S.J. Care Homes (Wallasey) Limited

Aynsley Nursing Home

Inspection report

60-62 Marlowe Road
Wallasey
Merseyside
CH44 3DQ

Tel: 01516384391

Date of inspection visit:
07 February 2017
08 February 2017
15 February 2017

Date of publication:
14 March 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out this inspection on 7, 8 and 15 February 2017. We had previously inspected Aynsley Nursing Home on 18 and 19 February 2015, and 21 and 25 January 2016. On both of these occasions we found that the home required improvement.

As a condition of the provider's registration with the Care Quality Commission, the home is required to have a registered manager. 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 2008 and associated Regulations about how the service is run.

The home had not had a manager who was registered with the CQC since August 2014. Following our last inspection we made the provider aware that this was a breach of the Health and Social Care Act 2008. We also wrote to the provider about this in July 2016.

This is a criminal offence with respect to Schedule 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Section 86 of the Health and Social Care Act 2008.

During this inspection we also found breaches of regulations 9,10, 11, 12, 15, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the premises were not adequately maintained or refurbished and there was unsafe equipment in use. There had been very little training for staff and there was insufficient evidence that all new staff had been recruited safely. People's capacity to consent to care and treatment had not been assessed and care plans did not adequately describe the individual characteristics of people living at the home. People's dignity was not always upheld. There was a poor standard of record keeping and no evidence that the provider had oversight of the service being provided at the home.

Areas we had identified as needing improvement at our last inspection had not been addressed by the provider and there was no development plan to show how the service would move forward.

The service is registered to provide accommodation with personal care or nursing care for up to 28 people and 25 people were living there when we visited for this inspection.

During our visits we saw that there were enough staff to support people and meet their needs. People we spoke with described the staff as kind and caring and we observed warm and respectful interactions between staff and people who lived at the home. However, two people had contacted CQC to tell us that their relative had not always received the care they required at Aynsley Nursing Home.

Records relating to the recruitment and employment of new staff were incomplete so did not provide evidence that staff recruitment had always followed safe procedures to ensure that new staff were of

suitable character to work with vulnerable older people.

Staff had received training about safeguarding vulnerable people from abuse in September 2016, however little other training had taken place since 2015 and there was no training plan. Some staff had attended individual and group supervisions over the last year but there were no records to identify staff who may not have had supervision.

Some people were potentially at risk from inappropriately fitted bedrails and from hot radiators. Maintenance records were incomplete. This meant that we could not be sure that all equipment and services had been tested and serviced.

The service had not followed the requirements of the Mental Capacity Act 2005 because people's capacity to make decisions about their care and treatment had not been assessed.

People's needs were assessed before they moved into the home and referrals were made to medical professionals as needed. Care plans recorded people's care and support needs but were not person-centred.

The manager completed a series of monthly quality audits but these were not verified in any way and had not identified the shortfalls that we found.

The home looked 'tired' and in a poor state of repair and decoration in some areas, but was clean and there were no unpleasant smells.

Medicines were stored safely and people received their medication as prescribed by their doctor.

Most people we spoke with were happy with their meals.

Complaints records were maintained and showed how complaints had been addressed. Regular meetings were held for people who lived at the home and their families, and for staff. These gave people opportunities to express their views.

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.

People were potentially at risk from inappropriately fitted bedrails and hot radiators.

Maintenance records were incomplete so did not provide evidence that utilities within the home were safe.

Recruitment records for new staff were incomplete so did not provide evidence that new staff were safe and suitable to work with vulnerable older people.

Medicines were managed safely.

There were enough staff to support people.

Is the service effective?

Inadequate

The service was not effective.

There had been little staff training since 2015 and no training programme was in place.

People's capacity to make decisions and give consent was not assessed.

Parts of the building were shabby and some were in a poor state of repair. There was no programme of refurbishment to show how this would be improved.

Menus were planned to suit the choices of the people who lived in the home and alternatives were available.

Is the service caring?

Requires Improvement

The service was not always caring.

People we spoke with during the inspection and their relatives told us that the staff were kind and caring, however two people had contacted CQC to tell us that their relative had not always received the care they required.

