff support at lunch time was not offered this.

People told us there were enough staff to meet their needs. One person told us "I never have to wait long for help to get up in the morning." Another said "When I ask for help there is always someone around to help, if I press my call bell someone comes". Whilst there were enough care staff to support people living at the home the lack of management leadership impacted on the support staff received.

We made compliance actions in relation to; Care and consent to treatment, management of medicines, staff support, quality assurance, care and welfare, record keeping, food and nutrition and respect and involving people.

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?

Inadequate

The service was not safe. Medicines administration was not safe at the home. People were put at risk of being given medicines inappropriately.

Some people had risk assessments and care plans to keep them safe but not all. This put some people at risk of harm that could have been avoided or minimised.

People were supported by sufficient numbers of care staff to meet their needs

Is the service effective?

Inadequate

The service was not effective. The service was not effectively meeting the needs of the people who used the service and inadequate arrangements had been made in relation to the Mental Capacity Act.

People were supported by staff that knew some of their needs but the training available to them did not equip them with the skills and knowledge to support and care for people living with enduring mental health illness.

Is the service caring?

Requires Improvement

The service was caring but improvements were required. A caring approach was observed by staff but this was not consistent. Some people were respected as individuals but not all.

Staff were aware of some people's daily routines and supported them in the way that they wished but this was not consistent for everyone.

People were not consistently enabled to make individual choices about how they spent their time.

Some people were supported to maintain contact with friends in the community.

Is the service responsive?

Requires Improvement

The service was not fully responsive to people's needs. Health care interventions were not planned safely which meant that some people were at risk of health acquired infections.

People told us they had been consulted about the way they wanted to be supported but the documents available did not record their views.

Some people were provided with activities based on their interests but not all.

Is the service well-led?

Inadequate

The service was not well led. There was no registered manager to provide support and leadership to the staff.

Summary of findings

The systems in place to monitor care practices and ensure ongoing improvements had lapsed. This led to many areas of the quality of the service falling below an accepted standard.

Senior staff worked hard to provide leadership but they did not have support to achieve and sustain improvements.

Tyndale 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 9 and 10 December and was unannounced. At the time of the inspection the provider was in the later stages of the sale of Tyndale Nursing home. The inspection was completed by one inspector.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. At the time of the inspection a Provider Information Record (PIR) had not been requested because the inspection was in response to information of concern. In order to gain further information as to how the service was managed we spoke with the seven people living at the home and two visiting relatives. We also spoke with seven members of staff.

We looked around the home and observed care practices throughout the inspection. We reviewed five people's care records and the care they received. We reviewed records relating to the running of the service such as environmental risk assessments, fire officer's reports and quality assurance monitoring audits.

We contacted two health care professionals involved in the care of people living at the home to obtain their views on the service.

Observations, where they took place, were from general observations. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us

Inadequate

Is the service safe?

Our findings

People were not protected from the risks associated with the use of medicines as practices were unsafe. Medicines received into the home could not consistently be accounted for as staff had not always recorded how many tablets had been delivered. Staff had not always signed the medicine administration records (MAR) to evidence that medicines had either been administered or refused. This made it impossible to ensure that medicines were given as prescribed. This also meant that medication audits that had been carried out were unreliable as there was insufficient evidence that medicines had been dispensed as prescribed. Records in relation to the administration of controlled drugs were inaccurate as a controlled drug had been signed for as administered but had not been. This is a breach of regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they felt safe and did not have any concerns about their safety. Relatives said they were not concerned about their 'loved ones' safety at the home. However, we found that people were not always kept safe. People's care records illustrated the risks that they faced, but the plan of action to protect the person from these risks was not effective. For example, we noted in one person's care records they had epilepsy and were at risk of falling. We did not see any guidance to staff to minimise this risk apart from staff to monitor them, staff did not comment on the risks of falling when asked. This person also required the assistance of a wheelchair but the risk assessment, whilst noting the risk of falling from a wheel chair, did not link the risk to epilepsy. Another person was at risk of choking at meal times and required staff support to eat. Staff were aware of the need to support this person at mealtimes but were unclear as to what food to avoid. The person had not been referred to a specialist for advice on the foods to encourage and the foods to avoid. This meant that people were placed at risk of harm that could have been minimised through clear guidance to staff. This is in breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient numbers of staff on duty to meet people's needs, but not management staff to support them. People told us there were enough staff to support them when required. One person said, "I never have to wait long for help to get up in the morning." Another said, "When I ask for help there is always someone around to help, if I press my call bell someone comes". The staff told us at times they could do with more staff but agreed that at the time of the inspection they did not need extra. The care staff rotas confirmed that the current staffing levels had been maintained in the previous month. However senior staff were covering in the absence of a registered manager. They told us that they were trying to run the home and to cover their own work allocation. This meant there were insufficient staff at senior level to safely manage the home.

