HC-One Limited

Leighton Court Nursing Home

Inspection report

112 Manor Road
Wallasey, Wirral
CH45 7LX

Tel: 0151 638 9910
Website: www.hc-one.co.uk/homes/leighton-court/

Date of inspection visit: 01 and 03 December 2015
Date of publication: 16/02/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This comprehensive and unannounced inspection took place on 01 and 03 December 2015. It was triggered because we had received some information of concern.

Leighton Court Care Home is part of the HC One group of health care services. The home is registered to provide accommodation for up to 48 people who require residential, nursing or intermediate care. At the time of our inspection, there were 47 people in total living in the home.

The home is a modern building, with accommodation on the ground and first floor and other facilities on the second floor.

Summary of findings

The ground floor has bedrooms for up to 24 people who need permanent residential or nursing care. The first floor is for up to 24 people receiving intermediate care. Intermediate care a short term intervention (usually up to six weeks) and is intended to give people who are discharged from hospital, time to recover and receive rehabilitation in order for them to return safely to their own homes.

The kitchen and other ancillary rooms such as the staff room are on the second floor. Stairs and a passenger lift link all the floors. Outside there is an enclosed garden area to the rear of the building and car parking to the front.

The home required and had in post, a registered manager. 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. The same person had been the registered manager for several years.

We found the service to be caring and people and their relatives and other visitors confirmed this. A relative and a staff member told us they would be happy to place one of their relatives in the home. People told us they were treated as individuals, with respect and dignity and that their privacy was also respected.

The home was clean, tidy and smelled fresh. We saw that there was a good relationship between the people living in the home and the staff. Relatives and other visitors were made welcome.

NHS staff, who were seconded to the home to support people in the intermediate care unit, were also friendly and relaxed, but professional and focussed on their jobs.

We found breaches of the Health and Social Care Act 2008. These related to the administration of medicines, staffing levels, staff training, the application of the Mental Capacity Act 2005 and the management of the home.

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 always safe.

People told us they felt safe. However, staff had not received appropriate or recent training in safeguarding adults.

There were insufficient qualified staff on duty to meet people's needs and the medicines administration process had not been followed.

Requires improvement

Is the service effective?
The service was not always effective.

Staff training was not up to date.

People may have had their liberty unlawfully deprived. The home doors were secured and people did not have the key code to use them.

The premises were suitable for the people living there and had been appropriately maintained.

Requires improvement

Is the service caring?
The service was caring.

We heard from the people living in the home that they felt cared for, respected and they were able to retain their dignity.

We saw that staff treated people with respect and as individuals.

Visitors and a staff member told us that they would be happy if a relative of theirs was to live in the home.

Good

Is the service responsive?
The service was not always responsive.

People told us they had plenty of activities to do and we saw examples of these.

Some documentation was missing from care records.

Requires improvement

Is the service well-led?
The service was not always well-led.

People told us that the registered manager was approachable and fair. There were two managers for the home, the registered manager and the home manager.

However, the home manager was away and systems and procedures had not been maintained as no replacement manager had been provided.

Requires improvement

Leighton Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 comprehensive and unannounced inspection took place on 01 and 03 December 2015.

The inspection team consisted of two adult social care inspectors, a specialist advisor who was also a senior nurse 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. This expert-by-experience had been a senior manager in health and social care and had experience of elderly people with nursing needs and those living with dementia.

We contacted both Wirral local authority quality assurance team and Wirral Healthwatch for their views on the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also looked at our own records, to see if the service had submitted statutory notifications and to see if other people had made comments to us, about the service.

We talked with eight people who lived in the home, five visitors including four relatives and with two health care professionals. We also talked with the registered manager, with the provider's quality assurance manager and with the provider's relief manager. We talked with five nursing and care staff and with the chef.

We looked at nine care records and eight staff and training records. We pathway tracked four people's care. We also looked at other records related to the running of the home, such a medication and positional change records, policies, procedures and audits.

One inspector and the expert-by-experience took lunch with some of the people and the inspection team generally observed the care and support throughout the inspection.

The provider sent us some information immediately after the inspection, such as the training compliance summary.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe and visitors also confirmed that the home was safe. One person told us, "Safe? Yes, very" and another said, "I feel very safe here".

A visitor told us, "She's safe and she loves it here" and another said, "It's safe. Oh, yes, they've [the staff] been very good".