Some people shared bedrooms with people who were not related to them and there were no consents in place relating to this.

During the inspection we observed staff caring for people with warmth and kindness.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care plans we looked at recorded people's care needs but were not person-centred.

There were limited social activities taking place.

Staff were aware of people's individual needs and choices.

A copy of the home's complaints procedure was displayed and complaints records were maintained.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have a registered manager and had not had a registered manager since 2014.

There was no evidence of any active input into the service from the provider.

Areas for improvement identified during previous CQC inspections had not been addressed.

The standard of record keeping was poor in a number of areas.

Regular audits were carried out and recorded by the manager to monitor the quality of the service, however these were not verified in any way and had not identified the shortfalls that we found.

Aynsley 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 took place on 7, 8 and 15 February 2017 and was unannounced on the first and third date. It was carried out by an Adult Social Care Inspector and an expert by experience on the first day, an Adult Social Care Inspector on the second day, and an Adult Social Care Inspector and an Inspection Manager on the third day. 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 we contacted Wirral Council's Quality Monitoring and Contracts department. They told us that they had some concerns about the service. We looked at all of the information that CQC had received about, and from, the service since the last inspection.

During the inspection we looked at all parts of the premises. We spoke with ten members of staff, all of the people who lived at the home, and five visitors, who were all family members of people who lived at the home. We observed staff providing support for people in the lounge and the dining room. We looked at medication storage and records. We looked at staff rotas, training and supervision records, and recruitment records. We looked at maintenance records. We looked at care records for six people who lived at the home and records of the audits that the manager had carried out.

Inadequate

Is the service safe?

Our findings

We looked at the employment records for four members of staff who had started working at the home since our last visit. Staff records had not been well maintained and it was not always possible to find all of the information we needed to look at. This had been reported on our last inspection and had not improved. Some records were incomplete with only one reference that was not the person named on the application form and no references or Disclosure and Barring Service check on file for one member of staff.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19 because the provider had not ensured that robust recruitment procedures were followed including the relevant checks.

We spoke with the maintenance person and saw records of weekly health and safety checks he carried out. We were unable to find evidence that all services and equipment had been checked and maintained by visiting contractors. For example, nobody was able to find the home's electrical installations report, fire alarm, emergency lighting and nurse call system servicing records. There were records of Legionella testing and water tank chlorination up to 2015 but not since. The maintenance person told us they had worked at the home for ten years and was not aware of an asbestos survey being carried out and no records were available.

The maintenance person had recorded on numerous occasions that the call bell in one of the bedrooms was not working for the six months prior to the inspection. We tested the call bell and found that it wasn't working. The manager said she was unaware of this and no action had been taken. The maintenance person had also recorded on numerous occasions that there were problems with some of the fire precaution equipment. Again, the manager said she was unaware of this and no action had been taken.

During our last inspection we found that there were no radiator covers in some bedrooms which meant that people might be at risk of burns from hot radiators. This had not been addressed. At our last inspection we found that whilst most people who required the use of bedrails had been provided with adjustable beds that had integral bedrails, at least three people had metal bedrails attached to divan beds. This had not been addressed. The maintenance person recorded that he checked these daily and told us that he did as much as possible to ensure that the bedrails were fitted safely, however there was movement in the rails and gaps where people's limbs could be injured.

On the ground floor there was a sluice room which did not have a lock. There was a very hot boiler in this room and laundry in plastic bags had been placed adjacent to the boiler. We brought this to the attention of the manager on 8 February 2017 and when we visited the home on 15 February 2017 we found that the door was still not locked and laundry in plastic bags had again been placed adjacent to the boiler.

The manager told us that the service did not have any general risk assessments to record any risks identified either in the environment or in systems of working. The home did not have a 'grab bag' containing emergency equipment and information. The maintenance person had started putting together an

emergency file and this included brief unsubstantial personal emergency evacuation plans for the people living at the home, but this was not readily accessible for the staff on duty.

These examples are breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 because the provider had not ensured that the premises and equipment were safe.

Portable electrical appliances testing had been carried out in August 2016. During our visits we found that the home was clean and there were no unpleasant smells. Paper towels and liquid soap were provided in all appropriate areas. The kitchen had a five star food hygiene rating.