Staff had the knowledge to understand what abuse is and how to contact outside agencies should they have concerns about the people living at the home. Staff told us about their understanding of safeguarding people living at the home from abuse. They told us they had received training and were able to describe who they could go to if they considered people were at risk of abuse. What we were told reflected the provider's policy on abuse.

Inadequate

Is the service effective?

Our findings

Mental capacity assessments were not meeting the requirements of the Mental Capacity Act 2005 (MCA) as ongoing assessments had not been made. For example, we observed that one person was displaying disinhibited and aggressive behaviour. The person's care records demonstrated they had received the support of specialist health care workers who had concluded that the home could not met this person's needs and a further MCA assessment was needed, but this had not been completed. The senior member of staff told us they had been working with other professionals to address this issue but no progress had been made since July 2014. However there was no effective plan to meet this person's needs.

The senior staff told us that the person wished to stay at the home but there was little documentary evidence to support this. The plans of care demonstrated that although the person's needs had been kept under review the plans had not significantly changed from July 2014. We saw that actions that should have been addressed, such as a MCA assessment and best interest decision, had not been. The senior staff were inexperienced in meeting the persons mental health needs and were relying on other outside professionals to address this. There was no plan in place to indicate what the next steps to meeting this person's needs were. This is in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The senior member of staff was unsure who had received training in relation to the MCA. We were shown a training plan which indicated who had and who had not received training. The training plan was confusing as the dates recorded showed not only when training was due but also when it had been completed; there was no information to inform which date was which. Senior staff told us the training records were incomplete as some training that had been completed had not been recorded. These records showed that none of the senior staff at nursing level had received training in the MCA and Deprivation of Liberty Safeguards (DoLs) whilst 90% of the care assistants had. (A DoLS authorisation provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.) As senior staff were responsible for guiding and informing care assistants, their lack of training in MCA and DoLS meant that they may make inappropriate decisions.

The senior member of staff supporting us at the inspection identified eight people living at the home who lacked mental capacity to make certain decisions; by looking at people's care records we identified another two people. The MCA capacity assessments in the five care records were not completed. This meant that decisions regarding people's care may have been made outside of the MCA framework and their rights may not have been protected.

Some people could not go out into the community alone and needed staff support. DoLS authorisations had not been considered for these people. This meant that people's rights may not have been upheld. Where people required a Best Interest Decision (BID), some had been made, mainly in relation to bedrails, but these had not been kept under review in line with the homes policy. The above demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out an observation over the lunch time period in the main dining room. Nine people were not assisted to the dining tables to eat and were served their meal where they had been sat all morning. No one was offered a choice of meal. One person, who according to their care records would require support with their meal, was not given this.

We asked two people what choices they had been offered for lunch but they did not know. We asked three staff if people had a choice about where they sat to eat their lunch. They told us they should have been offered a choice but they did not today. We asked how people had a choice about what they had for lunch. They were unclear; one staff member thought that the kitchen staff knew what to serve. We did not have an opportunity to talk with kitchen staff.

