Foxholes Nursing Home Limited

Foxholes Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service well-led?	Requires improvement

Overall summary

This inspection was carried out on 04 December 2015 and was unannounced.

Foxholes Care Home provides accommodation and personal care including nursing care for up to 110 older people. At the time of the inspection there were 62 people living at the home. There was a manager in post, who was not currently registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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 and associated Regulations about how the service is run.

When we last inspected the service on 15 October 2015 we found them to not be meeting the required standards. This was a focused inspection to check if they had made the improvements necessary to meet the required standards. We found that they were still not meeting the standards because there was not enough staff to meet people`s needs safely at all times, people`s medicines were not managed safely. Records were not contemporaneous and not completed in a timely fashion to reflect what care people needed or received. At this inspection we found that they were 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.

People told us that they felt their needs were not met safely at all times. They had to wait a long time for staff to answer call bells. The manager has failed to monitor how long it took for staff to answer call bells and not listened to people`s concerns when they reported the shortage of staff. People`s nursing needs were not always met due to high numbers of agency nurses who were not familiar with people`s health needs.

Summary of findings

People had their medicines administered by staff who were trained, however we found when we reconciled medicines for people there were more tablets that there should have been or less. This meant that people had not received their medicines according to the prescriber`s instructions.

The manager failed to action any of the concerns we reported in the previous inspection, they had not conducted any audits, they did not monitor the safety or the quality of the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Agency staff were not knowledgeable enough about peoples` needs to deliver care in a safe way.

There were not enough staff to meet people's needs on some occasions.

People`s medicines were not always managed safely.

Is the service well-led?

Requires improvement

The service was not well led.

The systems used to quality assure services, manage risks and drive improvement were not effective.

People had no confidence in the management of the home or that their concerns would be acted upon.

There was a lack of contemporaneous records of what care people needed and received.

The manager had not conducted any audits and had no action plan developed following the concerns we raised at the previous inspection.

Foxholes Care 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 and to look if the service made the necessary improvement in the areas we reported in our previous inspection on the 15 October 2015.

The inspection was carried out on 04 December 2015 and was unannounced. The inspection team consisted of two inspectors and it was focused on the areas we found inadequate and requiring improvement at the previous inspection on 15 October 2015.

Before the inspection we reviewed information held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with nine people who lived at the home, four relatives, three staff members, one agency nurse, two team leaders, the home manager, deputy manager and the provider.

We looked at care plans relating to four people who lived at the home and other records relevant to the care, treatment and support people received.

Inadequate

Is the service safe?

Our findings

Last time we inspected we found that people had not received safe care or treatment that met their individual needs because there were not enough staff to meet people`s needs at all times. At this inspection we found that there were still a shortage of nursing and care staff available to meet people`s needs safely.

The majority of people we talked with said that there was not always enough staff available to meet their needs. One person told us that at night there was often only one care staff member on duty with one nurse who sometimes had to cover other floors as well. The person told us they needed two staff members at all times to support them but this did not always happen, particularly at night, and they sometimes had to wait for up to an hour for another care staff to come and assist them. Another person said, "Generally, the staff are good but [there] is not enough of them. I need to wait a long time before my calls are answered." Somebody else commented, "I ring my bell and it goes on for 30 to 45 minutes sometimes and no response. I was told this morning it was one nurse and one care staff [on duty]." They went on to say, "They are always short of staff here, they pick staff from different floors and I always need to wait."

We talked to a person who told us they liked to have baths in the mornings when they were feeling at their best, however this was not always possible due to lack of staff in the morning to support them. On the day of the inspection it was 11.30 and they were still in their night clothes waiting for someone to support them to have a bath. They told us that a day before they were unable to have a bath because it was offered after lunch and they were not up to it at that time. Staff also told us at times they had to work short due to the short notice of staff sickness which could not be covered.

The deputy manager showed us the staff rota's and told us that there should be 15 staff deployed across all floors of the service according to skill mix. If more staff were required these were requested and obtained from bank or agency staff. We saw that on occasion the Rotas had gaps and staff numbers reflected on the Rotas were below the 15. The deputy manager was not able to tell us how staffing was arranged to meet people's dependency needs and who assessed the need for the 15 staff.

We found that the provider was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they did not ensure that there were sufficient numbers of suitable staff to meet people`s need safely.

When we previously inspected the home we were concerned that people had developed pressure ulcers due to inadequate pressure care management. At this inspection we were still concerned that people were still at risk to develop pressure ulcers due to staff not turning people at the required times. We found that a person who required repositioning as they were being cared for in bed had a repositioning chart which detailed that they needed staff to turn them every three hourly. The chart showed that at 08.30 they were positioned on their back and at 13.30 they were repositioned again on their back. This meant that they had not been repositioned to a different position to relieve pressure to their sacral and back areas. We discussed this with a senior member of staff who had no explanation how this happened. They told us staff had been reminded several times in handovers to ensure they turn people at the right times and they complete the charts.

We found a person who had a pressure ulcer which they developed whilst living at the home. Their care plans detailed individual needs and provided guidance for staff on the actions to take to meet their needs however it was not detailed who had recommended for this person to be turned three hourly. We discussed our concerns regarding how often people were repositioned with a team leader who told us that the frequency was established by a nurse who no longer worked for the provider. We were not able to establish if the frequency of repositioning was recommended by a specialist nurse or GP or if these plans followed nationally recognised guidelines. This meant that, although people were repositioned by staff at the frequency recommended by a nurse no longer employed at the home, these may not have followed national guidance or met people`s needs.

