Mr Joginder Rai

Portland Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

About the service
Portland Nursing Home is a residential care home providing personal care to up to 40 people. The service provides support to older people with a range of health conditions. At the time of our inspection there were 24 people using the service. The accommodation is across three floors, with communal areas on the ground floor.

People's experience of using this service and what we found
Call bells were not responded to in a timely manner as the system was not maintained by the provider. Medicines were not safely managed as temperatures were not routinely monitored, protocols were not in place for as required medicines and medicine records were not always clearly written or fully completed. People were not always protected from the risk of abuse as incidents were not always reported. Fire safety risks had not always been assessed or actions taken to mitigate. Infection control in the laundry needed to be reviewed as it was unsafe.

Meals were not always well presented, and people were not always offered alternative options. Practice fire evacuations had not been completed regularly, storage was limited and impacted on accessibility to a bathroom. Two people were sharing a room and a solution had not been found to ensure this did not impact on relatives visiting.

People's privacy and dignity were not always respected, and people were subjected to institutionalised practice. Bathing routines and other care needs were displayed in a communal area. We found a person sitting in a wheelchair without foot plates.

The complaints procedure was not clear, and records of complaints were not maintained. The provider had no analysis of complaints. People had complained and this had not been recorded. Relatives were not clear on complaints procedure, and one was worried about complaining. People were not engaged in activities and people spent most of their time in their rooms. People's communication needs were not always fully considered.

Governance and quality assurance systems were ineffective, and the provider had failed to monitor and identify areas of improvement needed. There was no engagement with people or relatives to improve the outcomes for people.

People were not always supported to have maximum choice and control of their lives and did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at

www.cqc.org.uk

Rating at last inspection:
The last rating for this service was good (published 28 September 2017).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We have found breaches in relation to medicines management, the provider's quality assurance systems, person centred care and handling of complaints. Please see the action we have told the provider to take at the end of the full version of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Portland Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Portland Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We looked at notifications sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 04 April 2023 and ended on 25 April 2023. We visited the service location on 04 April 2023. We spoke with 4 people that used the service and 11 relatives about their experience of the care provided. We spoke with 7 members of staff including a registered manager, deputy manager, nurses and care workers.

We reviewed a range of records. This included care records for 5 people and multiple medication records. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection we have rated this key question inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment; Learning lessons when things go wrong

- There was no system in place to monitor call bell response times. One relative told us, "I arrived for a visit last week at 2:30, [Relative] had already been waiting for some time for the buzzer to be answered, someone finally arrived at 3:45 and this was not the first time the wait had been far too long."
- Staff could not always respond to people's call bells. The call bell system was linked to pagers carried by staff. The registered manager told us there were not enough pagers for every staff member to have one as some had been lost and not replaced by the provider. One staff member told us, "They are short of pagers at the moment." This meant people needing support would have to wait longer.

The provider had failed to maintain equipment causing unsafe and unreasonable delays to people's care needs being met. This was a breach of Regulation 12 (2) (e) (f) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was using a dependency tool to calculate the number of staff required on shift to meet people's needs. We reviewed rotas that confirmed the planned staffing levels were in place. One staff member told us "It can be challenging at times if people are unwell." One relative told us, "When I first visited the home there was always a member of staff passing by the door and popping their head in to say 'hello', now when I visit, it can be an hour and half and I see no one walk past the door."
- Staff were recruited safely. The provider obtained references from previous employers, checked identity and eligibility to work in the UK, and undertook criminal records checks.

Using medicines safely

- People's medicines were not always managed safely.
- Where people received medicines via a patch (applied directly to the skin), staff did not always document where these had been placed on people's body. We could not be assured staff rotated the application site as per manufacturer recommendations. This placed people at risk of sore skin.
- Medicines were not always stored safely. For example, the medicine fridge and room temperatures were not consistently monitored. Prescribed creams were also stored in people's rooms where temperatures were not monitored.
- Medicines given as required (PRN) did not always have protocols in place. For example, one person had been prescribed urgent PRN for seizures, however no protocol was in place to guide administration.
- Medicine administration records were not always clearly written. For example, notes were handwritten to the back of charts about medicines given. This meant people were at risk if notes were missed by nurses.

● One person was receiving their medication covertly, however the decision making in the persons best interest had not been recorded. This was raised with the registered manager. and we were assured this had been rectified.
● Management audits carried out had not identified any concerns.

The provider had failed to ensure people's medicines were administered safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk from abuse
● People were not always protected from the risk of abuse and incidents were not always thoroughly investigated. We found examples of the provider reporting safeguarding concerns, however 1 concern relating to a staff member's practice was not reported. Records did not detail action taken by the manager.
● Staff had received training in how to safeguard people from abuse. Staff understood how to report any concerns they had to relevant professionals, however records did not demonstrate this had always happened.

