Care Quality Commission

N. Notaro Homes Limited

# Casa di Lusso

## Inspection report

Bower Lane
Bridgwater
Somerset
TA6 4GU

Tel: 01278557100

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06 June 2018

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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 well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

We undertook an unannounced focused inspection of Casa Di Lusso on 6 June 2018. This inspection was undertaken in response to concerns we had received about the service.

The inspection team inspected the service against three of the five questions we ask about services: is the service well led, safe and effective. No risks, concerns or significant improvement were identified in the remaining Key Questions through our on-going monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

At the last inspection in October 2017, the service was rated Requires Improvement.

Casa di Lusso is a purpose built 90 bedded care home specialising in the care of people living with a dementia. At the time of the inspection there were 71 people living at the home. The home is split into eight units all with Italian names, Colosseum, Tuscany, Positano, Pantheon, Pisa, Trevi, Vesuvius and Pompeii on the top floor.

There was a manager in post but they were not registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was not available during our inspection, the Quality and Performance Manager was overseeing the service in their absence.

Although people and their relatives told us they felt safe living in the home, the systems in place to protect people from harm needed to be improved. There were frequent incidents involving people becoming anxious and physically challenging to other people and staff. Incidents were not being reviewed for themes and trends to identify factors that could prevent further incidents from occurring.

Staff had not received all of the training required to ensure people and staff were safe during incidents. Staff from other countries received training that included the English language, where this was identified as a need.

The provider had not notified the Care Quality Commission and the local authority of safeguarding incidents in line with their legal responsibility. The governance systems had not been fully effective in improving the quality and maintaining the safety of people. A new governance system was in the process of being introduced.

People received adequate nutrition and hydration, although records demonstrated prior to the inspection these needs had not been met. Further details were required in some of the care plans in relation to

people's dietary needs.

Staff felt staffing levels had improved but there were key times of the day in the smaller units where an additional staff member would benefit people's needs being met in a timely manner.

## 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**

Some aspects of the service were not safe.

The systems in place were not suitable to protect people from the risk of harm.

There were key times that needed to be reviewed to ensure there were enough staff available to meet people's needs in a timely way.

### Is the service effective?

**Requires Improvement**

Some aspects of the service were not effective.

Staff did not receive all of the training required to meet people's needs and to keep them safe.

People received adequate nutrition and hydration.

### Is the service well-led?

**Requires Improvement**

Some aspects of the service were not well led.

The governance systems to monitor and improve the quality and safety of the service people received were not fully effective.

The provider had not notified the Care Quality Commission of all incidents in line with their legal responsibility.

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# Casa di Lusso

## 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 focused inspection was prompted by concerns we had received about the service relating to staffing levels, the management of incidents involving people becoming anxious and physically challenging towards other people and staff, staff training, concerns relating to people's nutrition and hydration and concerns relating to staff not being able to effectively communicate with people.

The inspection took place on 6 June 2018 and was unannounced.

This inspection was carried out by two inspectors, a specialist professional advisor who was a nurse and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with ten people and seven visitors including people's relatives, about their views on the quality of the care and support being provided. Some people were unable to tell us their experiences of living at the home because they were living with dementia and were unable to communicate their thoughts. We therefore 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.

We spoke with the quality performance manager, the deputy manager and eight members of staff including the registered nurses.

We looked at the care records for ten people living at the home. We also reviewed training records and the provider's governance systems.

Requires Improvement

# Is the service safe?

## Our findings

Although people and their relatives told us, they felt safe living at Casa Di Lusso we found the systems in place to protect people from harm needed to be improved. For example, some people living in the home, due to their specific needs, at times experienced anxiety, and confusion, which could lead to physical and verbal incidents towards other people and staff. Records demonstrated these incidents were occurring frequently. Whilst staff described how they managed people's anxieties and the incidents, we found there was a lack of detailed guidance for staff to follow, to prevent the risk of incidents occurring, or the action to take during incidents. Staff told us these incidents were, "Sometimes manageable and sometimes not" and "Difficult." This meant people and staff were placed at risk of being harmed due to the levels of incidents and lack of action being taken to prevent this.