We found that the provider continued to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they did not ensure that the identified risks to people's health and welfare were sufficiently mitigated to keep people safe.

At the previous inspection we looked at how information in medicine administration records and care notes for people

Inadequate

Is the service safe?

who lived at the service supported the safe handling of their medicines. Medicines were stored safely for the protection of people who used the service and at correct temperatures. Staff authorised to handle and administer people's medicines had received training and had been assessed as competent to undertake these tasks. However, medicine records did not confirm that people received their medicines as prescribed. When we compared medicine records against quantities of medicines available for administration we found discrepancies.

At this inspection we found that the improvements required to ensure that people received their medicines safely had not been made. For example, one person had medicines to prevent them having seizures. When we reconciled the tablets we found that there was one tablet more than it should have been. Therefore this person was placed at risk due to not receiving their medicines in accordance with the prescriber's instructions.

Another person were taking medicine every morning. We have checked the medicine administration records and saw that there were signed as administered daily however when we counted the medicines with the deputy manager we found five extra tablets in the box suggesting that the medicines had been signed for however there were not administered. This meant that the person was exposed to risks associated with mismanagement of medication because they had not received the prescribed medicines in accordance with the prescriber's instructions.

People were concerned that there was no continuity of nursing staff and their health needs were not appropriately monitored or met. One person said, "There is no continuity of nursing staff which makes things difficult when you have a condition that nurses need to monitor." For example, they told us that agency staff needed a long time to carry out the medication round. On the day of the inspection they received their medication at 12.30 instead of 08.30 and that this meant they were not able to have their dose for 14.00 because they had to have a four hour window between the tablets. They told us that the medicines were for a medical condition and they had to take them regularly to prevent the symptoms of the condition causing them discomfort. Another person told us, "I never get my medicines in time. I took my medicines independently until I moved in here and I know I have to have one tablet before my food in the morning, however I never do."

One person told us they had to be vigilant when agency nurses administered their medicine as on one occasion they brought them medicines at the wrong times. They told us, "I am lucky because I know what tablets I need to have every day at different times. I always have to check very well when agency nurses are working." The provider told us they only had two permanent nursing staff employed at the home and they were covering the vacant nursing and care staff hours with agency staff.

We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as they had not ensured the proper and safe use of medicines.

Requires improvement

Is the service well-led?

Our findings

People and relatives told us they had no confidence in the management of the home. One person explained they told the manager that they felt there were not enough staff to meet their needs and about the increased waiting times for staff to answer call bells. They told us they felt that their concerns were not taken seriously by the manager or dealt with properly. They told us that their relative raised the issue of nurse shortages with the manager and they were told "We have difficulties in finding good nurses." Another relative told us, "The manager is 'wishy-washy', they promise a lot and they do nothing."

We were met by the manager when we arrived at the home. We asked them to tell us when they opened the first floor as they told us at the previous inspection that the first floor was not in use. They could not remember and they went to find out the exact date of the floor opening. It appeared that they were not able to access this information from their own office or had the info at hand. They were gone for more than 10 minutes so we left the office and went up to the first floor where we were told by a team leader that the floor opened at the end of October 2015. We had not seen the manager throughout the inspection; we had to give feedback on our concerns to the provider.

Last time we inspected we reported that records central to people`s care were not accurately completed and were not reflective of the care people received. At this inspection we found continued failings in record keeping and a lack of oversight from management which adversely impacted on the monitoring of the service for safety and quality. We found records which were not contemporaneous, not completed in a timely manner and they were not a true reflection of the care people received. For example turning charts had gaps in recording the times when people were turned. We found gaps in medicine records.

We identified that people`s needs were not met safely due to high usage of agency nurses and poor oversight of the manager and the provider with lack of auditing and monitoring. We discussed this with the provider and they agreed that it was a combination of lack of staff and leadership the cause of these failings. They reassured us they will address the lack of effective audit systems and they will start recruitment for a clinical lead and permanent nursing staff. The manager had not analysed data available to monitor the length of the call bell response times although people complained about long waiting times.

We met the manager at the end of our inspection as they conducted a medicine audit following the concerns we raised when we had checked the medicines earlier. We asked them if they had conducted any audits following the previous concerns we raised on the 15 October 2015 and they told us they had not done any medicine audits or other quality audits since then. They told us they were just conducting a medicine audit and help the agency nurse to administer medicines to people which should have been administered to people at 14.00 however the audit in the same time slowed the process. We noted that it was 16.35 hours. This meant that people did not receive their medicines in time due to the manager who had delayed the medicine administration by conducting an audit in the same time. We raised our concerns with the provider about the manager`s ability to ensure people received a safe service due to their lack of responsiveness and actions into the concerns reported on 15 October 2015.

We saw that the provider had arranged meetings with relatives to inform them about the findings of the inspection carried out on the 15 October 2015. They reassured people and their relatives about their intention to improve in the areas that required improvement.

Due to lack of accurate recordings, lack of systems to identify shortfalls of the service provision and the lack of responsiveness to improve the quality of the service provided we found the provider continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure that there were sufficient numbers of suitable staff to meet people`s need safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure that the identified risks to people's health and welfare were sufficiently mitigated to keep people safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure the proper and safe use of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There was a lack of accurate recordings, lack of systems to identify shortfalls of the service provision and lack of responsiveness to improve the quality of the service provided.**