Primrose (2013) Limited

Blackdown Nursing Home

Inspection report

Mary Tavy
Tavistock
Devon
PL19 9QB
Tel: 01822810249
Website: www.blackdownnursinghome.co.uk

Date of inspection visit: 6, 9 and 12 November 2015
Date of publication: 18/12/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 6, 9 and 12 November 2015.

Blackdown Nursing Home is a registered home for a maximum of 33 people. The home offers nursing care for people with a variety of physical and mental health needs including advanced dementia. There were 33 people living at Blackdown at the time of this inspection.

Our inspection in May 2015 found five breaches of the regulations. People's legal rights were not upheld, care and treatment was not designed around people's needs and preferences, records were not always clear or complete and risks were not always assessed and managed. The provider sent us an action plan following that inspection. We felt the action plan was not sufficiently detailed but the registered manager was not available to discuss the plan at the time. This inspection found there was improvement at the home but one breach remained.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of Health and Social Care Act and associated Regulations about how the service is run.

Staff did not comply with the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. This was not being done and had led to staff making unlawful decisions on other people's behalf.

Deprivation of Liberty Safeguards (DoLS) provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The required steps to gain the legal authority to subject people to continuous supervision and control, including preventing them from leaving, were being taken.

Staff had good knowledge of people's backgrounds, behaviours and day to day needs. More information about each person, as an individual, was recorded in people's care files. However, people had very little to stimulate their interest which might bring back important memories and give them feelings of well-being and contentment. This might include objects which remind them of important times in their past life. We recommend that this service explore and follow the relevant guidance on how to make environments, and activities used by people with dementia more 'dementia friendly'.

The home appeared clean but there was odour of urine in some areas of the home.

The provider had frequent contact with the home and provided resources as necessary. People and their families expressed a lot of confidence in the registered manager (Matron). However, Matron not having enough time to fulfil her management duties adversely affected the running of the home and her responsibility to meet legal requirements.

The staff and management at Blackdown Nursing Home were kind and caring. People told us, "Without exception staff are lovely; kind and caring" and "Always friendly and helpful." The standard of nursing and personal care promoted people's health because there were enough staff and they were trained and supervised to ensure standards were met.

Assessment and management of risk and servicing and maintenance of the premises provided a safe environment for people.

People were protected from abuse. Recruitment practice meant new staff were checked before starting work at the home and there were enough staff to keep people safe. The management of individual risks to people's health and welfare helped keep people safe and healthy.

New care files were helping staff to find information more easily and a computerised record system was about to be introduced which the registered provider felt would improve recording.

People liked the food and they were supported to maintain a healthy and varied diet. Concerns were followed up and specialist dietary needs were met.

Medicines were managed so people received their prescribed medicines in a safe way and when needed.

Complaints the service had received had been investigated and where it was felt necessary an apology or compensation was given. People felt confident they could take any concern to the registered managers, provider or staff members and it would be followed up.

People and staff's views about the service were sought and plans to improve the service took their views into account. Plans for improvement, such as monitoring the service were started but were not yet embedded.

We found one repeat breach of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of this 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?

Good

The service was safe.

Staff understood how to protect people from abuse and harm.

Safe recruitment protected people from staff who might not be suitable to work with vulnerable people.

People's needs were met in a safe way due to the staffing arrangements.

People received their medicines in line with their needs.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not comply with the legal requirements to make sure people's rights were protected.

Staff received training, observational supervision and regular support in their role. More formal supervision was not yet up and running.

People enjoyed their food and people's dietary intake was monitored and dietary needs met.

Arrangements were in place for people's healthcare needs to be met.

Is the service caring?

Good

The service was caring.

People received kindness from staff who had a caring attitude.

People were treated with respect, dignity and their privacy was upheld.

Staff provided compassionate end of life care.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care planning was improved but did not include activities that would be meaningful to people based on their personal history and preferences.

Staff responded quickly to any identified need, such as physical and emotional support.

The complaints procedure and process had been effective.

Summary of findings

Is the service well-led?

The service was not always well-led.