We looked at five people's care records in relation to their diet, choices of food and monitoring their weight. Their care records recorded some of their choices. There were monitoring records of people's weight but some weight loss had not resulted in any action by staff for example. One person had lost weight. The care records informed that if the person continued to lose weight, which they had, a

referral to the dietician should be made but this had not been done. A check on the systems in place to monitor nutrition, carried out in December 2014, had failed to note this. Therefore people were at risk of not have their nutritional needs met. This is in breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about how they supported the 19 people living at the home to bathe. They told us that whilst there were three bathrooms only one was available for use because of access restrictions and lack of suitable equipment. Some of the carpets in communal areas and hallways were worn and presented trip hazards to those living in the home.

Staff told us about the training available to them. Staff told us that they had received some training recently but this had stopped due to complications with the company appointed to deliver the training. They also told us that apart from face to face training all of the training they received had been distance learning. Two staff told us they did not like to train in this way as they valued having the opportunity to discuss issues with others in a training environment. We looked at the records relating to the training that staff had received in the past 12 months. These showed that some training had taken place but the records were unreliable to make a full evaluation. People told us that they felt staff had the necessary skills to meet their needs, one person stated “The staff know how to help me, they must have had training as I have special needs”. The records relating to staff training failed to reliably illustrate a programme of ongoing improvement in staff skills.

People’s care records evidenced there were regular health care interventions based on need. People had access to healthcare professionals according to their specific needs. People told us if they felt unwell a doctor or other health care professional would be called. Two relatives told us staff ensured that people saw a specialist health care advisor when needed.

Requires Improvement

Is the service caring?

Our findings

We spoke with one person about how they experienced care at the home. They told us "Staff talk too much, but they are good to me. What I like to do is knit, it keeps my fingers moving, it's all I really do but that's enough". Another person told us "it's alright here, the girls (staff) help as some things are difficult for me, when I need support they come". For those people who could not inform us how they experienced care we observed that the some staff did not talk with them or make time to ensure they were comfortable.

A number of staff at the home had worked at Tyndale for a number of years. As such they knew some of the people's needs well and had built up positive relationships with them. We spoke with staff about people's daily routines, their likes and dislikes. From these discussions it was clear that some people's needs were well known whilst others were not. For example, staff could describe what time a person liked to get up, what activities they enjoyed and what they like to eat. However for another person they could only describe the task they performed such as support with washing and dressing. For one person who displayed challenging behaviour the staff did not understand their behaviour. From discussions with staff it appeared that no one had formed a caring relationship with the person in order to be able to support them in a positive manner. This is in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that when some staff addressed people they were respectful and polite and listened carefully to what people told them, others did not. When people required support to go to the toilet some of the staff were discrete and supported them without fuss. We observed that when a person required help to get from a chair to a wheelchair the staff were patient and talked with the person to reassure them they were safe. However this was not apparent in all the support observed as we observed another person hastily assisted to transfer from a wheelchair to lounge chair, by way of a hoist, with no discussion between staff and the person being assisted.

There was little evidence people living at the home had been included in the reviews of their needs. We spoke to five people and asked if they were consulted about their needs. One person told us "I'm not sure, staff ask if I want anything and if I am ok", another told us "I leave it up to my family". Other people we spoke with could not comment about how they were consulted due to enduring mental health illness. Their records did not evidence that they had been consulted about their care needs and about how they experienced the service on offer at Tyndale nursing home.

Requires Improvement

Is the service responsive?

Our findings

People who required nursing support did not always have their health care needs responded too in a planned and coordinated way. We looked at the plans of care for people who required a urinary catheter to support people maintain their continence. We asked nursing staff how they ensured that people's catheters were changed as regularly as required. They told us that the change date was recorded in a diary. We looked at the diary to confirm the planned date was within the licence. The date of the proposed change date would have been outside of the licence by four days and would have put the person at risk of health acquired infection. This is in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. which corresponds to regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they had been consulted about their interests and aspirations. However people's care records did not evidence this. In most of the care records there was some information about the person's life, what work they had done and some of their interests. The information provided an overview of the person on admission but this had not been built on in their time living at the home or used to provide meaningful activities.