The staff team had all completed training about safeguarding in September 2016. We asked some members of staff what they would do if they saw or heard anything that they were worried about or that was inappropriate. They all stated that they would go to the manager that they felt very confident that she would deal with it quickly and fairly. During our last inspection in 2015 we found there was no information readily available about how to contact social services to report any concerns. During this visit we were again unable to find any information on noticeboards which would be readily available for staff or visitors who might have concerns.
A number of people had personal spending money in safekeeping at the home. The administrator showed us the detailed records of people's finances they maintained and we saw that people's money was kept in individual wallets. A system was in place for the manager to check and countersign the records.

We looked at staff rotas and these showed that there was always a registered nurse on duty at the home. The manager usually worked supernumerary to the staff rota, but could cover for nurses' holiday or sickness as she was a registered nurse. There were five care staff on duty in the morning, four in the afternoon, and two at night. In addition to the care staff, there were two staff working in the kitchen and two domestic staff each day.

The manager told us that it was difficult to recruit both nurses and care staff and a number of shifts each week were covered by staff from agencies. The manager told us that the agencies were able to provide some consistency in the members of staff who went to the home so that they got to know the people who lived there. However, there was no information about the agency staff, for example their qualifications and DBS number.

We looked at the arrangements for the management of people's medicines. Medicines were only handled by registered nurses. Adequate storage was provided in a locked room.

Monthly repeat medicines were dispensed mainly in blister packs and a running total was maintained for all non-blistered items. A record was kept of any items that were carried forward from one month to the next. In general, the records we looked at and checks of the items in the medicine trolley showed that people received their medication as prescribed.

Medical equipment belonging to person who was now deceased was being used as 'stock'. We found an inhaler in one bedroom that was dated April 2016. There was also a nebuliser on a table in a shared bedroom that did not have any labelling to show who it belonged to.

Inadequate

Is the service effective?

Our findings

At our last inspection we observed that some improvements had been made to the environment, for example new flooring in communal areas and in en-suites. During this inspection we did not see that any further improvements had been made and some areas of the home were in a very poor condition and had deteriorated further. After the inspection, the provider sent us details of seven bedrooms that had been redecorated during the last year.

There were a number of areas in a poor state of repair, for example damage to the walls outside the lift, some poor ripped and stained carpets and creaking floors, damaged doors, damaged walls and shabby furniture. The poor décor had been commented on by relatives in a satisfaction survey and at meetings. Poor bathrooms had also been commented on by relatives. The home had two lounges. One of these had a large screen TV but the other had a very small TV which people could not see.

These are breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 because the premises were not suitably maintained.

Several staff members told us they had worked at the home for many years. They told us that training was regularly available. However, the records we looked at showed that very little training had been provided since 2015. For example, no staff had received fire safety training since May 2015. The training information was haphazardly stored with no system to show when training had been carried out and when it was required to be updated.

During our last inspection, the manager told us they had been informed by the provider that an e-learning programme was going to be introduced in October 2015 and staff would be working towards the Care Certificate; however this had not yet been implemented. At this inspection, in February 2017, we found this still was not in place.

We saw records of staff supervisions that the manager had carried out over the last year. These covered a variety of different topics and included both individual and group supervisions. However we saw no records to show that all of the staff team had been involved in the supervisions and there was no plan for 2017. The records were crammed in a file so it was impossible to see what had been carried out and when. The manager told us that staff appraisals had been carried out in September 2015 and we saw records of these.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 because the provider had not ensured that staff received adequate support, training and supervision needed to carry out their role.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

At the time of this inspection, no DoLS had been applied for with respect to people living at Aynsley Nursing Home although some of the people living at the home had dementia related conditions. We saw some very rudimentary mental capacity assessments in some people's care files, which were out of date, but none in others. The ones we saw were not detailed and did not provide any information regarding what decisions the person was able to make. In one person's care file it was recorded that the person had 'full capacity', however a 'do not resuscitate' order had not been discussed with the person and a consent form had been signed by a relative. Another person's care file recorded that bed rails were being used as a method of restraint.

