Care Quality Commission

Conewood Manor Care Limited

Conewood Manor 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?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

The inspection took place on 05 May 2015 and was unannounced. This was the first inspection since new providers had taken over the service in September 2014.

Conewood Manor Nursing Home accommodates up to 42 older people, some of whom live with dementia. There were 37 people using the service when we inspected.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered

Summary of findings

necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection we found that applications had been made to the local authority in relation to people who lived at Conewood Manor Nursing Home and were pending an outcome.

People who used the service, their relatives and staff members expressed concerns about the numbers of staff available to meet people's needs according to their personal preferences. Staff recruitment processes were safe and a range of training was provided to staff to give them the skills and knowledge required to undertake their roles.

People told us that the staff team were kind and caring. Care and support was delivered in a way that protected people's privacy and promoted their dignity. Activities were provided for people but had not been tailored to meet people's specific interests. The provider had arrangements in place to support people and their relatives to raise complaints or issues of concern and provide feedback about their experiences.

We received positive comments about the management team from people who used the service, their relatives and the staff team. People were encouraged and supported to raise concerns and the manager closely monitored and sought feedback about the services provided to identify areas for improvement and drive forward improvements in the home.

We found that the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?
The service was not always safe.

There were not always sufficient numbers of staff available to meet people's specific needs.

Staff knew how to recognise and report allegations of abuse.

Staff did not start work until satisfactory employment checks had been completed.

People's medicines were managed safely.

Requires Improvement

Is the service effective?
The service was effective.

People received care and support from staff members who had regular supervision and training relevant to their roles.

People were supported appropriately in regards to their ability to make decisions.

People were supported to eat and drink sufficient amounts to help them maintain a healthy balanced diet.

Good

Is the service caring?
The service was caring.

People were treated with kindness and respect.

People who lived at the home were encouraged to be involved in the planning and reviewing of their care by staff who knew them well.

People's privacy was promoted

Good

Is the service responsive?
The service was not always responsive.

There was provision of activities; however, these did not reflect the individual preferences of people who used the service.

People who lived at the home and their relatives were confident to raise concerns and had them dealt with appropriately.

Requires Improvement

Is the service well-led?
The service was well led.

The manager had developed a positive culture at the home and people who used the service and their relatives had confidence in staff and the management team.

Good

Summary of findings

The manager had systems to monitor, identify and manage the quality of the service.

People who used the service, their relatives and staff spoke highly of the management team.

People were given the opportunity to influence the service they received; they were kept informed of important information about the home and had the opportunity to express their views.

Conewood Manor 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 met 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 under the Care Act 2014.

This inspection took place on 05 May 2015 and was unannounced. The inspection team was formed of two inspectors.

Before our inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we observed staff support people who used the service, we spoke with nine people who used the service, four care staff, two nursing staff and the manager. We spoke with four relatives during the inspection to obtain their feedback on how people were supported to live their lives and with a further four by telephone subsequent to the inspection visit. We received feedback from district nurses and representatives of the local authority commissioning team. 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.

We reviewed care records relating to six people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Is the service safe?

Our findings

People who used the service praised the staff team for the care provided but some people raised concerns about the numbers of staff available to meet their needs. Some people told us that the care staff 'rushed' through their care instead of taking their time and working at the person's own pace. One person said, "The staff are usually rushing and at times it is really hectic." Another person said, "I find at night time, in particular, I am rushed to get changed and go to bed." One person said that sometimes staff sickness meant there were less staff available to care for people, they told us, "I am often left in bed, in an uncomfortable position."

Relatives also told us they were not completely satisfied with the staffing levels in the home. One person said, "The staff are sometimes tied up elsewhere and people have to wait a little while. It does seem that there is not enough staff on at the weekend. Staff tell us that people phone in sick with little warning and they are not able to replace them". Another relative told us, "There should be more staff. They are so busy. There are barely enough of them to get everything done. They work so hard."