Staff did not provide any meaningful activities or consistently engage with the people living at the home. This was evidenced whilst observing staff in the main lounge / dining area. One person received attention being supported by two staff in playing cards, whilst the other eight people just sat and looked around. We noted that one person was supported to go into the community by a staff member to attend a community activity. The person told us how much they were looking forward to this. However no other activities were observed during the inspection. There was little staff led discussion with people such as, discussing things that maybe important to the person like the daily news events or sport.

The people we spoke with were aware of how to make a complaint and that if there was an issue they would tell staff who would address this. The provider had policies and procedures for dealing with complaints or concerns. This was made available to people and their families. At the time of the inspection the compliant log did not indicate that there had been any formal complaints for the provider to investigate.

Inadequate

Is the service well-led?

Our findings

The home was not well led. At the time of the inspection the provider was in the later stages of the sale of Tyndale Nursing home. There was no registered manager providing leadership at the home. The senior member of staff covering the management responsibilities at the home did not have any support for this role. We spent time talking with them about the challenges they faced. They acknowledged that there was no clinical support or supervision for the nursing staff. However they had some guidance from the NHS Somerset Clinical Commissioning Group (CCG) and district nursing staff.

The senior member of staff acknowledged that a number of checks on the quality of care provided had not been completed. They showed us a structured plan that they had drawn up to address this but they had yet to make any progress on this plan as they did not have the support to achieve this. They told us that they needed guidance and more knowledge of the expectations within the regulations, as set out in the Health and Social Care Act 2008 (HSCA 2008), in order to ensure the home was meeting these requirements. One of the consequences of the staff member not understanding the requirement of the HSCA 2008 was that they had failed to report significant incidents such as a controlled drugs error as required. This is in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not made suitable arrangements for the management and support of staff during the period without a registered manager. The impact of this was that the home was not fully meeting people's needs in a consistent and planned manner.

The people living at the home could not identify who was managing the home at the time of the inspection. Staff told us that they were trying to support the provider with some of the duties of management but people's roles and responsibilities were not clearly defined. An example of this was one staff member told us they had recently offered to complete formal staff supervision that had lapsed. (Staff supervision is an opportunity for staff to talk with their line manager about their developmental needs and any issues that affect the way they do their work). Whilst they were clear that these supervisions needed to be carried out, they were unclear about the purpose of supervision. The senior member of staff helping us confirmed that this staff member would start staff supervisions shortly.

Staff were not protected from abuse by people living at the home. We saw in one person's care records that they were racially abusive to staff. The provider's policy on racial abuse stated that staff will be protected and management would be proactive in ensuring staff did not suffer racial abuse. The staff told us, "that's just the person's way of saying I don't want personal care". The person's care records did not identify this issue as cause for concern and did not offer guidance to staff on addressing this issue with the person. This above demonstrates a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us about what it was like to work at the home. They talked about the problems they faced and the uncertain future of the home. They told us that they felt supported by the senior member of staff and that the "team" (staff) work well together to meet people's needs. The staff told us that team meetings had recently restarted. All of the staff told us they appreciated these meetings as it gave them the opportunity to discuss concerns and be given information on what was happening with regards to the sale of the home.

We spoke to health care professionals of the CCG who told us about their concerns that reflected what we had observed and had been told by staff at the home.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines because the provider had not made appropriate arrangements to manage medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had a system to regularly assess and monitor the quality of service that people receive but this was not fully effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Where people did not have the capacity to consent, the provider had not acted in accordance with legal requirements.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not consistently planned or delivered in a way that was intended to ensure people's safety and welfare. People were not adequately protected from the risks of inadequate nutrition and dehydration.
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People’s views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.