Another visitor said, "There always seem to be plenty of staff and they all seem to be regular ones. There's no large turnover".

In the medicines room we found out of date material, such as copies of the Royal Pharmaceutical Society guidance for handling of medicines, published in 2007 and information about wound dressings from 2005. The medicines room was generally clean and tidy, apart from a badly stained carpet, which was not hygienic. The room and fridge temperatures were recorded daily and were within safe limits. Appropriate storage was provided for controlled drugs and these were recorded in a controlled drugs register. We saw records of disposal of unused medicines. Some were dated and signed for by staff and others not.

Monthly medicines audits were carried out in 2015. Until October all recorded a perfect score. In November 2015 there were two 'fails' but no actions were identified. We were told that a daily spot check of five medicines from each trolley had been carried but it was unclear where the records of this were filed. A member of staff told us they, "Put them under the manager's door".

There were different medication systems for the ground floor and the first floor and two different suppliers were used. People living on the ground floor received their medicines in boxes or bottles from the pharmacy. People on the first floor received most of their medicines in a weekly blister pack supplied by another pharmacy. The manager told us that this was because it would be the system people would be supplied with when they went home; however they were not involved in administering their own medicines whilst in the home so this was not relevant. This meant that staff, who moved between the floors, had to deal with differnent systems which could have been confusing.

Each floor had a large, heavy trolley but the ground floor one was disorganised. The blister packs contained minimal information about the specifics of administration, such as being taken with food and did not include descriptions of the drugs they contained as good practice recommends. We discussed this issue with the registered manager who told us they would talk to the pharmacy in question. However, one person told us, "They brought my breakfast early because I'm going for a scan and need my tablets with my food. I know what they're for".

A file in the medicines room contained the previous month's medication administration record (MAR) sheets for the ground floor. The quality of these was variable. For example, a handwritten MAR sheet for one person had been completed in full and signed by two members of staff, but another person's was not signed at all. Most medicines were checked in on the MAR sheet to show staff had checked that they were correct, but a few were not. There were very few missed signatures which indicated that people generally received the medication that was prescribed for them. We noticed that when items were prescribed to be given 'as required' (PRN), staff routinely recorded 'N' to indicate that the item had not been given during that medicine round, however this is not the correct way to record PRN medication. Staff we spoke with were unsure how often they should record a 'running total' of medicines that were not in blister packs and they said that counting all of the medicines was a very time-consuming process. The MAR sheets showed that this had been done erratically.

All of the people we spoke with said staff provided their medication and they received their medication regularly. One person told us, "Meds are always on time".

One person was managing one of their own medicines but we found no record of a risk assessment either in the medication records or in the person's care notes, to show that the person was able to store and administer the medication safely. There was no record of any checks of how many tablets the person had taken and whether they were effective.

Medication training was divided into eight different topics that did not seem to be linked. Some topics were for nurses only, others included care staff. There was some doubt about dates of completion of these training modules; however the records appeared to show that seven staff, nurses and senior care, last completed a competency test in September 2014. The recent training summary sent to us

Is the service safe?

by the provider did not contain information about training for medicines management. This meant that it was difficult to monitor which staff needed this training or needed updates to it.

These examples are breaches of regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (The proper and safe management of medicines).

We noticed that staff were not using universal precautions to promote safe and effective infection control and prevention practices. On raising this with the registered manager, we were informed that the supply of stock gloves had been used and a further order was awaited. This meant that the failure to use disposable gloves when managing potential contagious infections placed the people who lived in the home and all staff at risk of contracting a contagious infection. A senior manager advised that they would address this issue immediately and bring in supplies from one of their other homes.

Many of the people living in the home required their positions to be changed regularly in order to reduce the risk of developing pressure ulcers. Charts were available to record when these changes had taken place and by whom, but we saw that there were several omissions in the charts. This meant the records did not show that people were being turned, as required and so people may have been at risk. Some people had a waterlow assessment, which gives an estimated risk for the development of a pressure ulcer in an individual person.However, we saw that some of these had not been completely completed, which then did not give an accurate assessment.

There was a provider safeguarding policy available and also we saw that the local authority safeguarding policy was stored in the office. The training matrix told us that over half of the staff were up to date with their safeguarding training, but 30% were late with it or it had 'expired'.

