Avery Homes (Cannock) Limited

Abbey Court Nursing Home - Cannock

Inspection report

Heath Way
Heath Hayes
Cannock
Staffordshire
WS11 7AD
Tel: 01543 277358

Date of inspection visit: 14 October 2015
Date of publication: 30/11/2015

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?	Good
Is the service well-led?	Requires improvement

Overall summary

We inspected this service on 14 October 2015. The inspection was unannounced. This was the service's first inspection under the management of Avery Homes (Cannock) Limited. Our last inspection took place on18 February 2015 and at that time we found the service was not meeting the regulations associated with the management of medicines and consent to care and treatment. At this inspection we found that whilst there had been improvements in the way people's consent was obtained there were still concerns regarding the safe management of people's medicines.

Summary of findings

Abbey Court Nursing Home is a care home which provides accommodation, personal care and nursing care for up to 83 people, some of whom may be living with dementia. There were 72 people living in the home at the time of our inspection.

There was no registered manager in post. An acting manager had been appointed and had started the process of registration with us. 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.

We found that improvements were needed to ensure that there were sufficient staff to respond to people's requests for support. People were not supported to eat and drink in a relaxed and sociable environment to encourage them to enjoy their meals. Some staff did not demonstrate a kind and compassionate approach to care. People who lived with dementia did not receive social support to improve their wellbeing. Some members of staff did not feel they had been well supported during the management changes.

Risks to people's safety and wellbeing were assessed and planned for. Staff knew how to recognise and report abuse and we saw that concerns about people's care were investigated appropriately. Staff sought people's consent before providing care. Some people who used the service were unable to make certain decisions about their care. In these circumstances the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed.

People's care plans were being improved to provide staff with more information about the way people wanted to be supported. Relatives were involved in the assessment and review of their family member care to ensure it met their needs. People and relatives knew how to complain if they wanted to raise concerns. There were audits in place to identify what was working well in the home and the areas which needed to be improved.

We found two breaches of The Health and Social Care Act 2008 (Regulated Activities) 2014 at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe. We found that people's medicines were not administered, recorded or stored safely. There were insufficient staff to respond to people's requests for care. People were cared for by suitably recruited staff who recognised abuse and knew how to escalate any concerns.

Requires improvement

Is the service effective?
The service was not consistently effective. People were not supported to enjoy a pleasurable mealtime experience or encouraged to eat their food when they showed a lack of interest in the meal. Staff had access to training to improve their skills and knowledge of care. People were referred to health care professionals when specialist support was required.

Requires improvement

Is the service caring?
The service was not consistently caring. Some staff did not demonstrate a caring and kind approach with people. Some people's dignity and right to privacy were not respected. People were able to maintain the relationships which were important to them because their family and friends could visit at any time.

Requires improvement

Is the service responsive?
The service was not consistently responsive. People who were living with dementia did not have support to take part in social activities or hobbies to improve their well-being. The care plans were being improved to reflect people past life experiences and their preferences for care. Relatives were able to support their loved ones when their care was reviewed.

Good

Is the service well-led?
The service was not consistently well-led. Some staff did not feel they had been supported through the recent management changes. The provider was auditing aspects of care to identify where improvements could be made.

Requires improvement

Abbey Court Nursing Home - Cannock

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 took place on 14 October 2015 and was unannounced. The inspection was carried out by three inspectors 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.

We looked at the information we held about the service and the provider, including notifications the provider is required to send us by law about significant events at the home.

We spoke with 12 people who used the service, nine relatives and visitors, eight members of the care staff, the cook the acting manager and the regional manager. We did this to gain views about the care and to check that the standards were being met.

We looked at seven care plans to see if the records were accurate and up to date. We also looked at records relating to the management of the service including quality checks, training records and staff rotas.

Requires improvement

Is the service safe?

Our findings

At our inspection of Abbey Court on 18 February 2015 we found that the way medicines were managed was not safe. We saw that some people had been prescribed 'when required' medicines to support them during periods of anxiety. We found that some of the people were receiving the medicine on a regular basis however their care records did not show there was a need for this. This was a breach of Regulation 13 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2010 which corresponds to Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014 and relate to the safe management of medicines.

At our inspection on 14 October 2015 we found the provider had made improvements to the way medicines to be used occasionally for anxiety, were administered. However, we found that other areas of medicines management were unsafe. We observed the medicine administration rounds on both floors of the home. On one floor we found some people were not observed taking their medicines and we had to intervene to stop a person from picking up a loose tablet prescribed to someone else, and taking it. We heard another person questioning the nurse because they did not feel they'd received the correct amount of medicines. The nurse re-checked the medication administration record (MAR) and confirmed the person was correct. This demonstrated that although the information was on the MAR, the nurse had not read it accurately.