Mental capacity assessments had not been completed in relation to decisions that had been made and we could not see that any best interests meetings had been held.

This is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 because people whose capacity to give consent to care and treatment was in doubt had not been assessed in accordance with the Mental Capacity Act 2005.

We observed how people received their meals at lunchtime. Only three people went into the dining room for their meal. One of these people was not sitting in a suitable position for eating because their wheelchair did not fit under the table which left them too far away from their plate. The person was distressed about spilling food on their clothing. We brought this to the attention of a member of staff who said that the person usually had a cushion behind their back and this staff member then went to get a cushion.

Other people had their meal in the lounges or in their bedroom. This meant that they did not have a change of position or environment. Some people required support to eat their meal and carers sat with them and supported them with this. There was a pleasant, relaxed and unhurried atmosphere. Two visitors also assisted their relatives to eat their lunch.

All but one of the people we spoke with said they had enjoyed their lunch. One person said they didn't really like beef. We asked them if they could have had something else and they said that they probably could, adding that if they didn't like anything available they could have a sandwich, but they "didn't like to fuss". Menus were displayed in the entrance area and showed that people were offered a varied diet and there were always two alternatives available. Records showed that a number of observations of mealtimes had been carried out. These commented on the presentation of the dining room, showed what meals had been served, and recorded people's comments. They mainly recorded a positive experience.

People's weights were recorded monthly in a 'weight book' and a nutrition risk assessment was included in each person's care plan and was reviewed monthly.

Requires Improvement

Is the service caring?

Our findings

During the morning we observed staff supporting people using moving and handling equipment in a safe and proper manner. Staff communicated with people kindly and with understanding of their abilities and independence. Staff we spoke with were knowledgeable of people's care and support needs, knew them well, and appeared fond of them. People we spoke with said the staff were very good to them, caring and kind and that nothing was too much trouble for them. We observed that staff were patient and supportive and respectful of people's dignity.

Following the inspection, the provider informed us that a relatives' survey had been carried out in September 2016 and 15 replies were received. All of the relatives who responded chose excellent, very good or good in the caring section.

Visitors said that they were free to visit at any time and were always made welcome, having drinks offered and often meals particularly on special occasions. Parties were arranged at the home to celebrate special birthdays and anniversaries.

We also saw many thank you letters and cards and these contained comments including "She could not have been better looked after."; "Thank you and every member of our team who are a real credit to you. Our Mum received the very best care and support from all of you right to the end."; "Thank you for party. The whole family were delighted and grateful as we could be together with her on a day we will all remember." and "Aynsley is a wonderful home. I knew as soon as I walked in that it was a place where my Mum would be happy, safe and well cared for and I was right. You and your wonderful staff care for all your residents with love and respect. The whole place has a family atmosphere, visitors are made to feel welcome, everyone is treated as an individual."

However, two family members had contacted CQC because they considered that their relative had not always received the care they required at Aynsley Nursing Home.

In people's bedrooms there were photographs and other personal belongings. One person told us she liked her bedroom because it was warm and cosy.

Some people were accommodated in double bedrooms and privacy screening was available in each of these rooms. However, we observed that screening was dusty which suggested it had not been used recently. We asked the manager if there were consents in place for people sharing a bedroom with someone who was not related to them and she said there were not. In one shared bedroom we found a plastic wash bowl which was not identified with anyone's name. This meant that people could be using shared washing facilities and was not dignified. This had also been reported on our last inspection.

We saw that a 'bath book', which recorded on what day and at what time people would have a bath or shower, was kept and there was also a 'weight book' which recorded everyone's weight. This did not reflect person-centred care and was an institutionalised practice. We asked the manager about this and they told

us that they had no knowledge of a bath book, however, the home's administrator had produced it on request.

As part of the inspection we looked at the home's bathrooms. The sign on a bathroom door indicated that it was vacant. When we knocked and entered the room we found a person seated on the toilet. This was un dignified for the person and their privacy was not protected.

These are breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10 because people were not always treated with dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

Visitors we spoke with said that they were consulted with regard to the care of their family member and that they were invited to regular relatives' meetings as a group and individually. All five family members we spoke with stated that if they had any concerns that they would discuss them with the manager and that they attended relatives' meetings and could raise concerns in this situation.

