Peck & Packer (Care Homes) Limited

Martin Hall 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?	**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

This inspection took place on 29 November 2016 and was unannounced. Martin Hall provides care for older people who have mental and physical health needs including people living with dementia. It provides accommodation for up to 40 people who require personal and nursing care. At the time of our inspection there were 27 people living at the home.

There was a registered manager in post. 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.

At this inspection we found that the provider had failed to ensure that previous improvements had been sustained. We found that there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of this report.

Medicines were not managed appropriately and safely. People did not always get their medicines as prescribed.

Staff were kind to people when they were providing support. People did not consistently have their privacy and dignity considered. We have made a recommendation about privacy and dignity. Staff were able to tell us about people's needs. Staff knew how to safeguard people against abuse.

We found that people's health care needs were assessed. People had access to healthcare professionals such as the district nurse and GP and also specialist professionals.

Staff were provided with training on core areas and training in areas specific to the needs of people who lived at the home such as care of people living with dementia. The provider had a training plan in place and staff had received supervision.

The provider did not always act in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find.

People had their nutritional needs assessed but were not always supported to eat their meals to keep them healthy. Where people had special dietary requirements we saw that these were provided for.

People had access to limited activities. Signage in the home was poor and not provided in a manner which assisted people with dementia to orientate themselves to their surroundings.

Records were not accurate. Care plans were not updated consistently and did not reflect the care people required.

Systems were not in place to adequately assess, monitor and improve the quality and safety of the services. Audits were in place for areas such as medicines and infection control however they had not consistently improved the quality of care. Accidents and incidents were recorded.

Staff felt able to raise concerns and issues with management. Relatives were aware of the process for raising concerns.

The provider had informed us of notifications as required by law. Notifications are events which have happened in the service that the provider is required to tell us about.

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 consistently safe.

Risk assessments were not always in place.

Medicines were not administered safely.

There were sufficient staff to provide care.

Staff were aware of how to keep people safe from abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not act in accordance with the Mental Capacity Act 2005.

People had their nutritional needs met. People were not always supported with their meals.

Staff had the knowledge and skills to carry out their roles.

Is the service caring?

Requires Improvement

The service was not consistently caring

People did not have their dignity consistently maintained.

care was focussed around tasks.

Staff were aware of people's care needs.

Is the service responsive?

Requires Improvement

Care records did not reflect the care people required.

People had limited access to activities.

The complaints procedure was on display and people knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems and processes in place to check the quality of care and improve the service were not always effective. The provider did not have adequate systems in place to ensure that the service was well-led.

A registered manager was in post.

Martin Hall 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 29 November 2016 and was unannounced. The inspection was completed by an inspector, a pharmacy advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We 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 also looked at notifications which we held about the organisation. Notifications are events which have happened in the service that the registered provider is required to tell us about and information that had been sent to us by other agencies.

During our inspection we observed care in the home and spoke with the registered manager, the nurse manager and three members of care staff. We spoke with one person who used the service and three relatives. We looked at seven people's care plans and records of staff training, audits and medicines.

Requires Improvement

Is the service safe?

Our findings

People who lived at the service received care that was not consistently safe. We found there were shortfalls in the way the provider managed the administration of medicines and people were at risk of not receiving their prescribed medicines. We looked in detail at the medicines and eight medicine administration records (MARs) for people living in the home. We found that people were receiving their medicines as prescribed providing that the medicine was available in the home and the medicine was prescribed to be given regularly. Records were kept of medicines received into the home and given to people. These showed that one person had been without three of their medicines for four days and that another had been without their regular pain medicines for one day in November. One person had been prescribed eye drops for a condition which without treatment could cause loss of sight or permanent damage to the eye and we found they had not received these for four days because the medicine had not been available in the home. People didn't get these medicines as there was none available in the home for them to have.

When people had patches applied no records were being kept to ensure that the patches were applied to different parts of the body in line with the manufacture's guidance to avoid people's skin getting sore.

Some people had been prescribed medicines on a when required basis (PRN) or at a variable dose, such as one or two tablets. There was no information in people's care plans to show the staff how and when to administer these medicines, so that they were given in a clear and consistent way that met people's individual needs. One person whose records we looked at had refused all of the doses of one of their medicines for the previous four weeks. A second person, who often refused their medicines, had refused all of their medicines for three consecutive doses. Neither of these people had information specifying when to seek medical advice if they did not get their prescribed medicines.

