Morleigh Limited

St.Theresa's Nursing Home

Inspection report

St Therese Close
Callington
Cornwall
PL17 7QF
Tel: 01579 383488
Website: www.morleighgroup.co.uk

Date of inspection visit: 15 September 2015
Date of publication: 23/11/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

St Theresa's Nursing Home is a care home that provides nursing care for up to 45 older people. On the day of the inspection there were 24 people living in the home. Some of the people at the time of our inspection had mental frailty due to a diagnosis of dementia.

We carried out an unannounced comprehensive inspection of this service on 6 August 2015. After that inspection we received concerns in relation to the safety of the nursing care provided to people living at St Theresa's Nursing Home. These concerns were about how risks to people in relation to pressure area care, wound care, nutrition and hydration and medicines were identified and managed. Concerns were raised about staffing levels and competency, particularly in relation to nursing staff, and a general lack of confidence in the management of the service. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Theresa's Nursing Home on our website at www.cqc.org.uk.

The service is required to have a registered manager and at the time of our inspection a registered manager was not in post. 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 and associated Regulations about how the service is run.

Summary of findings

We found there were serious risks to people's safety because the service had not adequately assessed the risk to people in relation to pressure area care, wound care, weight loss and falls. Where people were assessed as being at risk of skin damage due to pressure, weight loss and falls or in need of wound care, insufficient and inconsistent action was taken to provide safe and appropriate treatment. Systems to ensure consistent treatment was given to people were either not in place, or if put in place, were not followed. Risk assessments were not being updated when specific risks to people changed.

The service significantly disregarded the needs of people in relation to their care and treatment. The service had failed to recognise, in a timely manner, when one person was in need of treatment. When this was realised, action was not taken to give appropriate treatment to relieve the person's pain and distress. When the noise from a pump on a mattress for another person was causing the person to become distressed, the service failed to take appropriate action to alleviate their anxiety and provide equipment that was safe.

There was not a safe or proper system in place to manage medicines. Inappropriate medicine was being given to one person because the medicine was not suitable to be chewed when given disguised in food. The correct procedure for handwritten Medicine Administration Records (MAR) was not being followed. Records showed people did not always receive their prescribed medicines in a timely manner. Records of medicines, that required stricter controls by law, held by the service did not match the stock held.

There were adequate numbers of suitably qualified care staff on duty. However, there were insufficient numbers of permanently employed nurses who knew people's needs.

People did not receive care and treatment that was responsive to their individual needs. Care records were inconsistent and where the need for treatment had been identified, care plans for that treatment had not been written to give staff clear instructions to follow. The lack of specific care plans related to where it had been identified that people should be re-positioned at regular intervals, had been assessed as being at risk of losing weight and in need of wound care.

The management of the service was inconsistent which had resulted in poor outcomes for people. The management and monitoring of the nurses and the nursing care provided to people was inadequate. There was a lack of communication between nurses and management regarding the day-to-day provision of nursing care.

The service had failed to actively seek the views of people and their families. The culture of the service and the changes in management meant people and their families had lost confidence in the service and, as a result no longer shared their views and concerns. The three relatives all told us they had lost all confidence in the service because of the change of managers and the shortage of permanent nursing staff. They said there was no point in telling a manager or nurse anything because they would then leave the service and nothing would be done.

Audit processes were not effective and had failed to identify shortfalls in relation to medicines, care plans, tissue viability and maintenance of equipment.

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at St Theresa's Nursing Home in the two years the Morleigh group has owned the service. The Care Quality Commission has carried out seven inspections (including this one) of the service since November 2013. At each inspection there have been breaches of the regulations. At five of the seven inspections the service was not meeting the required regulations in relation to the management and organisational governance of the service.

We identified three breaches of the Health and Social Care Act regulations. We are taking further action in relation to this provider and will report on this when it is completed.

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?

Inadequate

The service was not safe.

Lack of appropriate and timely care in the service placed people at risk of harm. Inadequate and inconsistent action was taken to provide safe and appropriate treatment in relation to nursing care needs such as pressure ulcers, wound care or weight loss. The service significantly disregarded the needs of people in relation to their safe care and treatment.

There was not a safe system in place to manage medicines.

There were adequate numbers of suitably qualified care staff on duty. However, there were insufficient numbers of permanently employed nurses who knew people's needs.

Is the service responsive?

Requires improvement

The service was not responsive. People did not receive care and treatment that was responsive to their individual needs.