During our last inspection we found that people's care plans were not person-centred in style and did not entirely capture the personhood of those they cared for. However, we considered that the care plans were reflective of people's current care needs and they were kept up to date with monthly evaluations.

The care plans we looked at during this inspection contained a series of risk assessments which generated a numerical score. We noticed that the scores had not always been added up correctly. We could not identify how the risk assessment scores were used to inform the plans for people's care and neither the nurse on duty nor the manager was able to explain this.

We found the care files to be disjointed with no apparent order to the documents. For example, in one person's care file a sheet at the front described a chest infection that the person had in November 2016. This had not been updated to reflect the current situation. There was little information about people's past lives or about their personal choices and preferences. We found no evidence that people were supported to maintain their mobility.

We looked at a care plan for someone who had lived in the home for three months. There was no personal information or person centred information recorded in this person's file. It would be impossible to know how this person wished to be cared for from their care file.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 because people who used the service did not receive person-centred care and treatment that was based on an assessment of their needs and preferences.

At the time of our inspection there were no social activities taking place because the activities organiser was off sick. The manager said that she was unsure whether this member of staff would be returning to work. The administrator told us that she had organised a game of Bingo last week and there had been a professional entertainer on another day.

We saw that a copy of the home's complaints procedure was displayed in the entrance area for families and other visitors to be aware of. The complaints procedure referred people to CQC and Social Services if they wished to raise concerns. We saw records that showed complaints had been logged, responded to appropriately and addressed. However, CQC has received concerns from two family members who considered that their concerns were not addressed and felt they were discouraged from making a complaint.

Inadequate

Is the service well-led?

Our findings

The previous registered manager left the home in August 2014 and the current manager took up post in September 2014. The current manager was a registered nurse with considerable previous experience in managing nursing homes, however they had not applied for registration with CQC.

This is a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009 which requires the Registered Provider to ensure that the regulated activities are managed by an individual who is registered as a manager.

When we arrived at the home on 7 February 2017, the manager told the inspector and the expert by experience that she had the forms ready to submit for registration with the CQC but she remained concerned that the provider was not funding necessary refurbishment of the home and so had not submitted the application.

During our last inspection we saw no evidence that the provider had a role in monitoring the quality of the service provided and we saw no evidence that the manager was supported in the management and development of the service. During this inspection we asked to see a copy of the home's development plan. The manager told us she thought the provider had a development plan but she hadn't seen it. We also saw no evidence of a response to areas for improvement which we highlighted in our last report.

The manager had developed monitoring and auditing processes within the service. These included regular monitoring of the standard of meals; a number of different medication audits; monthly health and safety checks; monthly infection control monitoring; monthly kitchen audit; and monthly laundry audit. We saw that records were kept of all of these audits; however they were not verified in any way and had not identified the shortfalls that we found during the inspection.

There were no quality assurance systems in place to monitor training and supervision, care files, mental capacity assessments and DoLS applications and risk assessments which were all found to be insufficient and records poorly maintained.

These are breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 because the provider did not have systems in place to ensure effective governance of the service.

We found poor record keeping in a number of areas, for example staff personnel records and maintenance records. Some of the documents we asked to look at could not be found. Some files were jumbled and incoherent. During our inspection the administrator was working in the nurses' office as this had the only computer in the building. The care staff kept their notes in the dining room. The quality monitoring officer from Wirral Council informed us that some of the home's policies and procedures were out of date and we asked the manager whether this had been addressed. She told us that the provider had new policies and procedures at another service and these were going to be shared with Aynsley.

Family members spoke of regular relative meetings, of their ability to speak with the manager whenever they needed or wanted to, of being involved with all decisions with regard to their relative and having their views listened to positively. Records showed that the manager held regular meetings for staff and for people who lived at the home and their families. This gave them opportunities to express their views. We also saw records of regular staff meetings and meetings for specific groups of staff.

Accidents and incidents were recorded and analysed each month to find out if there were any recurring issues that could be addressed. We saw that very few accidents were recorded.