We spoke with two staff members about about safeguarding. They were able to demonstrate a full understanding of the issue and told us who to and how it should be reported. However, a senior staff member was less able to tell us about this and was not confident about how to follow the provider and the local authority's safeguarding processes. We did not see any information about safeguarding or the numbers to contact, on any of the noticeboards.

Staff were recruited using appropriate methods of recruitment and we saw they had the necessary checks completed, such as disclosure and barring scheme (DBS) checks and satisfactory references, proof of right to work in UK and address checks. We saw grievance and disciplinary policies and procedures and other policies relating to employment, which referred to legal requirements, which meant that staff and the employer knew about their correct working arrangements.

Call bells were generally answered in a reasonable time of a few minutes. One person told us, "The buzzer? I use it occasionally, they usually come quickly, and they're very attentive", but another said, "It's not so long (to wait) in the day but at night it's worse".

We saw that risk assessments for the people living in the home, such as for nutrition, dependency and bed rails, had been completed and reviewed recently.

We visited the kitchen, which was large and tidy. We noted that fridge, freezer and cooked food temperatures were taken regularly and were within the recommended range for safety. The kitchen had been rated three stars out of a possible five, for food hygiene but we were told this was because some new equipment was needed and this was on order.

The home was clean and generally tidy, with no unpleasant odours. Some equipment such as hoists and wheelchairs, was left in corridors, which was a trip hazard. All the equipment within the premises had been serviced and checked regularly and the checks were in date. The electrical and gas installations had been checked and were 'in date', as was the fire alarm and firefighting equipment and the passenger lift.

The home had an emergency evacuation plan. However, we saw that fire doors were propped open to the smoking area outside and the connecting rear stairwell. Unprotected stairwells are considered risky areas for fire spread. This meant that any fire could quickly spread throughout the rear of the building. We discussed this with the managers who advised this would be addressed.

Requires improvement

Is the service effective?

Our findings

One person said, "Staff are trained enough, they use the hoist properly", and a relative told us they felt "Staff seem skilled".

Another told us, "Meals are O.K. I've had better, and had worse. There's choice, if you don't like it you're offered an alternative. There's enough food and snacks. I choose where to eat it's no problem".

A third person told us, "The food is excellent…I like the days out".

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 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.

We saw there had been eight applications for DoLS made to the 'supervisory body' (the local authority), since 2014. It was unclear whether any of these applications had been authorised. The information about safeguarding, the DoLS policy and procedures and the DoLS applications was mixed up, in one ring binder. This did not lend itself to easy reference for either and indicated to us that the difference between the two may not be completely understood.

The home was secured on both levels by keypad locks on the doors to the building and to the first floor. We were told that all the people on the first floor in the intermediate beds remained in their rooms or needed the assistance of staff to move around the home. Most people on the ground floor also required the assistance of staff to mobilise, but some were independent. We were told that everyone who was able was allowed to go outside but only with the assistance of staff or a relative. One person told us, "No, I don't have the key codes". This might constitute a deprivation of liberty unless an appropriate DoLS had been put in place. We discussed this with the registered manager who assured us that the situation would be reviewed but we have not yet been advised that this has happened.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Need for consent).

We looked at the staff files which also contained their training records. We were also emailed the providers summary of the training records. Both our checks and the provider's summary showed us that a significant number of staff required new or updated training in subjects such as infection control (33%), manual handling, (41%) and and understanding equality and diversity (43%). The overall figure for all courses was that 30 staff needed training. Some staff not included in these figures were booked to go on various courses (overall, 8%).

We saw that there had been supervision sessions and annual appraisals which took place with a senior staff member and the support staff. However, these had not been continued since the home manager had been on long term leave; we were told this was because the registered manager was part of the nurse rota and their time was committed to nursing duties in the main. This meant that staff had not had individual supervision for four months at least, at the time of our inspection. Supervision should be a two way process designed to support both the individial's practice, support and training and the organisations aims and objectives. This lack of supervision demonstated poor leadership within the service.

These examples are breaches of regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Staff should recieve appropriate training and supervision).

We joined some people for lunch which was a chatty time with plenty of pleasant interaction between them and staff. We commented that some people might better to be supported to eat if they were given plate guards and better designed crockery and cutlery. Plate guards were immediately produced which showed they were available

Requires improvement

Is the service effective?

and on the second day of our inspection, we noted they were being used. One of the provider's managers told us that more appropriate crockery and cutlery had been ordered.