When incidents occurred between people these were recorded by staff, however they not always reported to the safeguarding team or to the Care Quality Commission. In addition, the incidents were not reviewed and analysed for themes and trends to prevent further incidents from occurring. We discussed this with the Quality and Performance Manager who told us the new computerised care planning system would enable incidents to be reviewed and analysed, they also told us they would ensure care plans included more details relating to the action staff should take to prevent and manage incidents.

Records demonstrated one person had made a safeguarding allegation on three occasions. Whilst staff had reported this to the senior member of staff, a safeguarding alert had not been made to the local authority. We discussed this with the quality and performance Manager who told us they would ensure a safeguarding alert was raised.

People and their relatives told us they felt safe living at Casa Di Lusso. One person told us, "I am safe here I have nothing to worry about." Other comments included, "I have no worries here about anything, I feel safe", "No concerns about safety at all here" and "Not concerned about anything here, they (pointing at the staff) keep us all safe and sound."

Prior to the inspection, we received concerns relating to the staffing levels at the home. During the inspection, we found there were enough staff on duty to ensure people received the care they needed. Throughout the inspection, people's needs were met in a timely manner, and call bells were responded to promptly.

People and their relatives told us there were usually enough staff available to meet their needs and staff responded quickly to call bells. People told us, "Plenty of staff around here" and "Plenty of staff around here to look after me, if you ring the bell, they come very quickly." Comments from relatives included, "Always plenty of staff here, they all seem to know what they are doing", "Plenty of staff here, everything my [relative] needs is carried out in a timely fashion", "I never have to wait for my [relative] to be attended to, they sort everything out straight away", "There are plenty of staff here, you can call them for help anytime and they respond straight away, you ring the bell and it is answered within seconds, good" and  "Enough staff here to meet my [relative's] needs, you ring the bell and it is answered quickly."

However, we did receive some feedback there were a small number of times this was not consistent. One relative commented they thought the home was short of staff on some weekends, they commented, "Generally there is enough staff here, however, some weekends there does not appear to be enough staff, this is a problem if someone rings in sick at short notice."

During our conversations with staff and visitors, we received feedback that the two smaller units Pisa and Colosseum could at certain times of the day require an additional member of staff to support people. Staff commented that although generally, the staffing level was sufficient, during personal care periods in the morning and evening additional support would be beneficial to meet people's needs timely. Although the service had deployed a 'floating' member of staff to support, they were not always immediately available to support. We advised the Quality and Performance Manager of this who stated they would review current arrangements for these units.

We spoke with the Quality and Performance Manager about staffing levels, staff deployment, and admission strategies. We were told that staffing had recently been increased and that staffing rotas had been forecast two months in advance to help stabilise staffing numbers. Staff we spoke with confirmed staffing had improved recently and people's needs were met. One staff member told us, "I have no concerns with the general staffing levels." Other comments from staff included, "Staffing levels are a lot better than they were" and "Staffing levels have got better." Another staff commented how the new electronic care plans had improved care and said, "[It] gives us more time with the residents."

We discussed the calculation of staffing levels within the service with the Quality Performance Manager. They told us that currently no formal dependency assessment or tool was used. Staffing levels were currently calculated by observations around the service and feedback from people, the relatives, and staff. In relation to recruitment, the service had recently recruited 15 new care staff who were awaiting pre-employment checks to be completed to commence. Interviews for the two nursing staff vacancies were planned. The service would then be fully staffed. Current vacant shifts were covered by regular agency carer staff or existing staff.

We also discussed the projected admission strategy for people moving into the service. There were plans to commence a staged admission process when the new care staff commenced to ensure people's needs could be met. The top floor of the service that had 16 large individual rooms was currently empty and plans were being made to commence using these rooms.