Assessing risk, safety monitoring and management
● Fire safety risks had not always been assessed and action had not been taken to mitigate the risk.
● Personal emergency evacuation plans (PEEPS) were not in place for all people using the service. We found 1 person without a plan.
● COSHH products were not always locked away. For example, a chemical spray bottle was found in a sluice room accessible to people as the door was unlocked and a cleaning trolley was found unattended in the corridor.

The provider had failed to monitor and take action mitigate risks to people. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Repositioning records showed people were supported to turn regularly to reduced, the risk of sore skin.

Preventing and controlling infection including the cleanliness of premises
● The provider did not always promote safety through the layout and hygiene practices of the premises.
● We found clean and dirty laundry areas were not clearly defined.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● Relatives and friends were able to visit people in the home without restriction.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- Meals were not always well-presented and the dining experience was not monitored.
- People's meals were served in their rooms and people were not offered the choice to use the dining room. This meant staff support was more limited and people were isolated.
- Meals were not well presented, one person told us "The meals are mediocre". Another person told us, "They are hit and miss."
- We found 1 person had not eaten their meal and pudding was served 10 minutes later. We asked staff if there was an alternative for the main meal for this person and they were offered a cup of soup.
- The manager told us people chose to eat in their rooms since the pandemic and they had tried to change this.
- Meals were ordered through a prepared meals service and heated by staff. The manager told us this was because of difficulties recruiting a chef.

The provider had failed to ensure people were offered a choice of meals supporting their wellbeing and quality of life. This was a breach of Regulation 9 (3) (i) (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support, training, skills and experience

- Staff had not always received the required level of training. For example, the last practice fire evacuations had taken place in 2021. One staff member told us their last practical fire training was before the pandemic.
- Staff had access to online refresher training and had an induction when they started. Staff confirmed they completed mandatory training before they were able to start supporting people.
- The registered manager had systems in place to support and supervise staff. Staff received regular supervision, this included one to one sessions and competency checks which included feedback on performance.

Adapting service, design, decoration to meet people's needs

- The decoration and design of the home did not improve people's quality of life or promote their wellbeing.
- Storage was limited and impacted on accessibility to some areas. For example, a hoist and wheelchair were stored in a bathroom, staff told us these were moved out each time someone used the bathroom.
- Communal rooms were all on the ground floor which could be accessed by a lift.
- Signage in the home supported people with conditions such as dementia to orientate.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been assessed, and considered areas of need including mobility, healthcare, personal care, relationships, and communication.
● People's care and support needs were regularly reviewed to ensure care plans were up to date and meaningful. One staff member told us, "I have time to read the care plans and risk assessments."
● Care plans detailed people's preferences, likes and dislikes. One staff member told us they make sure people have everything they need.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's health needs were considered and reviewed in partnership with other agencies. Systems to refer people were in place and care plans evidenced involvement from other health care professionals such as the GP.
● Records evidenced appropriate referrals had been made when people were experiencing weight loss or had deteriorating mobility.
● Guidance from external professionals had been included in people's care plans for staff to follow. Staff had a good understanding of the guidance in place and we observed the guidance to be followed by staff.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● Staff had received training around MCA and DoLS and were able to tell us how people's capacity was assessed. The manager held a tracking list for DOLs applications.
● Where people were deprived of their liberty, DoLS were in place and people were supported in line with their agreed plans.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- The provider did not consistently ensure people's privacy and dignity were maintained.
- People were subject to institutionalised practice. For example, we found bathing schedules in place which did not evidence people had choice or control in when they had a bath or shower.
- Personal information and routines were on display in communal areas. For example, fluid intake levels, dietary requirements and bathing schedules were written on whiteboards and 1 person's allergies were displayed on their door. This practice did not promote people's individuality and shared personal information about their care.
- Two people were sharing a room. One relative told us, "I hate the fact that [relative] is in a shared room. The staff can't help that but sometimes you miss your visiting time as the person in the next bed needs personal care."
- Continence aids and equipment had been left out in people's rooms. For example, incontinence pads were found stored on the floor by 1 person's bedroom door.