Staff members told us that they were often short staffed due to sickness. Staff rotas showed the number of healthcare assistants on duty varied between five and six each day plus one senior carer and two nurses. The manager said that agency staff were not used to cover for last minute staff shortages but that staff that were not rostered on duty were asked to provide cover. We asked staff what happened when they had less staff on shift than planned and they said that the focus would move to task driven routines, rather than delivering care that was responsive to people's needs. An example given was that people who required assistance with personal care would receive this support two or three times during the shift as opposed to when they might individually require this assistance. This meant that people would not always receive person centred support to manage their continence needs.

On the day of the inspection the home was fully staffed according to the rota with two nurses, one senior and six care assistants. Additionally there were kitchen, laundry and domestic staff, an administrator, the maintenance person and the manager. However, during the afternoon we noted that some people were wearing their night clothes. We asked staff why this was, they told us that people had needed their clothes changed after lunch and that it 'was easier' and would save time later in the day if they were changed into their night wear early.

During the lunch service we noted that a number of people chose to remain in their rooms to eat their meals. We saw that staff working on the top floor of the home delivered the meals on trays to people's rooms and then assisted some people to eat. We noted one person pushing their food around the plate with little interest in eating, staff told us that they went to people's rooms at the end of service to encourage and prompt them if needed. We saw that the person's food was cold and unappetising by the time they received the additional support and encouragement to eat.

The manager had completed a dependency assessment to determine if the staffing levels currently provided were appropriate to meet the needs of the people who used the service. The assessment identified that there were 27 people who lived at the home who required two care staff to meet their needs in terms of support to transfer and personal care. However, the dependency assessments did not take into account the complex layout of the home. The house is a converted Grade11 listed building and the accommodation was arranged over four separate areas on three floors. There were many people who were cared for in bed and people who chose to stay in their own rooms. This meant that there were occasions where people were left unsupervised because care staff needed to provide support elsewhere in the home. This was especially so at night where staff numbers reduced to one nurse and three care staff for the whole home.

We discussed these issues with the manager and the provider. The provider that they had increasing staffing since acquiring the home in Sept 2014 and that there were plans for an additional staff member to be deployed during the day time specifically to manage the drinks and meals trolley service. Once this staff member was in post this would free up a member of staff to be able to provide additional support during the day but does not affect the situation at night time.

We found that the provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff were provided to meet the needs of the people using the service. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service safe?

People told us they felt safe living at Conewood Manor Nursing Home. One person said, "I feel really safe here, it is nice and quiet and the staff are really nice." A relative told us, "The staff are really great; they are really responsive to people's wishes and understand people's needs so well."

We asked a relative if they felt the environment was safe and they said, "Yes I do feel my relative is safe here. I had a concern once and raised this with staff and it was resolved straight away."

Staff members told us they had received safeguarding training and regular updates and demonstrated awareness of how to record and investigate safeguarding concerns appropriately. One staff member said, "I am familiar with what abuse is and I would report any concerns if I had any straight away. Abuse would not be tolerated here." There had been no recent safeguarding incidents but the manager understood their responsibilities in regards to informing CQC and the local authority should any incidents occur. There were suitable arrangements to safeguard the people who lived at the home which included reporting procedures and a whistleblowing process.

We found that safe and effective recruitment practices were followed to ensure that staff did not start work until satisfactory employment checks had been completed. This practice was confirmed by a newly recruited staff member.

We spoke with staff about how they might keep people safe as well as enabling positive risk taking and involving people in those discussions. One staff member we spoke with said, "We need to appreciate that our residents have led full lives, worked, raised families and achieved so many things in their lives. This needs to be respected and where possible we should enable residents to make some decisions, no matter how small."

Risk assessments had been developed in areas such as the likelihood of developing pressure areas, moving and handling needs and the risks associated with poor nutrition and hydration. We noted inconsistencies across the records, with some containing generic assessments, for example with mobility risks and tissue viability. Others were more personalised and we were able to see that people had been involved in the development of the risk assessment. For example we spoke to one person who said, "I like to be as independent as possible and the staff try to let me do as much as I can for myself which I appreciate." We saw that this information had been incorporated in to the risk assessment.

We noted that all people had individualised emergency evacuation plans which were clearly identified in the care records and in each bedroom in the premises. Staff were able to describe procedures to be followed in the event of an emergency, for example a fire.