Requires Improvement

# Is the service effective?

## Our findings

Staff had not been suitably trained to meet people's needs and keep them safe.

Although training was provided, we found that training in a key area to safeguard staff and meet the needs of some people at the service had not been provided.

Staff however were not supported through appropriate training to respond when people displayed behaviour that may be challenging, this included when people were both verbally and physically abusive towards them. Some people living at the service had complex mental health needs. We found evidence within the records we reviewed of numerous occasions where staff had been spoken to aggressively, had objects thrown at them or had been physically assaulted by people.

Staff told us they had not received any training in relation to supporting people at times when they were anxious, which could lead to them displaying aggression towards other people and staff. Records demonstrated there were frequent incidents between people, and incidents resulting in staff being physically hit. Staff told us they did not think they had the right training to support people at these times. Staff we spoke with gave accounts of incidents where they were unsure how to respond to acts of aggression towards them. One member of staff commented, "[I have] been in a situation when a resident has gone for me when we were standing. I didn't know what to do." Another member of staff told us they felt vulnerable at times and said, "We could do with that sort [management of challenging behaviour] of training, definitely." Other comments included, "Sometimes incidents are manageable, and sometimes they are difficult. We do not have enough training to manage incidents" and "We could do with training on managing incidents."

Records showed that no training for staff was provided in the management and response to this type of behaviour. This placed people at the service at risk and exposed staff to the risk that they may respond inappropriately to a situation. This could result in the risk of harm or injury to both people using the service and staff as an inappropriate response may escalate a situation.

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

The provider had an induction aligned to the Care Certificate. This is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. Staff received training in other areas, for example moving and handling, safeguarding adults and infection control. Staff we spoke with commented positively on the training provided.

Prior to the inspection, we received concerns about people not receiving adequate nutrition and hydration. Improvements had been made but people were at risk of receiving inconsistent support to meet their nutritional needs.

Some people received their nutrition and hydration via a percutaneous endoscopic gastrostomy tube (PEG). This feeding tube is placed directly into the stomach. Staff are responsible for ensuring the right nutrition and fluid is given via the tube. We looked at the previous months records of nutritional, hydration intake and found staff were not following the guidance in place in relation to the amount of fluid, and nutrition people should receive. However, we noted this had improved.

Although there was guidance in place for staff to follow to support people to receive hydration and nutrition via the PEG, the guidance was lacking specific and clear details for staff to follow. For example, the guidance stated for one person water should be used to flush the feeding tube after each meal. However, instructions were unclear regarding flush volumes following nutritional supplement administration. Records demonstrated there were some inconsistencies over the amount of fluid the person was receiving, with them receiving over the amount detailed in their guidelines. Whilst staff described the care they gave in relation to the care of the PEG, for example, cleaning around the site, this information required for safe PEG feeding was not clearly recorded in the care plans.

Information in relation to health professional instructions about people's dietary needs was not always available in care plans. One person's records stated they should receive a specific consistency thickened drinks and textured diet, however staff were unable to find any instruction from a Speech and Language Therapist to confirm this was the correct type diet for the person. The person had been prescribed a new thickening agent to be added to their drink because they were at risk of aspiration. Two of the staff we spoke with were unclear on the amount of thickener that should be used to ensure the fluid was at the correct consistency. We observed them adding too much thickener to the persons drinks. We discussed this with the Quality and Performance Manager who told us they would ensure staff would receive further training on the use of the thickening agent. The deputy manager told us they would ensure the health professional instructions were present in the care plans.

During the inspection, we found some people had not been receiving adequate nutrition and hydration, however we saw this had improved more recently due to the measures put in place by the Quality and Performance Manager. These included on the use of food and fluid charts to monitor what people ate and drank. In addition an electronic system was being used to identify and highlight to staff people's requirements in relation to this.