We observed people being given their medicines. On the day of the inspection the morning medicines were not all given until 12 noon, and staff told us that the round was usually completed between 11:00 and 12:30 each day. This could result in someone being given their next dose of a medicine without an adequate time gap since their morning dose. This was further compounded by the fact that the records did not show the actual time given but indicated that they had been given at 9am. We saw one person given a medicine at 11am but the record showed that it was given at 9am. This medicine required a four hour gap between doses and so a second dose could have been given at 1pm based on the information in the records resulting in only a two hour dose gap. People were at risk of receiving more medicine than required which could result in adverse effects to their well being.

We saw the nurse prepare the medicines for one person by placing all of their liquid medicines into a single beaker and the resulting liquid was then thickened to meet their swallowing needs. There was no assessment of the risks of giving these medicines in the way, nor any care plan describing how to give the medicines. Also, the liquid medicines were administered in a single beaker which meant it was not clear what medicines they were being administered. The person was unable to consent however a best interests decision had not been completed.

This was a breach of Regulation 12(2) (b) (f) (g) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

More positively records were kept of medicines received into the home and given to people. There were few gaps on the MARs. Clear records were kept of when to give the next dose of medicines which were not given every day and people were getting these medicine at the right times. People were protected against being given medicines that they were allergic to. Their allergies were recorded on their MAR and on the information sheets kept with their medication records. Medicines were stored in locked cupboards according to national guidance. Processes were in place to ensure that medicines were disposed of safely and records maintained regarding stock control.

Individual risk assessments were completed for issues such as a risk of falls and skin care. However risk assessments were not consistently in place where equipment was used such as bed rails and for ensuring people received their medicines. Information was not available to staff about the risk of using this equipment and how to minimise the risk to ensure people were kept safe. There was a risk of injury to people. Accidents and incidents were recorded and investigated to help prevent them happening again.

The nurse manager told us they had implemented a plan for infection control. However when we walked around the building we found areas that had unpleasant smells despite being cleaned. We also observed the clinic room floor to be sticky underfoot.

A relative said, "Yes I think there is enough staff. I don't hear buzzers going off and that and there's lots of room for those that like to wander to go up and down and get exercise walking around this place." We observed during the day of our inspection that although there appeared to be sufficient staff available to meet people's needs they did not always respond to people in a timely manner. We observed people were left without intervention for long periods of time during the day. However staff told us they felt there were sufficient staff to provide care to people. We looked at staff rotas and saw they were as described by the nurse manager and that both care staff and nursing staff were available in order to meet people's needs.

The registered provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. They also carried out Disclosure and Barring Service (DBS) checks to ensure that prospective staff would be suitable to work with the people who lived in the home. These checks ensured that only suitable people were employed by the provider. The nurse manager told us they were currently in the process of recruiting to vacant posts but had been using a small amount of agency to cover any gaps in the rota. They told us they tried to use the same agency staff to assist with continuity of care and staff we spoke with confirmed this.

Staff were aware of what steps they would take if they suspected that people were at risk of harm. They were able to tell us how they would report concerns, for example to the local authority. Staff told us that they had received training to support them in keeping people safe. The registered provider had safeguarding policies and procedures in place to guide practice and we had evidence from our records that issues had been appropriately reported.

Requires Improvement

Is the service effective?

Our findings

The registered provider did not act consistently in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 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.

We observed three people had bedrails in place to keep them safe and did not have the capacity to consent to these. There was no evidence that a best interests decision had been made with regard to these items to ensure that staff were providing care in the person's best interest. Another person received their medicines without them knowing (covertly) and was unable to consent to this method being used, however a best interests assessment was not in place to protect the person from receiving inappropriate treatment.

Six of the people whose care records we looked at had do not attempt cardio pulmonary resuscitation orders in place. However in two of the records the order stated that the decision had been discussed with the person although their care record stated they did not have the capacity to make complex decisions. We also found that on two occasions the relative's making decisions on behalf of their relative did not have lasting power of attorney (LPA) for health and welfare and were therefore not authorised to make these decisions on the person's behalf. Additionally best interests decisions were not in place for these decisions.

We found in six of the records we looked at best interests decisions did not detail the specific issue for which staff were making decisions on people's behalf. People were at risk of having decisions made for them unlawfully.

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

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 , and whether any conditions on authorisations to deprive a person of their liberty were being met. If the location is a care home the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find. At the time of our inspection there were nine people who were subject to DoLS authorisations. DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. We observed the appropriate paperwork and processes had been followed.