There were suitable arrangements for the safe storage, management and disposal of people's medicines, including controlled drugs. Staff told us they had received medication training and that there were regular assessments undertaken to ensure their continued competency to administer medicines safely. Each person had a medicine administration record (MAR) in their name with associated photograph to ensure staff could identify that person correctly prior to administering their medicines. We observed a staff member encouraging people with their medication, going at their pace and without rushing them. This helped to ensure that people received their medicines safely.

We found most areas of the building were maintained to a good standard of cleanliness. People had individual named slings for use with mechanical hoists; this meant that the risk of cross infection was reduced. We noted that some skirting boards, doors and some walls were showing signs of damage and generally the building was in need of updating and decorating in areas. The provider acknowledged this and reported that a comprehensive refurbishment programme was underway. Staff told us of significant improvements that had been made to the environment over the preceding six months. Relatives also commented on the improvements made and one said, "The car park can now be used and the new owner has plans to further improve the premises. Cleanliness has improved a lot."

We noted that the passenger lift had failed on the day of the inspection and the engineers were on site trying to rectify the problem. We noted this made the movement of the medicine, food and beverage trolleys between the three floors difficult and took up considerably more care staff time. The manager informed us that remedial work on the lift was planned to provide a more robust, longer term solution.

Is the service effective?

Our findings

People told us that staff understood their needs well and had taken the time to listen to them and their relatives. One person said, "They [staff] really do listen, if you have something to say you can say it, they take notice." Results from a satisfaction survey undertaken by the provider in March 2015 showed that 100% of respondents rated the standard of care provided and the calibre of staff and their abilities as good or excellent.

Staff were appropriately trained and supported to perform their roles and meet people's needs. New staff were required to complete an induction programme and were not permitted to work alone until they had been assessed as competent in practice. We spoke with staff about the induction process and all commented on how thorough it had been

All staff members were supported by regular 'one to one' sessions with senior staff during which individual performance was reviewed and discussed. We found that staff received regular training updates to support them in their role. Nursing staff told us about specialist training they received such as to support people to maintain their tissue viability and prevent the risk of developing pressure sores. This meant that people received their care from a staff team who had the necessary skills and competencies to meet their needs.

Staff told us they had received training about the MCA 2005 and DoLS. They demonstrated a good understanding of what the requirements meant in practice, for example when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. They had an awareness of what steps were needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful. At the time of the inspection we found that 17 applications had been made to the local authority in relation to people who lived at Conewood Manor Nursing Home and nine had been approved.

Staff sought people's consent before providing care and support. For example, when supporting a person with lunch in their room we heard staff ask if they needed anything before they ate. They continually checked that they were going at the person's own pace. Where people did not have capacity to consent to care and treatment staff told us they liaised with family members to ascertain people's wishes as much as possible. The manager told us that two people who used the service had the involvement of external advocates to act on their behalf.

We noted that a plentiful selection of beverages and snacks were offered to people at regular intervals throughout the day. Where people had been assessed as being at risk from inadequate nutritional intake, we saw that dieticians and speech and language therapists had been consulted to help ensure people ate and drank sufficient quantities. Records of food and fluids consumed were maintained and monitored daily by nursing staff. Kitchen staff told us of the steps they took to fortify people's calorie intake by adding cream and butter for example.

People told us that their health needs were well catered for. They told us that chiropodists, dentists and opticians visited the home when people needed them. We saw that people had easy access to their GP who came to the home once a week and that staff contacted out of hours GP services when required. People said that they were satisfied with the health care they received at the home and enjoyed good links' to all local health and social care services.

We looked at the care records for people with complex physical health needs and we spoke with staff about the care plans in place. We noted that timely referrals had been made to external health care agencies and that medical staff visited the service each week and that they had reviewed treatment and care plans for these people. One person had lost weight over the preceding four months and we saw evidence that a dietician, speech and language therapist, a doctor and a specialist team had reviewed the person's care needs and that the advice given had been incorporated into the person's care plan and implemented. This showed us that people's day to day health care needs were met and that external agencies were consulted as needed and on an on-going basis.

Is the service caring?

