Accord Housing Association Limited

Probert Court Nursing Home

Inspection report

Probert Court
Probert Road
Wolverhampton
West Midlands
WV10 6UF

Tel: 01902444067
Website: www.accordgroup.org.uk

Date of inspection visit:
12 July 2018
13 July 2018

Date of publication:
05 September 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

The inspection took place on 12 and 13 July 2018 and was unannounced. This was the first inspection of the service since it was registered under the new provider in March 2017.

Probert Court is a 'care home' for people who require a period of assessment while their long term care options are considered. People stay at the service for a period between seven days up to six weeks while assessments of their needs takes place. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service accommodates 25 people in one adapted building. At the time of the inspection, there were 18 people living at the service.

There was a manager registered with us. However, we were made aware prior to the inspection that the registered manager had recently left their role at the home and that an interim manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always feel safe. Incidents that may have required investigation under safeguarding procedures had not been investigated and risks to people were not always managed to keep people safe. Although the service was staffed appropriately, people continued to have extended delays waiting for support. Medicines were not always managed safely.

Although people's dietary requirements had been met, we found that mealtimes were not a sociable experience for people. People's rights were not consistently upheld in line with the Mental Capacity Act but staff knowledge of this was inconsistent. People were supported by staff who had received training, although staff did not always feel the training was sufficient. People had access to healthcare services where required.

People were not always treated with dignity as staff did not know people's names. People's choices in relation to their personal care was not always respected. People did not have opportunity to develop relationships with staff as their interactions were limited to when care tasks were being provided.

People were not involved in the planning and review of their care and did not consistently know the reasons for their stay at the home. There was a lack of activities for people. Where complaints were made, these had been investigated and resolved by the provider.

There had been a recent change in management that had caused instability at the home. Audits completed

had not identified the areas for improvement found at this inspection. Records held were not always detailed or accurate. People were asked for their feedback and this was acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people's safety had not been managed by staff.

People were not given their Medicines consistently as prescribed, or in a safe way.

There were enough staff to meet people's needs but people continued to experience extended waits for support when they required this.

Is the service effective?

Requires Improvement

The service was not always effective.

Although training was provided, staff felt this required further work to support them to care for people effectively.

People's rights were not always upheld as staff knowledge of Mental Capacity Act and how to apply this was inconsistent.

People's dietary needs were being met although mealtimes were not a sociable experience for people.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not treated with dignity as staff did not always know people's names.

People's choices in relation to personal care had not been respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not involved in the planning for their care and did not always know the plans for their stay at the home.

People did not have access to many activities on some units.

People's complaints were investigated and resolved.

Is the service well-led?

Requires Improvement

The service was not well led

People did not receive a well-planned , and safe service as the direction from managers was in need of improvement.

Audits completed had not identified the areas for improvement we found at this inspection.

Records were not consistently detailed or accurate.

People were asked for their feedback on their experience of the service.

Probert Court 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.

The inspection was prompted in part by information of concern we received about the care provided at the home. These concerns related to a high number of safeguarding incidents being report by the provider and allegations of neglect. We looked at the concerns raised at this inspection about this.

The inspection took place on 12 and 13 July 2018 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who had experience of using or caring for a person who uses this type of care service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with 12 people and eight relatives. As some people were unable to share their views with us, we used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who were unable to talk to us. We also spoke with two members of care staff, a nurse, the registered manager, the quality manager and the head of service.

We looked at six care records, as well as 10 medication records. We reviewed three staff files and records held in relation to accidents and incidents, complaints and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

Medication was not always managed in a safe way. People told us that they did not get their medications when they required this. One person told us, "The other morning it was over an hour, I needed my meds early and I rang at 7:00 it was answered at 8:50 and I got my meds at 9:10". Another person added, "I have stopped asking for anything for the pain as it never comes".

We looked at medication records and these indicated that medications had not always been given as prescribed. We saw that one person who required medication twice a day had on one occasion been given these three times in one day. For another person, where they required two doses of their prescribed medication, they had on occasions only received one of these. This meant that people were not receiving their medication correctly which could leave them at risk of ill health.

We found that some Medication Administration Records (MAR) had been completed by hand and the handwritten directions did not match the directive given on the person's prescription. This meant people were at risk of not being provided with their medications in the correct way as the information held about these were conflicting. These errors had not been identified by staff administering medication which indicated that the safe checking of medications prior to administration were not being followed.