We observed lunchtime and saw people did not have access to aids and equipment to assist them with their meals. For example a person chose to eat with their fingers, although with some difficulty. We observed most of the food was spilt off the plate and there was no plate guard on the plate to help to keep the food

on the plate. Another person poured their drink into their meal plate. The food was also spilt off the plate and again a plate guard was not in use. We did not see staff assist or encourage the person with their meal and the person got up and wandered off without eating their meal. There was a risk people were not getting sufficient nutrition. People were not offered choices at lunchtime however staff told us that people were asked what they wanted for their meal. However on the day of our inspection we did not see people being given an alternative meal everyone was provided with the same meal.

People had been assessed with regard to their nutritional needs for example where people had specific nutritional needs such as diabetes these were detailed in the care record and meals provided according to their needs.

Drinks were not available in the communal areas for people to access a drink when they chose to. However we observed drinks were offered mid-morning and mid-afternoon as well as at lunchtime. We looked at two fluid charts for the day of inspection and the month previous and saw that they were not completed consistently. We looked at fluid charts for two people for a period of six days. One person's chart was not consistently totalled which meant it was not clear whether or not they had received sufficient fluids. This was particularly important for this person as their care plan stated they required a specific amount of fluid on a daily basis. We also saw the record did not specify that drinks had been given after 7pm on four occasions and after 6pm on two other occasions. We saw that completion of fluid charts had been discussed at a staff meeting however we still found gaps in these.

People who used the service had access to local and specialist healthcare services. For example we observed people had been referred to specialist nurse services for advice about skin care and also to specialist mental health services.

We saw staff had received updates on core training on areas such as fire and health and safety. they had also received training on issues which were relevant to people living at the home for example, training about dementia care and nutrition. There was a system in place for monitoring training attendance and completion. Staff also had access to nationally recognised qualifications. When we spoke with staff who had recently returned to the home they told us that they had not received an induction. Staff were happy with the support they received from other staff and the manager of the service. They told us that they had received supervision.

Requires Improvement

Is the service caring?

Our findings

Staff did not consistently treat people with dignity and respect. We observed a person required assistance with their clothing as an item was too large for them and had fallen down. The person required alternative clothing and this was provided by staff in full view of other residents in the lounge area. We observed staff attempted to maintain the person's dignity in the process. We observed another person required assistance with their continence pad as it had fallen out in a communal area. Staff had not noticed this and we had to ask them to provide assistance to the person.

We recommend that the service seek advice and guidance about ensuring staff understand how to respect people's privacy, dignity and human rights.

The staff appeared generally focussed on tasks, for example we observed that care was provided according to a daily routine rather than based on people's individual needs and wishes. We saw drinks were provided at specific times during the day, for example, at mealtimes and when the tea trolley was brought around. We also saw that people were supported with their personal care, such as access to the bathroom at specific times in the day for example, before lunch rather than according to their individual needs. However we observed that people were given the choice by staff as to whether or not they required this support and wanted help. When we spoke with staff they were able to explain how people liked their care provided.

During the morning we observed people sat in the lounge/dining area. We observed there were long periods of time when staff were not around and there was little interaction with people. Most people in this area were asleep. We saw two members of staff in the lounge area writing in files. During this time they spoke briefly to two people who were wandering in the lounge area. We observed a person who was slumped in their chair having slid down. Despite staff being available they did not attempt to reposition the person in order to make them more comfortable.

A relative said: "They are very kind to my relative." We observed staff spoke kindly to people when providing support and explained what care they were going to provide. We observed a member of staff supporting a person to mobilise and saw this was done at their pace.

Requires Improvement

Is the service responsive?

Our findings

We saw that care plans had been reviewed however they did not accurately reflect the care people required. For example one person required support to prevent them becoming distressed, and the care plan did not indicate what support they required to achieve this. Where people's needs had changed care plans had not been updated to reflect this. For example a person had had their medicines changed to liquid form but their care plan had not been revised to reflect this. Another person's emergency plan explained how they required support from sleeping on a mattress at floor level. However we observed they now slept in a specialist bed and the support they required would be different. There was a risk the person would not receive appropriate and safe care.

The care records we looked at detailed people's past life experiences. Information such as this is important because it helps staff to understand what activities people have previously enjoyed so they can try to offer similar experiences. Staff were able to tell us what things people liked, for example a member of staff told us about how a person enjoyed Christmas films and music.

Where people required specific one to one support we observed staff providing this in a sensitive manner. A member of staff told us they all provided this support to the person during the day because this helped the person to speak with different staff throughout the day and provided them with variety. We observed the person responded well to staff and the support they received. When staff changed over we observed this was carried out in a sensitive manner, for example staff asked, "Would you like to walk with me now?"