People and their relatives commented positively about the food, they told us there was enough food available. Comments from people included; "The food is very good here, you get plenty to eat, look at me I am putting on weight", "Food, you can have what you want", "Food is very good, plenty to eat, never go hungry" and "You get plenty of food here." Relatives told us; "The food here is very good, my [relative] has put on two stone since being here", "My [relative] eats well, not a worry about their food. They require assistance from the staff they make sure they always have plenty to eat" and "My [relative] had supplements and a soft diet, the supplements were always provided as required, no problems." We observed people being offered drinks and snacks throughout the day of the inspection.

Prior to the inspection, we received information of concern that some staff did not have the ability to communicate effectively with people, as their level of spoken English language was not very good. We raised these concerns with the Quality and Performance Manager. They told us that as part of their recruitment of staff from other countries through an accredited agency, staff were required to attend a language course.

Newly employed staff from other countries would attend college on one day a week over the course to improve their language. They told us although all staff that arrived had a basic level of English as that was a requirement; the course was paid for by the provider to support the new staff. In addition to this, the Quality

and Performance Manager advised that on occasions agency staff had been sent to the service to work and had a poor level of English speaking. They had requested these staff did not return due to the communication difficulties it created. They also gave examples of how they had addressed matters when concerns were raised about staff communicating with each other in their first language in front of people.

Requires Improvement

# Is the service well-led?

## Our findings

The governance systems used to monitor and improve the quality and safety of the service were not fully effective. We reviewed the current governance arrangements that monitored, incidents, accidents and instances where people may display behaviour that may challenge. Whilst it was evident that individual records of these incidents were created and retained, it was established that there were currently no systems in operation to monitor areas such as incidents, accidents, and instances where people may display behaviour that may challenge to establish trends or patterns.

We saw the last incident and accident review to establish trends, themes, or patterns was completed in October 2017. This meant the incidents where staff had been spoken to aggressively, had objects thrown at them or had been physically assaulted by people were not monitored effectively. If an accurate oversight of these incidents had been collated, it could have identified the number of incidents that occurred and identify the need for training quicker, as reported on in the 'Effective' section of this report.

Staff concerns around the lack of specific training had not been identified so that action could be taken

Whilst we found people were receiving adequate nutrition and hydration at the time of the inspection, records demonstrated they had not been prior to this. The systems in place to monitor people's food and fluid intake had failed to identify there was a lack of consistent guidance in place.

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

We discussed the governance arrangements in place at the service and arrangements for monitoring going forward. The Quality and Performance Manager showed us the provider level governance systems that had been in operation for approximately two months and were due to be successfully implemented and in operation at the service in the very near future.

The new system encompassed the service undertaking a self-assessment against the Key Lines of Enquiry (KLoE) inspected against by the Care Quality Commission during a comprehensive inspection. In addition to this, all incidents, accidents, nutritional needs, and training would form part of the new electronic record. This system would subsequently allow continual monitoring of incidents and accidents within an individual service within the providers group.

The Care Quality Commission (CQC) had not been notified of safeguarding incidents in line with legal requirements. Providers are required by law to notify CQC of specific incidents, this is so that we can ensure the correct action has been taken. We discussed this with the Quality and Performance Manager who reassured us all further relevant incident would be reported to us in line with their legal responsibility.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

There was a manager in post but they were not available during the inspection. The Quality and Performance Manager told us they were overseeing the service in the manager's absence. Staff commented positively about the management of the home. Comments included; "[Name of Quality and Performance manager] is amazing, you can approach them with anything" and "[Name of Quality and Performance manager] is very approachable and they listen."

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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had not notified us of all incidents in line with the regulation. Regulation 18 (5) (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The systems in place to assess, monitor and improve the quality and safety of the services provided were not fully effective. Regulation 17 (2) (a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not received appropriate training to enable them to perform their role. Regulation 18 (2) (a) |