We looked at other Medication Administration records and found that for some people, the number of tablets they had available did not match the amount of tablets the MAR said they should have. This indicated that some medications had been signed for by staff and not given. MAR charts had not been completed accurately and so we were unable to determine if all medications had been given correctly. For example, where people required medication that could be in one or two doses, staff were not recording how many doses had been given. For others, the amount of tablets available had not been accurately recorded at the start of the medication cycle and so these could not be audited to check they had been given safely. We found missing signatures on some MAR's that meant we were unable to determine if medication had been given to these people.

We spoke with the registered manager about these medication concerns and found that although medications were being checked by nurses and management, the poor practices and recording in this area had not been identified.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they did not feel there were enough staff to support them. One person told us, "The staff do what they can but they are always so busy and rushing about we are just here and alone". Another person said, "You wait an age for the bell to be answered then they answer it and don't come back". This reflected the views of staff who also felt that more staff were needed. One member of staff told us, "There is not enough staff due to sickness levels. There's not enough nursing staff".

We found that although the manager had ensured the right amount of staff were on shift in accordance with the funding given, staff were not deployed in a way that would ensure there were enough staff for people. We saw that people had extended waits for support with one person's call bell ringing for five minutes before being answered by staff. We also saw that people in the communal lounges did not consistently have staff available and this led to people having long waits for support.

We spoke to the manager about the staffing levels and were informed that a recruitment process was ongoing and that they had just recruited a new clinical nurse lead and were interviewing for two additional nurses. While recruitment was ongoing, we saw systems were in place to ensure that regular agency staff were used and these staff received an induction before starting work.

People told us they did not always feel safe at the home. One person told us, "I don't always feel safe and secure because it's not home". Another person added, "It might be safe for some here but not for me". Although people told us they did not feel safe, we found that staff understood what abuse was and could explain the actions they would take if they thought someone was at risk of harm. We found that where concerns were raised, the manager had mostly referred these to the local authority safeguarding team. However, we identified two instances of unexplained bruising that had not been investigated or referred by the manager. We spoke with the manager about these but as this manager had only been in post for a few weeks, they were unable to determine what actions had been taken to investigate these injuries.

Risks were not consistently managed to keep people safe. We saw that staff did not always support people to move around safely. We saw staff support a person to stand. They did not do this in a way that would be safe and reduce the risk of the person falling. Once the person had stood, we saw that they were supported into a wheelchair that had a flat tyre and was therefore not safe for use. We raised this with the staff who provided assurances that this wheelchair would be marked as out of use until the tyre was fixed. However, we later saw other staff using the same wheelchair. This meant that staff were not ensuring the safety of people when using equipment, but were also not acting where risks were identified.

We found that there were safe recruitment systems in place. Before staff could commence work, they had been required to provide two references and complete a check with the Disclosure and Barring Service (DBS). The DBS check would show if a person had a criminal record or had been barred from working with adults. Records we looked at showed that these checks were in place.

The infection control practices within the home were effective. We found that staff had received training in infection prevention and that they use protective personal equipment (PPE) appropriately to ensure people were safe. We found the home to be clean and free from odours.

Requires Improvement

Is the service effective?

Our findings

People did not always feel that staff had the skills and knowledge to support them effectively. One person told us, "Staff try but they are not trained to deal with [my injury]". Staff told us that prior to them commencing work they had completed an induction that included completing training and shadowing a more experienced member of staff. We found that new staff were also enrolled on the Care Certificate. The Care Certificate is an identified set of standards that care workers must adhere too. Staff gave mixed feedback when asked about the training they were given. One member of staff said, "We do get training but not enough". Another staff member added, "We do get fairly regular training". The manager told us that there were no formal systems in place to evaluate the effectiveness of the training provided to staff. Systems such as this would have supported the manager to identify that some staff did not feel the training was enough to meet their learning needs.

We looked at records held in relation to training and saw that staff had attended training that covered several areas; some of which were specific to the needs of people staying at the home. The manager told us how they were sourcing additional training for staff that covered protected characteristics under the Equality Act such as sexuality.