Our findings

People gave us positive feedback about the care they received. One person said, “The staff are absolutely marvellous, nothing is too much trouble, they are diamonds.” Another person told us, “The staff here are very good. They are kind and caring. They work hard but usually have a smile.”

Relatives were also positive about the way in which care and support was provided. One relative told us, "You hear all about the bad care homes, this one is one of the good ones." Another relative said, “The staff are very caring and approachable. They always make a lovely fuss for birthdays and other special occasions, such as valentines’ day. Lovely, really.”

Results from a satisfaction survey undertaken by the provider in March 2015 showed that 100% of respondents rated the way in which staff promoted people’s dignity and privacy as good or excellent.

People told us that staff always knocked before entering their bedrooms and made sure that doors and curtains were closed when helping them with personal care. Relatives told us that they were able to visit people at any time without restrictions. We saw that staff knew and used people’s preferred names and that care and support was delivered in a way that protected people’s privacy and promoted their dignity. People’s confidentiality was promoted. We saw that people’s care records, which included confidential information and medical histories, were stored in a locked room when not in use by the staff.

We observed staff were polite and treated all people in a dignified manner throughout the course of our inspection visit. If people required support with personal care, they were supported discreetly back to their rooms to receive the necessary care in private.

Care staff were knowledgeable about people’s individual needs and preferences in relation to their personal care needs. We saw that people and their relatives had been involved in discussions about the care provided. Staff told us they had handover meetings between shifts to ensure that everyone had up to date information in the event that people’s health needs changed. For example, staff were updated about people who had been unwell during the previous shift.

We spoke with people about how involved they were in making decisions about their care and support. We received mixed responses which included comments such as, “Yes I do as I want and I make my own decisions about how I spend my time” but other people were not sure if they had seen their care plans. Relatives told us that they were involved in planning of people’s care and staff told us that they planned and organised people’s care with involvement from the person where possible. Relatives told us that the staff at the home usually kept them informed of changes.

We saw staff involving people in discussions about their care. For example we saw a staff member using some magazines as a way of engaging a person in conversation. The staff member then went on to ask the person if they had received all the care they had wanted that morning. We could see that the person was pleased to have been asked about their welfare. One relative told us, “Yes staff do offer my [relative] choice. For example, my [relative] likes to look smart and that is delivered, every day and my [relative] chooses the clothes every time. The staff know my [relative] very well and what they like and don’t like.”

Is the service responsive?

Our findings

Relatives told us that staff involved them with developing people's care plans where they were not able to do this themselves. They said they were always consulted with any decisions relating to people's lives.

We noted although people's views were sought their care plans were generic in style and content. More could have been done to personalise the assessment of care process. We saw that staff responded to people in an individualised manner subject to the availability of staff. However, this was not always reflected in the care records.

Information about people's lives, aspirations, preferences and wishes, in three of the six care records we viewed, was not particularly detailed. One example of this was in relation to one person's dietary preferences. One person said, "I dislike my food covered in gravy, but it always is." Another person told us they did not like carrots, but we saw they had been served carrots with their lunch. We asked people if they had opportunity to speak to the chef about their feedback and those asked by us said they had not. Results from a satisfaction survey undertaken by the provider in March 2015 showed that 67% of respondents rated the choice, quality and variety of food as good or excellent. We discussed this with the manager who told us he planned for the chef to interact directly with people who used the service in order to gain an understanding of people's dissatisfaction with the food provision. The provider told us that the chef had been tasked with attending the lunch service in the ground floor communal dining area to serve people's meals and gain a first-hand understanding of people's views.

Some people who used the service told us that they did not engage with the activity programme provided and that they had different interests. One person said, "I don't want to do anything on the activity list, I don't want to socialise or mix."The provider told us that there were two staff who were employed specifically to provide activity and stimulation for the people who used the service. One staff member managed the generic programme and one worked with individuals to provide person centred activities such as jigsaws, massages or one to one chats. We were told that the activity staff visited those people who chose to remain in their rooms, or were being cared for in bed, and engaged them in conversation about the news and anything that interested them. The activity staff were not at the home on the day of the inspection. There was a monthly activities plan which included such topics as movie time, massages, card and board games, flower arranging and exercises to music. We did not find any correlation between people's individual likes and dislikes and the activity plan. Whilst it is positive to note that activity and stimulation was offered for people this programme did not reflect people's individual preferences.