Some arrangements planned for improvement had not been completed within a reasonable timescale because of lack of management time.

There was improvement in risk and record management.

People using the service, their families and staff were happy with the way the service was run. Their views about the service were sought through surveys, meetings and the regular availability of the provider.

Requires improvement

Blackdown 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 6, 9 and 12 November 2015. The second date was announced. The provider was given 48 hours' notice because we needed to be sure that the registered manager or registered provider would be available for that visit.

The membership of the inspection team consisted of two adult social care inspectors.

Most people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

Visitors were informed that CQC was undertaking an inspection visits on 9 November 2015. We spoke to six people who lived in Blackdown Nursing Home, three people's visitors, three staff members, the registered manager and the providers. We looked at three people's care records and medicines administration records (MARs). We looked at six staff recruitment records and at staff training records. We also looked at servicing records, the staffing rota, a range of quality monitoring information such as survey results and spoke with two health care professionals about the service. These were a social worker and psychiatric consultant.

Good

Is the service safe?

Our findings

Our inspection of May 2015 found not all aspects of the home environment were safe for people.

This was because risk was not being assessed and managed to protect people, for example from the risk of legionella infection. This inspection found risk was being managed more effectively. For example, all equipment in the home was regularly serviced and maintained and there were regular checks of essential equipment such as wheelchairs and beds. A maintenance plan ensured the building remained well maintained and improvements were planned. For example, there had been a survey regarding the risk from legionella infection, an action plan and actions followed through.

People's safety was promoted. One person's family said, "I have never found a staff member I've had any reservations about."

The registered manager and staff were aware of the types of abuse and their responsibility to protect people from abuse and harm. They received training in the safeguarding of adults. The safeguarding and whistle blowing policies at the home set out types of abuse, how to recognise abuse and the steps which should be followed to safeguard vulnerable adults, such as working in partnership with the local authority. A lot of information with regard to how to protect people from abuse was clearly displayed at the home.

There was a well organised recruitment and selection processes in place. Staff files included completed application forms and interviews had been undertaken. Pre-employment checks were done, which included, in many cases, three references. Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Where staff had been employed from outside of the UK there was original documentation, and a translation showing they had been subject to an equivalent check in their home country.

The staffing arrangements ensured people's needs could be met. The registered manager and nursing staff said the staffing numbers could be flexible and they were based on an assessment of people's needs. For example, one person had required one to one support for their safety and this had been arranged. Our observation and information from the home's 2015 surveys indicated the staffing numbers were sufficient to meet people's needs. One person had commented, "Personal care was very rushed in the busy times but the ration of carers to clients has increased to their benefit." One person told us staff were always available when needed and one person's family said, "There are always staff close by." We used the call bell during the inspection and staff arrived quickly in response.

People received their medicines as prescribed. No person living at Blackdown was able to manage their own medicines and so their medicines were managed for them. Nursing staff helped individual people with their medicines before helping the next person. Medicines were ordered, stored, given and disposed of in a safe way, which promoted people's health and welfare. For example, should the possibility of distress or pain arise during end of life care 'just in case' medicines were available. The registered manager ensured medicines could be monitored from request to disposal and they did regular audits. Newly recruited nurses were supervised until they were confident in administering medicines safely.

Risks to individual's were assessed and managed. For example, one person was at high risk of pressure damage. To prevent this they were repositioned regularly; had a specialist mattress in place with the correct setting for their weight and they received regular skin care. People's family members felt people's safety was very well managed one saying, "They're spot on with risk prevention." A health care professional confirmed the skin integrity of a highly dependent person was well maintained.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time.

Our inspection of May 2015 found people did not always give consent for care and treatment because, where the person's capacity was in question, the two stage assessment of capacity as required by the MCA was not being used. Also, people's families were consenting to care and treatment when they did not have authorisation through Lasting Power of Attorney, to do so. Following the inspection the registered manager met with people's families and explained family could be involved in best interest decisions, where they did not have authorisation in place for care and treatment decisions.