People's feelings about the food were variable; most said there was enough and that there were choices, but some thought the food quality could be improved. The chef told us they were able to accommodate any dietary or cultural requirements.

Communication between the home and peoples' relatives we were told, by them, was good. One relative told us, "Communication is good, they contact us if there are any problems" and another said, "Communication with the family is good. They send letters if his cash is low [for chiropody etc.]".

The premises had been purpose built and had wide corridors and doorways for ease of access. Each person had their own bedroom with either an ensuite or easy access to a bathroom. People had personalised their rooms to their taste and this was particularly noticeable on the ground floor, where people lived long term.

Good

Is the service caring?

Our findings

People responded positively to the question when we asked if staff were kind and caring. One person said, "Carers are very nice, generally kind and caring". They went on to say, "They knock when they come in and treat me with respect. They know my likes and dislikes".

Another person told us they also were treated with dignity and respect. They said, "They treat me as an individual and I'm respected. They knock and ask before they enter my room".

A third said, "Staff are kind to me, they give me time. They treat me with respect and know what I need. But some I can't understand".

Another person said, "Anything I want they'll do it for me I love them all".

A relative told us, "Staff are caring; they have time for a chat. Mum loves them all". Another relative told us, "I can highly recommend it [the home]".

One staff member told us, "I would put my own relative here" yet went on to say, "We rarely have time to just sit with people. It would be great if we could". It would be a privilege to do that". They added, "The staff are extremely caring and really want to do what's best for the service user".

In conversation with staff and with visiting health care professionals, it was clear to us that the staff were caring. We observed the care, both on the ground floor and on the first floor and staff and people interacted well, with staff giving support in a kind and cheerful way. One health care professional told us, "The level of care here is very good; staff often stay late to finish notes".

When we talked to people about the way they were cared for, they were complimentary. One person described how they were treated during receiving personal care and said, "I'm treated with dignity and respect. If they're washing me they cover part of me up". Throughout our inspection we saw and noted that all the people who lived in the home were treated with respect and dignity by all grades of staff.

A visitor told us, when we asked if the person was cared for, "He always looks clean and his nails are clean too. They shower and dress him and put him in the wheelchair. He has regular haircuts and is always clean shaven".

On a notice board, we saw that there was a 'dignity champion' for the home. There was also a separate poster entitled, 'you said, we listened'. This had various issues raised by people and the homes' response and action. This demonstrated that the home involved people and respected their opinions.

Visitors were pleased that they could visit at any time and were made welcome. One told us, "We can visit anytime".

On the ground floor, we found that the care plans were kept in a cabinet at the end of the corridor. The care plans included all people's personal details, medical histories etc. A list of staff contact telephone numbers was also stored there. We found the cabinet to be unlocked. This meant that these records were not stored confidentially. On bringing this to the attention of the registered manager, we were advised that the cabinet was usually locked and that she would address this immediately. On checking the cabinet two and four hours later, it remained unlocked. We discussed this concern with a visiting manager from another home who assured us this would be dealt with; we found the cabinet to be locked on the second day of our inspection.

In the care files we saw that peoples end of life preferences had been recorded. We saw that two staff, one a carer and the other a nurse, had completed their end of life training , which reflected the NHS 'six steps end of life pathway'. At the time of our inspection, there were three people on end of life care. We saw that they were cared for according to their wishes.

Requires improvement

Is the service responsive?

Our findings

People told us they were treated as individuals who could make choices and with respect and dignity.

One person told us, "I had a fall going to use the toilet during the night so the staff now leave the commode in my bedroom at night for me and I can manage to use it myself."

Another said, "I choose when I get up and go to bed. I choose where I want to eat".

A third person said, "A carer wanted to wash me in my bed. I told him I wanted a proper shower. So they helped me with a shower".

We found that most of the care records were generally informative and person centred and included up to date risk assessments. However, we found the care plan folders very hard to use as they were stored in no obvious order and did not include a contents list. We found that many people did not have their admission information recorded which could have been important to the overall care plan.

We also noted that future review dates were not routinely recorded in the care records, although we saw a separate schedule of care reviews for the year. Some of these were three monthly and others were six monthly. No explanation was available to clarify the differences.