People did not always speak positively about the meals they were provided with. One person told us, "I have real issues with the food which is geared for the elderly palate and diet". Others were more pleased with the meals and told us, "The food at the home is beautiful". We found that mealtimes were not a sociable experience. People sat alone in the dining room on single tables or eat in their rooms. For the people who did eat in the dining area, there was little engagement from staff and no music to provide a more meaningful mealtime experience. We did see that people were offered choices of what they would like to eat and that the food smelled and looked appetising. Where people had specific dietary requirements, such as diabetes, we found that these needs were considered at mealtimes to ensure meals met people's needs.

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 Act 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that staff's understanding of MCA and Dols varied. We found that whilst some staff understood the importance of assessing capacity and seeking consent prior to supporting people, other staff did not have this knowledge and told us they had not received training in this area.

We saw that staff had mostly sought people's consent before providing their support, however during the lunchtime meal, we saw that staff had put clothing protectors on people without asking them if this was ok

first. This meant that although staff knew that they needed to seek consent, they had not consistently put this into practice.

We saw that there were systems in place to ensure that people had access to healthcare services where required. As people only stayed at the service for a period of assessment before moving back home or into longer term accommodation, there were a steady stream of health professionals visiting people to assess their needs. For example, we saw people receive visits from physiotherapists, Occupational Therapists and nurses. Records we looked at showed that the manager was in regular contact with people's doctors, consultants and social workers to ensure people's healthcare needs were addressed.

The home had recently undergone re-decoration throughout. We found that the home was spacious, easily accessible and met people's individual needs.

Requires Improvement

Is the service caring?

Our findings

People were not treated in a dignified way by staff. We found that staff had not taken time to learn people's names and were heard throughout the inspection referring to people by their room number rather than their name. We spoke with a member of staff who was about to support a person with their personal care. This staff member did not know the name of the person they were supporting. We asked another member of staff for a person's care records. The staff member did not recognise who we meant until they were given the room number for the person. We spoke with a nurse administering medication and asked for the name of a person we had seen in their room. The nurse did not know the person's name and had to refer to a sheet of paper to find out the person's name. We raised this as a concern with the manager who informed us they would address this with the staff team.

We saw that one person who had been at the home for several days was wearing a hospital gown. We queried with the manager where the person's clothes were and were told that they did not arrive with any and that they thought that family would bring in some clothes but had not followed this up to ensure that they would be returning. This had meant that the person had no personal items with them and was living in hospital gowns. We asked the registered manager what other action had been taken to support the person to access their own clothes and was informed that this is something the home would not get involved in. We informed the registered manager that we were concerned that the person had no clothes after being at the home for several days and the manager acted to contact the person's social worker and arrange clothing. However, this action was only taken following inspectors raising this as a concern and the manager had not been proactive in promoting the person's dignity by sourcing appropriate clothing for them.

People were not always given choice and involved in their care. People we spoke with overwhelmingly confirmed that they had not been offered a bath or shower since arriving at the home and that although they would like to have this, it had not been offered. One person told us, "I haven't had a shower or bath while I have been here". Another person said, "No, I don't get bathed or showered, just washed". A third person said, "Staff come and give me a swill down, but it's just a very quick swill down. Even a thorough swill down would be better if there wasn't time for a shower". This person went on to explain that although they would like to have a bath, they had come to accept that staff were too busy to support them with this. We spoke with the manager about this who informed us that baths and showers were available for people who wanted these but that people had declined them. We checked records and although we could see that personal care was given, we could not find any evidence that people had been offered a bath or shower and that this had been declined. This meant that people's choices with regards to their personal care had not been respected.

This is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that staff tried to be kind and caring to them but were limited in what they could do because of time constraints. One person told us, "The staff on the whole try to be kind and attentive to me". Another person said, "I don't want to trouble staff by asking them to help me as they are always so busy". We saw that although staff were friendly when supporting people, their interactions were limited to when care was

being provided. Outside of care provision, we did not see staff spend time with people or engage in any meaningful interactions with them.

Requires Improvement

Is the service responsive?