On the other floor we observed a nurse administering medicines. We observed that the nurse left the trolley cupboard open, with the keys in the lock throughout the medicine administration round, including times when they were unable to observe the security of the trolley. This meant that people who used the service, visitors and other staff could have accessed the medicines and this is considered to be unsafe practice.

We observed that the nurse did not record if people had received, taken or refused their medicines. At the end of the medicine round we looked at ten MAR's and saw they had not been completed. We observed the nurse completing the records retrospectively after we had identified the error. We saw some people were receiving their medicine covertly, this means without their knowledge. This is sometimes necessary to ensure, when people regularly refuse their essential medicines but do not the capacity to understand the risk to their health, their treatment can continue. There should be protocols and assessments in place to support the administration of the medicines in this way. We looked at the records for three people who were receiving covert medicines and saw the guidance for giving their medicines was undated. Therefore we were unable to confirm if covert medicine administration was still necessary for them.

These are further breaches of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. Management of medicines. We have issued the provider with a Warning Notice and told them they must improve by 31 December 2015.

The acting manager told us that people's needs were considered when they planned the number of staff required. We observed that people sometimes waited for staff to attend promptly when they needed assistance. We saw that people sitting in the communal areas had little contact from staff unless it was to deliver care or refreshments. We heard staff respond to people but saw there was often a delay before the care or request was completed. For example, one person asked a member of staff if they could collect a rug from their room as they were feeling cold. We heard the member of staff reply, "I'll go and get it for you. I won't leave you without it". However the member of staff did not return to the person for a further 25 minutes by which time, at our request, another member of staff had collected the rug. This demonstrates that, at times, there were insufficient staff to meet people needs in a timely manner.

People told us they felt safe living in the home. One person said, "I feel safe enough, I'm not frightened here". A relative told us, "My [the person who used the service] is safe here". Staff understood their responsibilities in protecting people from harm. Staff demonstrated a good knowledge about categories of abuse and the actions they would take if they had any concerns about people. One member of staff said, "I know how to look out for possible signs and always report it to keep the person as safe as possible".

We saw that risks associated with people's care were identified and assessed. Staff were provided with guidance to ensure they supported people safely. For example, when people needed support from staff to move, information was provided in the care plans and people's bedrooms to ensure this was completed correctly. People told us they

Requires improvement

Is the service safe?

felt secure when staff moved them using equipment. One person said, "I feel safe when they move me". We saw that there were contingency plans in place to support people in an emergency. The personal evacuation plans were personalised and provided information about the level of support people would need to leave the building as safely as possible. This demonstrates that the provider had arrangements in place to protect people.

Some people presented with behaviours that challenged their safety and that of others. We saw that people had specific management plans in place to ensure staff knew how to support them consistently when they were unsettled. Staff explained to us how they would try to reduce people's anxiety by moving them away to a quieter place or trying to distract them. One member of staff said, "We try to manage [the person who used the service] by moving them away from difficult situations and take them somewhere quieter until they feel calmer". This demonstrated that staff understood the best way to support people when they were anxious.

Staff told us when they started working at the service they had provided information about their past work experience and past employers to contact for references. One member of staff told us, "There were checks in place I had to complete before I started". This demonstrated there were suitable recruitment processes in place.

Requires improvement

Is the service effective?

Our findings

At our last inspection on 18 February 2015 we found there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2010 because staff did not understand the importance of consent and their responsibilities under the Mental Capacity Act 2005 (MCA). The MCA and the Deprivation of Liberty Safeguards (DoLS) set out the requirements to ensure, where appropriate, decisions about people's health, safety and well-being, are made in people's best interests, when they are unable to do so for themselves. We saw there were mental capacity assessments in some care plans and when necessary, best interest decisions had been made for people. The acting manager told us that after reviewing people's capacity they had identified that some people could be at risk if they left the home without supervision. Requests for DoLS assessments had been made to the local authority as required which demonstrated the staff understood their responsibilities under the Act. Staff explained to us what they did to support people who were unable to make decisions without support. One member of staff said, "Choice is really important". Another member of staff said, "Even if people don't have capacity you still need to explain what you're doing. Sometimes people will just nod or you can see from their eyes if they're happy with what you're doing".

We saw that some people were not supported to enjoy a positive mealtime experience because the lunchtime service was not well managed by staff. Several people needed to be supported to eat their meal in their bedroom which meant there was only one member of staff to serve and support people in one of the dining rooms. We saw some people waited up to 45 minutes longer than others to be served with their food. People were not observed during the meal and we saw people taking food and drinks from other people without the knowledge of staff. We saw people were presented with their food but not assisted to eat when they needed help. Some people showed little interest in eating their food. One person said, "I don't want any dinner". The member of staff said, "If you don't want it don't have it but please try". The person pushed their plate away and we saw the plate was removed without any further comment from staff.