Care plans, for people who were in need of nursing care, were not personalised to reflect their care and treatment needs. Care plans were not updated as people's needs changed.

Is the service well-led?

Inadequate

The service was not well led. The management of the service was inconsistent which had resulted in poor outcomes for people.

The management and monitoring of the nurses and the nursing care provided to people was inadequate. There was a lack of communication between nurses and management regarding the day-to-day provision of nursing care.

Audit processes were not effective and these had failed in identify shortfalls in relation to medicines, care plans, tissue viability and maintenance of equipment.

St.Theresa's Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 September 2015 and was unannounced. The inspection team consisted of three inspectors. This inspection was carried out to check concerns raised about the safety of the nursing care provided to people living at the service.

We gathered evidence against three of the five questions; is the service safe, is the service responsive and is the service well-led? This was because the concerns raised related to these three questions.

During the inspection we spoke with six people who were able to express their views and three relatives. Not everyone was able to verbally communicate with us due to their health care needs. We looked around the premises and observed care practices. We used the Short Observational Framework Inspection (SOFI) over the lunch time period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with six care staff, one nurse, the cook, the acting manager, the head of operations and the provider. We looked at five records relating to the care of individuals, staff rosters and some records relating to the running of the home. After the inspection we spoke with the community tissue viability nurse team, who worked with the service to support people who were at risk of pressure damage to their skin.

Inadequate

Is the service safe?

Our findings

We carried out this focused inspection in response to concerns raised with us. These concerns were about how risks in relation to people's pressure area care and medicines were identified and managed. Concerns were also raised about staffing levels and staff competency, particularly in relation to nursing staff.

We found there were serious risks to people's safety because the service had not adequately assessed the risk to people in relation to pressure area care and falls. Where people were assessed as being at risk of skin damage due to pressure, or falls, insufficient and inconsistent action was taken to provide safe and appropriate treatment. We looked at the care records for five people who had been assessed as being at risk of pressure damage because there were either cared for in bed or had reduced mobility. Systems to ensure consistent treatment was given to people were either not in place, or if put in place, were not followed. Risk assessments were not being updated when specific risks to people changed.

Care records for one person, who had been assessed as being at risk of pressure damage to their skin, showed red areas that could be, or could result in, a pressure sore had been identified. However, it was not clear what action had been taken once these concerns were raised by care and nursing staff. Nurses' daily report sheets stated on 6 September 2015 that the person had 'a red pressure ulcer on their lower back'. Creams were applied and a pressure cushion was put on their chair. On 8 September 2015 records stated 'left buttock looking very red and vulnerable'. On 10 September 2015 records stated that 'care staff had reported a pressure area and appears to have some skin tear …. high risk of infection'. On 11 September 2015 notes stated that care staff again reported their concerns about the red areas on the person's skin to the nurse on duty. On 7 and 10 September there were no notes of the care provided. After 11 September there was no further mention of the concerns about the reported pressure ulcer. The care plan and risk assessments had not been updated to record the affected areas. The last skin integrity care plan was dated 18 April 2015 and the last waterlow assessment was 24 August 2015 (The waterlow scale is a recognised tool for assessing the risk of developing a pressure sore). Care records stated that the waterlow assessment should be updated when any changes occurred. There was no current assessment of the risk of pressure sores and no treatment plan in place to manage and monitor the person's skin integrity. This meant the person was not being adequately protected from the continued risk of skin damage and developing further pressure sores. This was because when concerns about their skin integrity were identified action was not always taken. When action was taken these actions were taken in isolation by individual nurses, without any effective ways of communicating their actions to ensure that care and treatment was provided consistently.

Another person had been assessed as being at high risk of falls. It was not clear how the service was managing and monitoring this risk. A body map had been completed on 27 May 2015 which showed a cut to the left shin and a scab on their left heel. On the bottom of the chart a nurse had written 'I do not know how these injuries occurred'. We were advised that because the person moved into the service 14 days before this body map was completed these were old injuries sustained prior to moving into the service. Although, there were no records to explain this. Another body map had been completed on 25 August 2015. This body map showed marks on the person's body in six places. Three were described as bruising, one as a blister, one as a cut and one as an abrasion. The cut and the abrasion were dated as occurring on 12 August and the other marks were not dated. There was no record of any investigation into how these injuries had occurred. This meant possible action to prevent the re-occurrence of a fall, or other incident, had not taken place. The care plan had not been updated to reflect any changes to their needs as a result of these injuries. There had been insufficient action taken to reduce the risk of the person sustaining injuries from falls.