Our findings

We saw that before people moved into the home, an assessment of their needs took place. These assessments looked at people's current care needs and were completed by the funding authority who referred people to the home. People we spoke with told us they had not been involved with these and had not seen their care plan. People had not been involved in the planning for their care during their stay and this had caused anxiety for some people. One relative told us, "We do not know what the plan is for [loved one] now I suppose someone will tell us in time". Another person said, "I cannot understand why they accepted me here as it is not age appropriate and clearly is not a Rehab centre which is what I require". For example, we found that one person, who had been at the home for several days had not been supported to walk by staff. The person's relatives raised concerns with us about this. We saw that the person's assessment stated they required to be supported with transfers only and so staff had followed this direction. However, this was incorrect and on the second day of inspection we found that the person could walk and visiting professionals supported the person to do this. As the information provided to staff was incorrect, they had not provided the person with the support they required. We spoke with the manager about this. The manager informed us that staff would only follow the information provided to them in the assessment completed by a person external to the provider and as such, had not considered if the person could walk. This meant that as the manager had not assessed the person's needs to determine their capabilities or spoke with the person's loved ones who were aware that the person was able to walk, the person had not been supported to maintain their mobility in the first few days of their stay.

Records we looked at did not provide any personalised details about people's likes, dislikes or preferences with regards to their care. The detail provided about people was limited and this reflected in staff's knowledge about people. Staff we spoke with did not know people well and were only able to describe the care support that people needed. One member of staff when asked about the support provided to a person said, "I am just doing my job I do not know the answers to these questions". The provider's own quality team who had started to visit the home to drive improvements had identified this within some care records. For example, we saw that they had identified that people's diabetes care plans required further detail and that this was being addressed. People's religious needs had been considered and we saw that church service was held in the communal areas by a local church for those who wished to attend.

There was a lack of meaningful activities available for people. On the first day of inspection, we saw that no activities were held and that staff did not spend time with people other than when providing their care. This meant that communal areas were very quiet with little stimulation for people. One the second day we saw some staff complete activities with people in the communal lounge and that the people who took part in these, enjoyed the interaction. We spoke with the manager about the lack of activities and were informed that activities were not generally offered as the service was for people on a short-term basis. This meant that the provider had not considered the need for meaningful interactions and activities for people regardless of their length of stay.

People told us they knew how to complain. We saw that information was displayed informing people how they could make a complaint if they wished. We looked at the records held in relation to complaints and

found that where concerns had been raised, these had been investigated and a response provided to the complainant.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had recently left their role at the home. While recruitment was ongoing, an interim manager had been supporting the home and was going to manage the service until a new manager was found. Recruitment was ongoing for a new permanent manager. However, the recent turnaround of managers had a negative effect on staff; some of whom informed us they did not feel the service was well led. One member of staff told us, "It isn't consistently well led due to the management changes".

People spoke positively about the care they were provided with but felt communication could be better with management about the aim of the service and what the plans are for their care. People were not always aware why they had been admitted to the home, what they would be doing while they were there and what the plan was for the end of their stay. One person told us, "They [staff] have so much to do with everything they have to do for us. We must be grateful". A relative said, "We are happy with the care as far as we know but they don't tell us much". A third relative said, "I don't know what the plan is".

We found that audits had been completed to monitor the quality of the service. However, these were not always effective. For example, the management team had been completing audits of medicines, and although these had on occasion identified missing signatures, we could not see that this issue had been acted upon to reduce the risks of these errors re-occurring. During the medication check completed, we found that missing signatures continued to be an issue. We also found that where areas of concern in relation to equipment were identified, these were not acted upon in a timely way. The emergency lighting that would ensure people's safety in case of fire had been out of use since February 2018. This had been identified at each check of fire equipment since that date but had not been acted upon. This meant that audits had been ineffective at ensuring improvements were made.

Other audits completed had not identified the areas for improvement we found at this inspection. The medication audits completed had not identified that the handwritten directives were not accurate or that medication was not being given as prescribed. Further, the audits in place did not identify where staff practices did not promote dignity. As a result of this not being identified, a culture had developed amongst staff where it had become the norm to not know people's names or spend time with people to facilitate meaningful interactions and develop relationships with people.

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

Our conversations with the head of service indicated that the provider had recently begun to identify the shortfalls in quality of care at the service. In response to this, they had organised for their own quality team to come into the service regularly to complete audits. The head of service acknowledges that issues had gone undetected in previous months and provided assurances that this was now being acted upon.

We saw that people were given opportunity to feedback on their experience of the service at the end of their

stay. There was a 'You Said, We Did' board that showed where feedback had been acted upon. For example, we saw that comments had been made about the tired décor of the service and so a period of redecoration had recently been completed.

It is a requirement that the provider inform us of certain incidents or concerns that arise at the home. We saw that these notifications had been sent in as required. Staff we spoke with were aware of how to raise concerns and knew how to whistle blow if required.