The provider had failed to promote and maintain people's privacy and dignity. This is a breach of regulation 10 (Dignity and respect) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always supported to use equipment safely. For example, we found 1 person using a wheelchair in their room without footplates. This meant the chair would have been unsafe to move, it would have been uncomfortable and undignified for the person.
- Staff were kind to people. Staff spoke with people in a caring way, calling them by their preferred name and being respectful in their language and approach. People told us they liked staff.
- One relative told us, "The cleaner has a chat when cleaning [relative's] room. I was visiting once and the cleaner said, 'don't worry I will come back later'." Another relative told us "I do feel [relative] is safe …. Overall, I am very happy with their care."
- Staff completed equality and diversity training to help them understand people's needs.
- People told us they were happy with the care they received from staff. One relative told us "I am not involved in the care plan but am happy with the care [relative] gets".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- Complaints procedures were not clear and accessible to people and relatives. For example, we were told people should complain to anyone in blue, however the policy did not support this. One relative told us they tried to complain to a nurse about a staffing shortage, they were asked to put it in writing to head office. This was not in line with the home's complaints procedure.
- The provider's procedure stated verbal complaints should be followed up with a letter. One person told us they had complained about meals a few times, the last time being a few days ago and nothing had changed. There was no record or response for this complaint. One relative told us, "I did not want to complain officially as I was worried about the reprisals"

The provider had failed to operate an effective system for managing complaints. This was a breach of Regulation 16 (1) (2) (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Organised activities did not always engage people.
- The provider employed an activities coordinator, activities were arranged, however people did not engage and chose to spend time in their rooms.
- One relative told us, "I have been asking for a larger table in their room for a long time for jigsaws etc. My [relative] has no social interaction at all. I think it would help as others might pop in for a chat and fix a piece or two".

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Care plans did not always detail how staff should communicate with people. For example, 1 person's care plan identified they had difficulties communicating, however there was no identified interventions for staff to support the person's communication needs.
- People living in the home had lived there for varying periods of time and their individual communication needs were met by staff who knew them well.

End of life care and support

● Support plans for end of life care were detailed in people's care plans. Advanced care planning, emergency care and resuscitation preferences were recorded, where people had chosen to share these.

● Staff had received training in end of life care. One staff member told us, "We make people comfortable, making them look nice, if they want something, we would do everything we could for them, we don't want to see them in pain."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- People were not protected by robust quality assurance and governance systems.
- Accidents and incidents were not analysed for themes and trends. This meant people were at risk as action was not taken to prevent the risk of reoccurrence.
- Medicine audits had failed to recognise the unsafe medicine practices reported on in the safe domain of this report. This meant people were at a continued risk of receiving their medicines unsafely.
- Complaint records were not maintained. This meant the provider did not have oversight of themes and trends to identify improvements.
- The provider failed to ensure the systems in place identified risk to people and areas of improvement needed. Audits were completed by the management team, however these were behind schedule and not monitored by the provider. For example, the manager's monthly audit was last completed 3 months ago and a weekly mattress audit was last completed in August 2022.

The provider had failed to implement effective systems and processes to assess, monitor and improve the safety of the service provided. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider did not engage regularly with people or relatives.
- There were no recent records showing engagement with people using the service or relatives. For example, the last recorded meeting with relatives was in December 2020.
- People were not routinely involved in service development and planning their care. For example, meetings for people using the service were not facilitated.
- One relative told us, "They don't always respond quickly… [relative] trips and falls and any issues take a long time for them to tell us. Last time, [relative] rang us before the home had got in touch."
- The culture of the service did not always value people's individuality or work towards positive outcomes for people. For example, people spent most of the time in their rooms and communal areas of the home were mainly occupied by staff. The registered manager told us the culture had been difficult to change and people chose to be in their rooms since the pandemic.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibilities under 'duty of candour' to be open and honest when things went wrong, for example, notifying relatives if their family member had an accident or became unwell. There had been no incidents which met the duty of candour threshold.

● Staff knew how to raise concerns and told us they would escalate if they felt they were not being listened to or their concerns were not acted upon.

● People's records evidenced a significant level of contact with health and social care professionals. A healthcare professional told us, 'The registered manager engaged very well with me, they responded promptly to my emails and engaged well throughout the assessment.'

Working in partnership with others

● People's records evidenced people had contact with health and social care professionals. For example, the home had regular reviews with the GP.

● The registered manager told us they engaged with a registered managers, network group developed during the COVID-19 pandemic.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People using the service were not satisfied with meals, concerns about this were not recorded and meals were served in bedrooms which was isolating for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to promote and maintain people's privacy and dignity

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had to wait for care due to poor maintenance of the call bells system, medicines were not safely managed, fire safety risks were not always mitigated, people were not always protected from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints procedure was not followed and complaints were not always acted on or analysed for trends.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had no oversight of the service, feedback was not sought from key stakeholders and management auditing was behind.