We found that the air mattress for one person was deflated on the day of the inspection. We were advised by staff that this was because the pump was very noisy and was turned off for some periods of the day. We asked for the pump to be turned back on because it was vital that the person was on a pressure relieving mattress. The maintenance person carried out some repairs and by the afternoon the mattress was working and the noise of the pump had been corrected. However, records showed that when the tissue viability nurse carried out a review on 28 August 2015 they said that there was, 'improper use of mattress and requires urgent attention … home to assess prevention of pressure ulcers urgently'. After the inspection visit we spoke with the

tissue viability nurse who advised us that this particular mattress had an incompatible motor and as a result was not safe to use because it could not be inflated to the right level. The tissue viability nurse confirmed that they had reported this to the service on 28 August 2015. At the time of the inspection the service had not taken any action to provide the person with a safe pressure relieving mattress.

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

Systems for the administration of medicines were not safe. One person required their medicines to be given to them covertly. However, one of the medicines was a specifically coated capsule designed to protect the person's stomach from irritation. Such coating should not be cut or broken before being swallowed as the contents could be an irritant to the individual's stomach. We were told by the nurse in charge that the person was given their medicines in a jam sandwich and this was chewed. This meant the capsule was likely to be broken before it was swallowed. This concern had been recognised by the service but no action had been taken to attempt to reduce the risk to the individual.

There were other systems for the administration of medicines that were not safe and posed a potential risk to all people living in the service. Where Medicine Administration Records (MAR) were written by hand, following advice from a medical practitioner, these had not been consistently signed and checked by two members of staff as required. Records showed people did not always receive their prescribed medicines in a timely manner. There were some gaps in the MAR where nurses had not recorded if people had been given, or had refused their medicines. Records of medicines, that required stricter controls by law (Controlled Drugs), held by the service did not match the stock held. Three medicines were recorded as having stock held but these medicines were not present at the service. The nurse in charge told us these medicines were checked regularly by the nurse on duty. However, the three items shown as held in stock since March 2015 had not been identified by these checks. The last three audits carried out by the service on 15 July 2015, 27July 2015 and 26 August 2015 all stated the stock balance of medicines that required stricter controls was correct, and this was inaccurate.

Some people had been prescribed creams. Such creams had not been consistently dated upon opening. This meant staff could not be sure when the cream would no longer be safe to use. There were no records to show if these creams were applied as prescribed.

The service stored medicines that required cold storage. There was a medicine fridge at the service for this purpose. The maximum and minimum temperature reached within this fridge was not monitored on a daily basis. This meant the service would not be alerted to any fault with the fridge, and the safe storage of medicines therein could not be assured.

There were charts to help ensure staff were prompted to know how to rotate the site of people's pain relieving patches. This meant people did not have a patch applied to the same site repeatedly, which may have caused a local skin irritation. However, prior to this inspection a safeguarding concern had been raised to the local authority safeguarding unit, because three people who lived at the service had not been provided with their pain relieving patches as prescribed. An external pharmacist audit had highlighted the need for staff to amend their record keeping processes.

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

During the inspection a relative of a person living at the care home visited and spoke to us about how they had come into the service that day to apply cream to a sore area on the person's neck. The person showed us their neck and the skin was broken and very red. They told us it was causing them severe pain and discomfort. The relative was doing all they could to help the person because the service had not taken any action to treat the damaged skin areas and reduce their pain and distress. There were no records in their care plan of this condition despite staff carrying out personal care, including shaving, on a daily basis. The nurse on duty was not sure when the sore had first developed and had written in the communication book the day before (14 September 2015) that care staff should apply cream to the area. However, the nurse confirmed that care staff had not carried out this instruction and cream had not been applied. The nurse told us that this failure to provide treatment should, "not have happened". No treatment plan had been put in place

Inadequate

Is the service safe?

and there was no evidence that an assessment of the risk of infection had been carried out. This meant the service disregarded the person's needs and had failed to provide appropriate care and treatment to meet their needs.

On the day of the inspection one person told us the pump for their mattress was making a lot of noise. This had caused them a great deal of distress because they had experienced severe deprivation of their sleep for several days because of it. As explained above, the pump was turned off for periods of the day to give them a rest from the noise. However, until the day of the inspection the service had not taken any action to rectify the noise. Action was only taken, on the day of the inspection, three hours after inspectors first reported their concerns and after several reminders. This meant that even though the service had realised the distress this was causing the person, they had not taken any action to relieve their distress.