This inspection found improvement had been made. For example, each person had a capacity assessment in place. However, these did not relate to particular decisions and so did not follow the principles of the MCA that people should be supported to participate in decision making, as far as they are able to do so.

We looked particularly at the care of two people whose bedrooms were in an area of the home where they would need to access a key coded door to enter other parts of the home. One person also had a monitoring device at night and the other had bedsides. Staff agreed one was unable to consent to these arrangements but opinion varied with regard to the second person.. Instead, relatives of both people had signed a consent form regarding the pressure mats and bedrails. There had been no best interest meetings to consider the issues.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood that they should try to elicit people's consent to care and treatment and people were encouraged to make simple decisions. Staff said they did not provide care or treatment where it was clear the person did not consent, for example, if a person refused personal care they would accept the refusal but try again later.

One person's family said staff worked within their mother's 'living will' requests and also discussed their care with family on a regular basis to ensure their requests were met.

Where it was likely decisions needed to be made in people's best interest this was happening. For example, records showed a decision was made which included the person's family, their GP and the registered manager.

Deprivation of Liberty Safeguards (DoLS), provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty (such as preventing a person from leaving) appears to be unavoidable and, in a person's own best interests.

Our inspection of May 2015 found people were deprived of their liberty unlawfully. People, who were unlikely to be able to consent, were not free to leave, were under constant supervision for their safety and no authorisations to deprive them of their liberty had been applied for. This inspection found appropriate applications were being made because the registered manager had requested DoLS authorisation for 10 of the people using the service. Authorisations had yet to be confirmed when we inspected. The registered manager understood that because one person had capacity to consent to the arrangement an authorisation was not needed.

Staff had received MCA and DoLS training but we found that none we spoke with understood where they were depriving people of their liberty unlawfully. The two people whose bedrooms were accessed by a key coded door did not have authorisations to restrict their liberty in place at the start of the inspection. We saw the two people, when in their rooms, were regularly visited by staff and spent day time in a day room looking content and settled.

Before the inspection was completed DoLS applications were submitted for the two people behind the coded door. Immediately following the inspection applications for other people were being made, staff training was reviewed and a more in-depth training was arranged for the near future.

People and their family members had confidence in staff ability. Comments included, "Excellent"; "Staff do a fantastic job" and "I feel safe when being assisted by the staff."

Staff had an initial induction session that lasted two hours. This covered the essential issues to do with the home. We saw there was further induction including observation and supervision when learning, such as administering medicines. New staff were additional to normal staffing

Requires improvement

Is the service effective?

numbers until they were competent to work without supervision from experienced staff. The registered manager was aware of the Care Certificate, which was in place for staff new to care work, from April 2015. They said no care workers had needed this level of induction yet as they were all experienced care workers when employed.

A training matrix ensured no essential staff training would be missed. The broad training for one staff member during 2015 had included: medicines for mental health, complaints management, assessment and management, hepatitis awareness, catheter and continence care, dementia care, and diabetes.

Whilst staff received supervision through observation of their work face to face supervision was not embedded. Supervision provides an opportunity for staff to discuss work and training issues with their manager. It also provides the manager with an opportunity to feedback to staff issues around their performance. Most supervision files had one supervision form completed, however these were done in 2014. Plans were in place for allocated staff to provide one to one supervision of other staff. For example, the registered manager would provide supervision to nursing staff and the clinical lead would provide supervision to care workers. The registered manager said using this method it was more likely the supervision timetable could be met.

People received a varied and nutritious diet. People's comments about the food included, "Lovely, I like cottage pie" and "Fine but I would like some shell fish." We informed the registered manager about this preference and she said she would see if this could be provided.

Meals served during our three days at Blackdown included, fish and chips, cottage pie, baked potato with cheese or tuna mayonnaise with salad and chicken curry. The chef said a nutritionist would be advising on the new menu. They said how they tried new recipes so people had a wider variety to choose from; each meal included a choice. The chef was developing a folder with information about allergies and they had lists of people's menu likes and dislikes. They said, "For example, (the person recently arrived at the home) likes a bacon sandwich." One person requested mayonnaise during a fish meal and another was given a sherry, which they appeared to enjoy.