External entertainment was brought into the home, for example a saxophone player, animal handling experiences and an Elvis impersonator. Relatives told us they were encouraged to join in with the entertainment sessions where possible to increase people's enjoyment.

Staff told us that they had access to information about people's needs and preferences which enabled them to provide care consistently and in ways that people preferred. We found that people's care and support needs were closely monitored and updated on a regular basis so that any changes to their needs had been identified. We found that when people's needs had changed, staff had made appropriate referrals. This included, for example, to the dietician, dentist and opticians.

Meetings were held for people and their relatives to share their views on how the home was run. Relatives told us that the provider respected their opinions and views. For example, during discussions around the refurbishment plans for the home some relatives said that people would not wish to be moved out of their familiar rooms whilst the work was being done. The provider agreed that works could be undertaken during the times that people were occupied in the communal areas of the home avoiding the need for people to move out of their rooms. If people did not wish their rooms to be refurbished this was also respected. Relatives told us that they had been consulted over colour choices for the forthcoming refurbishment.

Relatives also told us that a suggestion they had made to employ a person to deliver food and drink service around the home had been embraced by the provider. This initiative was 'work in progress' at the time of the inspection and would result in more care staff being available to support people with personal care needs and eating and drinking.

The manager had a system in place to manage complaints and concerns. Information about this was made available to people and their relatives on enquiring about the home

Is the service responsive?

and a box for complaints and suggestions was situated in the communal hallway. We noted that the service operated a key worker policy; the aim being that people had one staff member they could speak with should they have any worries or concerns. People told us that they felt confident they knew how to make a complaint and who to talk to.

Is the service well-led?

Our findings

People's relatives told us they felt that the home was managed well and that they had confidence in the management team. One person said, "The manager has been there about a year and the owners since last summer. They are doing a really good job and making huge improvements". Another person said that they felt consulted about all aspects of the home and were encouraged to contribute any ideas they had.

Staff commented on the encouragement they were given to come up with ideas for improving the quality of the service. One new staff member said, "The home seems to really encourage good ideas for improvement. We were asked about our ideas during the induction programme."

The manager had worked hard to develop a positive culture at the home. Their values and philosophy were clearly explained to staff through their induction programme and training. Staff members confirmed that they understood their responsibility to share any concerns about the care provided, they told us they were aware of the whistleblowing procedure and that they would confidently use it to report any concerns. Some staff members told us that the manager was very supportive and had an 'open door' policy whilst others did not feel this was the case and told us they were not confident to approach the management team. We discussed this with the manager and provider who both undertook to ensure an open and transparent management ethos was communicated throughout the staff team. We saw that staff worked well together and they told us that they worked well as a team and had the same values and vision to have a safe and caring home.

The manager received support and regular supervision from the providers. There were opportunities for the manager to engage and network with colleagues from other services in order to share good practice, support learning and to improve the quality of services provided.

The manager had developed a system of audits in order to assess the quality of service provided in areas such as medicines management, health and safety, infection control and laundry services. We saw that the audit forms included a space for comments. The manager told us that he intended to develop an overview of the audit results in order to identify where shortfalls recurred or trends and patterns developed.

There were regular quality checks undertaken by the providers. These included spot checks out of normal management hours. People told us they were kept informed of important information about the home and had the opportunity to express their views. People were given the opportunity to influence the service they received and residents' meetings were held by the manager to gather people's views and concerns.

We saw that the local authority had conducted a routine quality monitoring inspection at the home in January 2015. The service had achieved a rating of 'good' with an overall score of 82.8%. At this inspection we found that the manager had taken the actions necessary to address the shortfalls identified by the local authority representative.

The provider had distributed satisfaction questionnaires to relatives of people who used the service. The manager told us that 35 questionnaires had been sent out but only 13 had been completed and returned. To improve the number of responses the manager had asked for people's email addresses so that future questionnaires could be distributed and completed electronically. This showed that the manager was proactive in encouraging people to contribute to the quality assurance processes.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken to keep people safe.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff were provided to meet the needs of the people using the service.**