During the inspection we identified a total of seven people who we felt were are at serious risk of receiving unsafe and inappropriate nursing care. Following the inspection we made alerts to the Safeguarding team at Cornwall Council so action would be taken, as was necessary, to protect these people from harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were adequate numbers of suitably qualified care staff on duty. On the day of the inspection there were five care staff and one nurse on duty from 08.00am to 08.00pm to meet the needs of 24 people. The acting manager told us there had been high levels of sickness and as a result some days staff numbers had been lower. The acting manager also told us since they started to work at the service, two weeks earlier; they had increased the number of staff in the afternoon from four to five to meet people's needs. This had been achieved by using staff from other services within the organisation and existing staff working additional shifts. Rosters also showed that for the last two weeks five staff had been on duty all day. People did not tell us they had any concerns about staffing levels and we saw that staff responded in a timely manner to requests for assistance from people.

However, there were insufficient numbers of permanently employed nurses who knew people's needs. There were only two permanent nurses and one of those was new to the service. Some people and their relatives told us they were concerned about the lack of consistent nurses working in the service. One person told us they would sometimes ask to go to bed early, while a nurse they knew was on duty, because they did not feel confident if a nurse they did not know had to support them.

Requires improvement

Is the service responsive?

Our findings

The Care Quality Commission had been made aware of concerns about how people's needs were met in relation to wound care, nutrition and hydration. We found that while care plans were recorded as being reviewed monthly and care plan audits had taken place, they did not accurately reflect people's care and nursing needs.

Care records were inconsistent and where the need for treatment had been identified, care plans for that treatment had not been written to give staff clear instructions to follow. The lack of specific care plans related to where it had been identified that people should re-positioned at regular intervals, had been assessed as being at risk of losing weight and in need of wound care.

The care records for one person showed they had been assessed as being at risk of pressure damage to their skin. Records showed that the person had a pressure ulcer on their heel that required daily monitoring and regular changes of dressings. The tissue viability nurse carried out a review on 28 August 2015 and instructed the service to check the wound daily and use a particular type of dressing. This advice was not followed. Charts used by the service to record when dressings were changed had not been completed daily. There were entries on 28, 29 & 31 August and 1, 2, 4, 9 & 10 September 2015 and gaps on 30 August and 3, 5, 6, 7, 8, 11, 12, 13 & 14 September 2015. Nurses' daily notes on 3 September 2015 showed that the dressing had been changed and more had been ordered because 'we are out of dressings'. The nurse on duty advised us that the "dressings arrived last night", which was 14 September 2015. This meant that for 10 days the correct dressings were not available to use. Where records indicated the dressings had been changed the wrong dressings had been used to treat the person.

Another person had also been assessed as being at risk of pressure damage to their skin. Their care plan stated that they should be re-positioned every 2 hours when they were in bed during the day and at night. This meant the risk of skin damage would be managed as the person would not stay in the same position for too long. However, records did not show that 2 hourly re-positioning had taken place. Records on 1, 2, 3, 5, 7, 8, 10 & 12 September 2015 recorded some re-positioning, but at the most only twice during each 24 hour period. There were no records of re-positioning on 4, 6, 9, 11, 13 & 14 September 2015. This meant that this person's skin integrity was not being managed and monitored in line with their assessed needs and put them at risk of developing pressure sores.

Care records for a third person showed they had been assessed as being at risk of losing weight. Their nutrition care plan was dated 14 March 2014. A care plan audit completed in August 2015 had noted that the nutrition care plan required updating. Records in the care plan dated 12 December 2014 stated 'refuses to be weighed' and 23 August 2015 'unable to weigh [person's name]'. A care plan review dated 28 February 2015 stated 'continues to have a small diet'. The nurse in charge on the day of our visit told us they were concerned about the person's weight. However, there was no evidence that the person had ever been weighed at the service and certainly not since December 2014. The nurse in charge advised us the service did not have any suitable equipment to weigh this person. Where people were unable to stand up to use weighing scales the service used equipment that weighed people while sitting in a wheelchair. This person was unwilling to consent to being hoisted into a wheelchair to be weighed. However, the service had made no attempt to ascertain an approximate weight by any other method. The service had failed to monitor this individual's weight putting them at risk of malnutrition.

Where people had been assessed as being at risk from their nutrition and hydration needs not being met, their food and fluid intake was monitored daily. However, the amount of food and fluid intake was not totalled each day and records did not show what was considered to be an adequate intake for individuals over a 24 hour period. People were at risk of their nutritional needs not being met because there was insufficient information for the service to monitor if people were having the necessary amount and food and drink.