People's dietary intake was monitored. Where people required a specialist feed regime this was well documented and staff had the relevant information available for the person's safety. Where people required thickened fluids to reduce any risk of choking this was in place and where people needed assistance with their food this was provided. Drinks were available throughout the day in the lounges and people had a jug of water available in their room.

People were supported to maintain good health. There were arrangements in place for routine health care such as chiropody and dentistry and frequent GP visits. A health care professional confirmed that a person they visited had regular dental and other health checks. A psychiatric consultant said they found the staff very helpful and listened to advice.

Good

Is the service caring?

Our findings

Only positive comments were received about the staff. These included, “Without exception staff are lovely; kind and caring”; “Always friendly and helpful” and “Excellent. Caring.” One person had recorded about the registered manager, “Matron is very kind and considerate.” People told us they were happy at Blackdown.

People responded with recognition and smiles when staff engaged with them. A care worker held a person’s hand and later talked with them about their son. There was some friendly banter and people clearly related to staff as people they trusted and liked.

Staff described a concern for people’s wellbeing. For example, a housekeeper asked the administrator to contact the person’s family to tell them they needed new pyjamas. One person said they were cold; the nurse closed the window, fetched a blanket, and then checked other people were warm enough. Staff were quick to engage with people to relieve any anxiety. For example, one person asked a nurse, “Am I safe here ? ”. When the nurse said yes the person smiled and relaxed.

Staff knocked before entering people’s rooms and all personal care was delivered in private. People were supported to present in a clean and dignified manner and the level of personal care people received was high. One person’s nails were manicured during our observation.

People’s choices were respected. For example, the registered manager made sure the staffing rota included male and female staff so people had the choice of who provided their care.

Staff readily provided information for people, telling them what was happening and why. Where people were more able to be involved in decision making that involvement was promoted. For example, one person chose to play the piano each day.

People’s families felt involved in the care their family member received. They were pleased they could contribute to the care delivered, such as helping a person to eat. Any person visiting the home could receive a meal whilst there and the registered manager, concerned for one visitor’s well-being, always made sure they were offered any food and drink available.

People received end of life care from competent and caring staff. A person receiving end of life care was comfortable and their needs were understood and met. Their family member confirmed the person’s wishes were taken into account and they were very pleased with the care provided. They said they had talked with one of the nurses about their end of life plan. The registered manager said, “People should be able to die without pain and discomfort.” They had called in palliative care expertise when necessary.

Requires improvement

Is the service responsive?

Our findings

Each person received an assessment of their needs prior to admission. The registered manager said admission depended on whether the home could meet the person's needs and in some cases people had not been accepted. A person recently admitted said the registered manager had visited them prior to admission and they felt staff had helped them to settle in well.

Care plans are a tool used to inform and direct staff about people's health and social care needs. Our inspection of May 2015 found people people's care plans did not ensure they received person centred care. At this inspection we found those plans had some improvement. For example, there was some information about the person's past, such as their interests, work and family. There was evidence of people, or their families, involvement in care planning. In one case a nurse told us a person was "quiet and shy". Their care plan said staff should, 'be calm and let him know the staff's faces'. Staff were therefore informed how to approach that person in a way which would help them.

When we asked staff to tell us about people they were able to do so in detail. Examples included: one person's knowledge of languages and another person's self-neglect prior to admission. This meant staff had knowledge of people's anxieties, needs and wishes and could respond if they recognised what people needed at a particular time. We saw people's needs were interpreted and staff provided the information, support and reassurance people needed.

Most people at Blackdown were living with advanced dementia, which meant activities needed to be adapted to make them meaningful for people. However, from our observations and from records we judged this had not taken place. The registered manager was able to demonstrate their knowledge of the importance of adapting the environment and activities to meet the needs of people living with advanced dementia but this knowledge had not been translated into practice. This meant there was little stimulation and opportunity for people living with dementia to connect with the world around them although one person liked to clean and so they dusted the surfaces from time to time. The registered manager provided the example of people urinating against white radiators in the belief they were toilet pans and there was odour of urine in some areas of the home.