When we case tracked some people, we noted that one had a pressure ulcer. We and the nurse on duty, were unable to locate any documentation in their care record relating to this issue. We also noticed that two people remained in bed at 13:00. The nurse was unable to explain the reason for this apart from that they were people living with dementia. There was no documented evidence within these people's care records that explained why they remained in bed. This meant that no documented record was available for staff to read in relation to these people, especially for staff who did not know them, such as agency staff. We discussed this with the providers' managers who assured us this would be addressed as soon as possible.

We saw that people had visitors throughout the time of our inspection and they were often included in chats in the lounges and in the activities people enjoyed. Visitors told us they could visit throughout each day with no restriction and we also noted that some people were able to go out with their relatives and visitors, maintaining friend and family contacts.

A programme of activities was listed on the noticeboard. Activities offered were things such as, films, entertainment, an owl show, quizzes, baking and chair based exercises. Days out were also on the board. On the first day of our inspection, we spoke briefly to the activities coordinator and another member of staff who was accompanying two people on an outing. They told us they were going with some people who lived in the home, for a visit to a garden centre, in the home's own minibus. They also said that the staff tried to ensure that everyone who lived in the home and who were able to, had the opportunity to go out on such outings, from time to time.

Visitors to the home confirmed that some people went out in the minibus; one told us about their relative, "Some people go out in the minibus, but he doesn't go out".

In the afternoon of our first day, we saw staff in the downstairs lounge singing Christmas songs with some people in the lounge. A visitor told us that people had recently been making Christmas cards.

We saw the complaints policy and a poster about this on the noticeboard. There was no clear record of complaints, but people told us they were satisfied with the way the home had handled any issues. One person had lost a valuable item. The home had searched for it and eventually it was found. The person and their relative were pleased with the response from the home.

Generally both people and their visitors were happy with the service. One said, "I've no complaints but would talk to the manager or the nurse on duty if I had because I'd feel listened to". Another said, "No complaints. I'm listened to and not rushed".

"One member of staff I didn't get on with, so they stopped him from supporting me. He's still here but doesn't come to me." I'm fine with that."

People told us they were able to see health care professionals of their choice. One said, "My own GP comes to see me" and another told us, "My own podiatrist comes in".

We discussed concerns with the provider raised by staff relating to the intermediate care that the home provided for people coming out of hospital. The provider informed us that they would address the concerns with the commissioners.

Requires improvement

Is the service well-led?

Our findings

One person told us about the management of the home, “They are very approachable. I’m treated as an individual. Don’t see much of the manager but girls do a good job”.

Another told us, “Matron [the registered manager] is strict in the right way, but she’ll joke with you.”

A third said, “The manager is brilliant and I’m treated as an individual. They’re all very, very good to me.”

A staff member told us, “The manager is very good; they make sure we do the care side properly. Both the managers are very approachable”.

We saw that there were various policies related to the running of the home, such as health and safety, infection control, medication and maintenance.

There were two managers for the home. One was the registered manager, who was a qualified nurse and who gave direct nursing care to people in the home. They were part of the normal rosta for each week. The other was the home manager and this person had routinely done, on a daily, weekly or monthly basis, various checks on the quality of the service, in conjunction with the registered manager. Up until the home manager had been absent from September 2015, things such as residents meetings, staff meetings and regular checks on the quality of the service such as medication audits and care file audits, had been generally completed. However, since September, these checks relating to the running of the home and the meetings had not been completed.

Registered managers have the legal responsibility for meeting the requirements of the law in relation to care homes. They, with the providers, are ultimately responsible for the running of the home and compliance with the law. The required statutory notifications had been submitted but since the absence of the home manager in September, other requirements had not been fully met, such as the completion of various audits and quality assurance processes. The frequency of these was defined in the providers own policies.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Good Governance).

We discussed this with the provider’s managers, who assured us that additional support would be provided. On the second day of our inspection, we were introduced to a relief manager who was to stay at the home for several weeks whilst the registered manager was on holiday and afterwards. This relief manager was also going to be supported by the providers’ quality assurance manager, until the home manager returned to work, which was hoped to be within a few weeks of our inspection.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services were not protected against the risks associated with unsafe medication processes. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: People who use services were not assessed appropriately in respect of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff were not suitably trained to meet the needs of the people they were supporting. Regulation 18(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes were not operated effectively to make sure the service was assessed and monitored. Regulation 17.