We read in people's care plans that risks associated with eating and drinking had been assessed. Some people were unable to eat whole foods because of difficulties with swallowing. Staff we spoke with were unclear about some people's individual needs. For example if they needed their food mashed, pureed or liquidised and what they told us did not reflect the information recorded in the care plans. This meant that people could be provided with the wrong consistency of food which could affect their safety.

Most people told us they enjoyed the food and confirmed they were able to choose what they would prefer to eat. One person said, "The food is good. I don't refuse anything. I like my dinners". We saw staff recorded information about the amount people had eaten and drunk throughout the day. The acting manager told us they were currently recording everyone's food and drinks because they had identified, when they started managing the home, that several people had lost weight. We saw that people were weighed regularly and there was a system in place to ensure when weight loss was identified, this triggered a referral for specialist advice. We observed staff giving one person several small snacks throughout the day to help increase their weight. One relative told us, "My [the person who used the service] had lost weight but they've put it back on again". This demonstrated that there were effective arrangements in place to identify and manage risks associated with people's weight loss.

People told us the staff knew how to care for them. One person said, "They know what they're doing and I don't worry". Staff told us their access to training had improved and that they were paid to come in if the session was scheduled for their day off. One member of staff said, "Our training is a lot better. For example, we had practical training on using the hoist and how to reassure people. It made it more real". Another member of staff told us how the training they received on living with dementia had made them understand much more about the reasons people behaved as they did. The acting manager told us they had identified gaps in staff knowledge when they started at the service and had provided training sessions in all the areas they felt were essential skill updates for staff.

There were arrangements in place to offer staff individual and group supervision sessions to support their professional development and performance. Staff confirmed they had received supervision. One member of staff said, "I had my supervision with a team leader. It was really good. We talked about me doing my job, looked at my skills and I got some positive feedback". New staff were

Requires improvement

Is the service effective?

provided with a period of supervised induction. Staff told us they felt they had been supported when they started working so they could get to know people. One member of staff said, "I've been shadowing experienced staff. I've been told I can ask for more help if I need it".

People told us they saw their GP and had access to support from other health care professionals when they needed it.

We read that records were kept of all professional visits and confirmation that people's relatives were kept informed about the person's health. We spoke with a visiting health care professional who told us, "The staff know people well and follow our advice".

Requires improvement

Is the service caring?

Our findings

We saw the way staff supported people and interacted with them was inconsistent. We heard some staff speak with people in a kind and supportive manner which demonstrated they had a caring approach. However we observed occasions when other staff did not support people kindly. For example we saw and heard one person calling for help from staff. There was a carer sitting next to the person but they did not respond to the person or offer them help or reassurance. We saw another person weeping. A member of staff spoke to them from the across the room and asked why they were upset. The person was not offered any kind gestures or words of comfort by the member of staff who replied, "Oh dear" but then walked away. On another occasion we saw a member of staff sitting in the lounge area completing paperwork. There was no interaction with people. This demonstrated a lack of care and involvement with people from some staff.

We also observed some situations where people's dignity was compromised. For example we saw one person's clothing was caught in their underwear which exposed parts of their body. We saw this person walking around but members of staff did not attend to them to ensure their dignity was preserved. Some people did not have access to call bells to alert staff they needed support. People sitting in the communal living room had no access to a bell and we heard people calling out when they required personal care. A relative told us, "I see this happening every time I visit. I think it's the only way people can get hold of staff". We heard one person, who was in their bedroom, say to their relative when they visited, "Thank goodness you've come. I'm desperate for the toilet and I can't reach my bell". The person's relative told us this was the second time they had visited and found the person's call bell was out of reach. People's right to privacy was not always recognised by staff. We saw some members of staff walking into people's rooms without knocking first and waiting for a reply which did not demonstrate they promoted people's right to privacy.

These are breaches of Regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the care they received. One person said, "They do their absolute best". A relative told us, "They look after [The person who used the service] fine".

Relatives told us they could visit the service at any time. We saw staff speaking with visitors and ensuring there were chairs available for them. One relative told us, "The staff always make you feel welcome when you come in". Another relative said, "I come in most days. The staff know my [Person who used the service] likes a bit of company so I know they pop in as well when I'm not here".

Good

Is the service responsive?

Our findings

People's preferences were considered when staff provided care. One person told us, "They know how I liked to be settled at night so I get a good sleep". A relative told us, "[The person who used the service] prefers to spend the day in their room. The staff know that". This demonstrated that the staff tried to provide people with the care they preferred.