We recommended at the May 2015 inspection, that the service finds out more about current best practice, in relation to the specialist needs of people living with dementia, and puts that knowledge into practice. At this inspection we found the registered manager understood about best practice but arrangements to make changes had not yet been considered.

There were some organised activities at Blackdown. During our visit people were entertained by visiting musicians and there was evidence of art and craft work. People confirmed that during the summer they used the gardens and we saw people engaged in a board game. Another had a manicure. A booklet about the home stated that the home provided 'regular outings' we were told this no longer happened. The provider said a minibus could be hired if needed.

People received a standard of nursing and personal care which met their individual needs. A health care professional told us, "The personI was reviewing is highly dependent and I was very pleased to see that his skin integrity is being maintained well and he has had regular dental and other health checks. I think he is well looked after-physically and practically." Where a need was medical, the plans for how to deliver the care were in place, for example, a specialist dietary regime and catheter care.

People said the registered manager and staff responded to any concerns they might raise. During 2015 there had been four formal complaints recorded. Within the complaints was cited: untidy drawers and wardrobe, a missing hearing aid, missing or incorrect clothing, a missed medical appointment, a medicine trolley left in room and one person felt the care had not been adequate. The registered manager had responded with explanation, apology and had met the cost of the hearing aid replacement.

Requires improvement

Is the service well-led?

Our findings

The registered manager of ten years was unable to manage the service as effectively as possible because of insufficient, interrupted time. For example, the week beginning 26 October 2015 she was one of the two qualified staff providing nursing care for 40 of the 50 hours she worked. When in the office, and whilst performing nursing duties, she was frequently interrupted. The registered provider explained the difficulties of finding nursing staff so the registered manager could have the time to meet her management responsibilities. There was ongoing recruitment of nursing staff which they hoped would provide more management time. A nurse started employment the day before the inspection and was receiving an induction to the home. The registered manager said another nurse was due to start employment January 2016. Steps were therefore in place to ensure the management time required would be available.

Our inspection of May 2015 found there were not effective systems to ensure risk was managed and did not ensure records were clear and complete. This inspection found some improvements had been made. For example, risks associated with the environment were better assessed and managed. Some areas for improvement had not yet been completed: completing policies and procedures for staff reference, instigating face to face supervision for staff and completing capacity assessment, best interest meetings and DoLS applications. The registered manager and registered provider stated this was due to lack of time. This meant the timescales they had provided in their action plan had not been met.

New files were in place for people's assessment and care planning which staff said made finding information much easier. We found them simple to navigate. A staff member had suggested keeping some documents in people's rooms. This had been followed through and so records, such as fluid intake and personal care delivery, were readily available for staff use. Although diet and repositioning records were completed those of personal care delivered had gaps. A health care professional said when they reviewed a person's records they did not have the level of detail needed. The registered provider had purchased a computerised record keeping system which was due to be installed. They expected this would overcome current recording issues, based on their research into its effectiveness.

People's views about the service were sought and the registered manager and provider were regularly available to speak with. For example, there had been surveys during 2015 which included questions about the food, availability of staff, overall management, standard of personal care and laundry. Almost all responses were 'very satisfactory' or 'fairly satisfactory'. Comments included, "Extremely satisfied with the care" and "I have had grumbles with matron in the past. Things have always been resolved." There was also a yearly resident and family meeting.

There was a quality assurance policy. The registered manager monitored the service through close contact with people and visitors and some audits. These included medicines and accidents audits.

The registered provider had a system called 'Audit of Processes'. This meant improved arrangements for monitoring the service were started. They told us, "The arrangement is decided and progress is being made but it is not embedded as regular practice yet." The process included, for example, an audit of kitchen working practices. There was also a system of care practice review which included, 'Treating residents with dignity and privacy'.

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 11 HSCA (RA) Regulations 2014 Need for consent **People did not always give consent for care and treatment and the provider did not act in accordance with the Mental Capacity Act 2005.** Regulation 11, (1) (2) (3)