On the day of the inspection the member of staff responsible for activities was unavailable as they were supporting a person with an external activity. We did not observe any activities being provided during our inspection. We observed the television was on when we arrived, however people did not appear to be watching it as we observed most people were asleep. Later in the morning the television was turned off and music was played. We saw staff supported people to choose which music they would like played. A member of staff was responsible for providing activities and on the day of our inspection had taken a person out. The nurse manager told us they had recently been visited by the local school choir and had organised activities related to remembrance. We saw records of activities which had taken place in November including animal therapy and Christmas crafts. A relative said, "I think they do what they can because it's difficult to get any of the residents involved in anything really, they do have a singer come in from time to time which they seem to enjoy and they do have sing songs which I hear."

Relatives we spoke with told us that they felt welcome at the home. "They are good to me as a carer and always offer me Sunday lunch and that." They also told us they were aware of their relative's care plan. One relative said, "I know about the care plan and could see it if I wanted."

The environment in the home was not responsive to the needs of people with dementia or provided in a way that would assist people with their orientation. For example, bedroom doors had numbers and some had photographs but this was not consistent and were unlikely to assist people to identify their bedrooms. In addition menus were in written form and not provided in picture format to support people with dementia to

make a choice at mealtimes.

A complaints policy and procedure was in place and on display in the foyer area. Relatives told us they would know how to complain. Where complaints had been made these had been addressed. The complaints procedure was only available in a written format. This could result in a lack of accessibility to people with poor reading skills.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have adequate systems in place to ensure that the service was well-led. We found the provider had not ensured that arrangements were effective and that previous improvements were sustained. As a result of this we found shortfalls in the care and treatment that people received throughout our inspection.

At our last comprehensive inspection we also found breaches in the legal requirements. Although when we followed these up, improvements had been made, we found at this inspection this progress had not been sustained and the quality of the service had deteriorated in these areas owing to the lack of oversight. At the previous inspection we had identified areas of concern about the safety and management of the service. The provider had not taken sufficient action to ensure that any introduction of quality processes were carried out in a systematic manner and maintained.

A local process was in place for checking the quality of some areas of the service and making improvements to the quality of care. However we found that the system was not effective in improving the quality of care to people, for example, the nurse manager told us they should carry out monthly audits on weekly checks on medicines but had been unable to do so due to capacity as the nurse responsible for these had recently left. We observed that audits on records had not identified the lack of consistency in care plans and completion of care records. Although infection control audits had been completed these had not resulted in prevention of the risk of cross infection due to poor hygiene and cleanliness.

Policies were available for some medicine handling tasks such as homely remedies and covert administration of medicines. However we observed that staff did not consistently adhere to these for example where people received covert medicines. There were however no procedures on how to carry out tasks such as ordering medicines, recording the administration of medicines nor what to do when medicines are prescribed to be given only as and when needed to ensure that staff worked within the policies.

There was a registered manager in post. 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. However the registered manager was working as the business manager and the nurse manager was responsible for the delivery of care to people on a day to day basis. The nurse manager told us that they worked closely with the registered manager even though they were not involved in the delivery of care. However the provider did not have arrangements in place to ensure that the regulated activity was being carried out in a manner which met the regulations. The nurse manager said that they felt supported in their role. However systems were not in place to ensure they had the skills appropriate to their role. They had not received a formal appraisal and were not sure who would provide this although they said they thought it would be the provider.

Surveys had been distributed to relatives. Relatives had identified two issues of concern in the survey, the issue of refurbishment and communication. We also saw positive comments regarding the care, for example

one comment said, "Appears comfortable and looked after." The survey results had not been collated, however the registered manager told us an action plan was in place which included refurbishment. We asked the registered manager to send this information to us following the inspection but have not received this.

This was a breach of Regulation 17 of (1) (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had notified the CQC about notifications as required by law. Notifications are events which the provider is required to inform the CQC about.

Staff said they felt supported in their role and that they worked as a team in order to meet people's needs. Staff and relatives told us that the registered manager and other senior staff were approachable and supportive. Staff said that they felt able to raise issues and felt valued by the manager. Meetings with staff had been held on a regular basis with staff. We looked at the minutes from the meetings and saw that issues such as care plans had been discussed.

A resident and relatives' meeting had also been held. We saw from the minutes of a meeting held issues such as refurbishment and staffing levels had been discussed. We saw a comment had been recorded that staff were working well together. A relative said: "I suppose it is well led I don't really know. I think it is old school. I would go to the manager if I wasn't happy and she would be on it. It's in their interest to sort things isn't it?"

The service had a whistleblowing policy. Staff told us they were confident about raising concerns about any poor practices witnessed and felt able to raise concerns and issues with the manager. The provider had informed us about accidents and incidents as required by law.