The care plans we looked at provided a variety of information about people. Staff were in the process of changing the format and content of the care plans to include more detail about people's preferences for care, their previous life experiences, and their likes and dislikes. The acting manager told us that when they started at the service they had identified areas of care which needed to be improved. We saw there had been reviews of people's needs and care requirements to ensure the information recorded accurately reflected the care required. For example the care of people's delicate skin to prevent damage caused by pressure. A relative told us they had been involved with their loved one's care. They said, "I was part of the review from the beginning to the end".

We saw some people on the ground floor, were supported independently to take part in hobbies and activities which interested them. We saw one person was encouraged to maintain their dexterity by feeling different fabrics, tying knots and closing zips. The member of staff encouraged the person and congratulated them when they completed sections associated with the activity. We also saw that staff were planning celebrations for one person's milestone birthday. In the lounge on the first floor people were provided with old time music but during our inspection we did not see anyone on this floor receive individual or group support to improve their well-being and prevent social isolation. The acting manager told us they recognised that people living with dementia needed specialist support. We saw there were plans in place to recruit another member of staff who would be responsible for providing more opportunities for people living with dementia.

There were meetings provided for relatives to discuss how their family member was cared for, changes taking place in the home and any suggestions they'd like to make. One relative said, "Some people can't speak for themselves or don't have relatives. So it's really important that we can discuss things together on their behalf".

Relatives we spoke with told us they knew how to raise concerns if they had any. One relative told us, "I know how to complain and I wouldn't hesitate if I needed to". We saw that there was information displayed to inform people what to do if they wanted to raise any concerns. People and their relatives also had the opportunity to share compliments about the care. We saw there was a process in place to ensure any complaints received were investigated and responded to within a timely period.

Requires improvement

Is the service well-led?

Our findings

There had been a change in the ownership of the home since our last inspection. As a consequence of this there were also management changes being implemented at a local level. The acting manager told us that they had started the process of registering with us to manage this and an adjoining home. The acting manager told us they had identified a number of concerns when they started working at the home. The concerns included safeguarding issues, the management of medicines and staffing. The acting manager recognised that there were further improvements to make in these areas. An action plan had been implemented to improve the management of medicines in the home and the competency of staff however further improvements were required. Additional management staff had been appointed to oversee the care being provided to people. People and relatives we spoke with an improvement in the environment with an ongoing refurbishment programme. Staff told us that their access to equipment had improved and told us that wheelchairs, mattresses and some beds had been replaced. One member of staff said, "It's good to have the new equipment. It helps us get our jobs done".

There had been significant changes with staffing since the change of management. Several members of staff had left and there had been an increase in recruitment. There were mixed views from staff about the changes they had been going through. Some staff we spoke with did not feel they had been well supported during the change of management and felt there was a blame culture in the home. One member of staff said, "We feel we're being blamed for everything that was wrong before". Another member of staff told us, "We feel we're being watched all the time. It's not nice". Other staff felt the changes had been beneficial. One member of staff said, "The culture has changed. The changes have been positive". The acting manager told us they recognised this had been a difficult time for staff but because so many concerns had been identified, action had to be taken quickly. This demonstrated that the acting manager recognised that the care and safety of people was the priority.

There had not been a recent satisfaction survey to give people the opportunity to share their views, anonymously if they preferred, about the service. However there were opportunities for visitors to offer their views on the service by using 'visitor survey forms' which were displayed prominently in the reception area. The acting manager had introduced a daily meeting for the heads of each department which was referred to as 'Ten at ten'. The meetings were an opportunity for the staff to discuss particular concerns within their own department and be updated about on going developments in the home. We heard staff sharing information during the meeting about events, for instance problems with kitchen storage during the refurbishment programme. Staff were able to share their ideas and solutions during the meeting on how to manage this. There were also meetings provided for staff to receive information on the service and changes which might affect them. An 'employee of the month' award system had also been introduced. This gave people, visitors and other staff the opportunity to nominate a member of staff who they felt deserved special recognition for the care they provided. The acting manager told us they felt it was important for staff to receive positive feedback. A relative we spoke with said they thought it was a good idea and gave them an opportunity to show their gratitude.

The provider had introduced a number of audits to monitor the quality of the service and determine where improvements needed to be made. The provider was fulfilling their registration requirements by submitting notifications to us. Notifications are submitted to inform us about significant events which affect people or the service, for example, information about injuries associated with falls. This demonstrated that management process had been implemented to monitor the quality of the service.

.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1). The provider was not providing care which met people's needs.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2)(g). The provider was not providing safe management of medicines.

The enforcement action we took:
Warning notice.