This meant people were at risk of receiving care and treatment that was not responsive to their needs because people's needs had not been robustly assessed. The delivery of care and treatment was inconsistent because staff did not have clear instructions and guidance to follow.

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

Inadequate

Is the service well-led?

Our findings

The service is required to have a registered manager and there had not been a registered manager in post since March 2014. A manager was appointed in May 2014 and they started the process to become the registered manager for the service. However, this application was withdrawn in December 2014 because they were moved by the provider to manage another care home in the Morleigh group at the beginning of January 2015. A second manager was appointed in February 2015 and left the service in April 2015. A third manager was appointed in May 2015 and left the service suddenly in September 2015, two weeks before the inspection. The Morleigh group has owned this location since October 2013. There was a registered manager in post when Morleigh purchased the service and they de-registered in March 2014. However, they were on sick leave for several months prior to leaving the group. So there has not been stable management at this location since the Morleigh group purchased the service two years ago. The lack of consistent management arrangements had resulted in poor outcomes for people.

We found there was inadequate management and monitoring of the nurses and the nursing care provided to people living at St Theresa's. A manager, without a nursing qualification, moved from another service to work at the service when the last manager left in September 2015. A newly appointed nursing qualified clinical lead for the organisation had visited the service for a day during the week before our inspection to check people's nursing needs and how they were being treated. However, these actions had not been enough to ensure that safe care and treatment was provided to people. Two nurses, who were both permanent staff, worked day shifts from 8.00am until 8.00pm. These two nurses had not met each other. All night shifts were covered by agency nurses. The nurse working on the day of the inspection was new to the organisation and had worked eight days in the service. They told us they had not been given any induction into the premises, systems or peoples' needs before they started work at the service. We found there had not been any regular clinical supervision of these nurses and no record of recent nurse meetings. The provider advised us that the last clinical supervisions took place in April 2015 and there had been a nursing meeting in June 2015. However, the nurse in charge on the day of the inspection started after this meeting took place.

There were systems in place for nurses to communicate between each other and with care staff. These included nurses 24 hourly reports, electronic handover records, communication book and diary. However, these systems were not being consistently used by nurses and were not always accurate. On the day of the inspection handover notes, given to nurses to update them with information about people's needs when they started a shift, did not accurately reflect the needs of people. It was evident that these electronic handover records were not updated as people's needs changed. As all night shifts, and some day shifts, were covered by agency nurses and one nurse was new to the service, it was even more important that there was effective communication between nurses and care staff. The provider had not identified the risks of running the service with a shortage of permanent nurses who knew the needs of people living at the service and were unable to support the extensive use of agency nurses. The provider had not taken appropriate action to ensure vital information about people's needs was known by the nurses who were responsible each day for people's nursing care. This put people at a high risk of receiving care and treatment that was unsafe or inappropriate.

The service had failed to actively seek the views of people and their families. The culture of the service and the changes in management meant people and their families had lost confidence in the service and as a result no longer shared their views and concerns. The three relatives told us they had lost all confidence in the service because of the change of managers and the shortage of permanent nursing staff. They said there was no point in telling a manager or nurse anything because they would then leave the service and nothing would be done. Another relative said, "No management consistency, anyone who is any good leaves. Last week I went to the nurse to ask that [person's name] be up by 9.30am the next day for an appointment with the hairdresser that I had arranged. I arrived to find [person's name] still in bed at 9.30am. The message did not get through although it was written in the book, lack of communication (is) admitted by the staff."

Systems to assess and monitor the quality and safety of the service provided were not effective. We found regular audits of medicines, care plans, tissue viability and maintenance were taking place. However, these audits were not effective because the audits had failed to identify shortfalls as detailed in the safe and responsive sections of this report.

Inadequate

Is the service well-led?

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at St Theresa's Nursing Home in the two years the Morleigh group has owned the service. The Care Quality Commission has carried out seven inspections (including this one) of the service since November 2013. At each inspection there have been breaches of the regulations. At five of the seven inspections the service was not meeting the required regulations in relation to the management and organisational governance of the service. In April 2015 two warning notices were served because the service was failing to meet legal requirements in relation to regulations 12 (safe care and treatment) and 17 (good governance). Although, in August 2015 we found that the warning notices had been met there were still two breaches of regulations. Further concerns about the care and treatment people received and the management of the service were raised shortly after the inspection in August 2015 and this was the reason for this inspection.

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