Barker Care Limited

St Teresa's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
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

We carried out an unannounced inspection of St Teresa's Nursing Home on the 5 and 12 March 2015. At the last inspection we found there were breaches of legal requirements of previous Regulations. Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2010. The provider said they would take action to address the concerns by 30 November 2014. At this inspection we found there had been some improvements in the way staff built relationships with people.

St Teresa's Nursing Home is registered for a maximum of 70 older people. The home is divided into two units. The Gainsborough Unit accommodates up to 27 people many of whom are living with dementia. The Bartelt Unit accommodates up to 43 people who need general nursing care.

A registered manager was not in post. The area manager and clinical lead had taken over the role of day to day management of the home. 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.

Summary of findings

Staff told us there was an induction for new staff but shadowing of experienced staff was not in place for all staff. Staff said they attended training which included safeguarding adults from abuse, dementia awareness and moving and handling. One to one and group meetings were taking place but not all staff had attended these meetings. This meant some staff did not benefit from this support or have the opportunity to discuss things such as career development. We have made a recommendation for staff to receive appropriate support to enable them to carry out the duties they were employed to perform.

People told us they were not able to communicate with some staff. They told us some staff were not able to communicate effectively because of their English Language skills.

Staff had a good understanding of helping people make day to day decisions. Mental Capacity Act (MCA) assessments were not undertaken to assess people's capacity to make decisions. This meant staff were not fully aware of the decisions people were able to make or the help they needed to make other decisions.

People's needs were assessed and care plans were in place, but these did not always accurately reflect the care and support given or required. Some plans and assessment had not been regularly evaluated. Records of interventions such as positional changes and food and fluid charts were not always being kept or were incomplete.

People and staff told us there was sufficient staff but there were vacancies for activities coordinators. There was a lack of support with regard to meaningful activity and social interaction for those people living with dementia.Relatives told us the staffing levels had improved with the recruitment of more staff.

People told us they felt safe living at the home and the staff treated them well. Members of staff knew the types of abuse and the actions they must to take for suspected abuse.

Risks were assessed and risk assessments were devised to reduce the level of risk. Assessments for people at risk of developing pressure damage and malnutrition were in place. Environmental risk assessments included fire risk assessments which assessed the potential of a fire in the premises. Individual emergency plans gave staff direction on the support people needed in the event the building needed to be evacuated.

People's medicines were managed safely and they had access to social and healthcare professionals.

Staff had developed positive caring relationships with people living in the home. They made efforts to respect people's privacy and dignity. People were helped to eat their meals and their dietary requirements were catered for.

People told us their views about the home were sought and they gave positive feedback about the home. Staff described the culture of the home and that there was a "caring" culture. Staff told us the management of the home had improved and the area manager said the focus was to provide stability for staff to concentrate on the culture.

Audits and quality monitoring checks were taking place to ensure people's needs were met and to assess the standards of quality were being met. Action plans were developed to ensure people's needs and standards were fully met.

We found breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 11 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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?

Good

The service was safe.

People told us they felt safe living at the home and the staff treated them well. Members of staff knew the signs of abuse and who to report alleged abuse. They also told us if they witnessed abuse by other staff it was their duty to report it.

Risk to people's safety and welfare was assessed which included risks to the person and to the environment. Risk assessments were devised to prevent people from the potential of harm happening or reoccurring. Staff told us accidents and incidents were analysed and the actions taken had reduced the number of accidents.

People's medicines were managed so that they had received them safely. They said their medicines were administered by the staff.

Is the service effective?

Requires improvement

The service was not always effective.

New staff had an induction when they started work. Some staff may not be inducted to the routines of the home and the preferences of people because shadowing of experienced staff was not part of the induction programme for all new staff. Staff attended core training to meet the needs of people which included safeguarding adults, dementia awareness and Mental Capacity Act (MCA) 2005. One to one meetings were not taking place for all staff. This meant they were not given an opportunity to discuss their personal development, training or concerns they may have.

People told us they were not always able to communicate with staff as some staff's ability to communicate was compromised by their English language skills.

People were supported to eat their meals and refreshments. There was a choice of meals at mealtimes and their dietary needs were catered for.

People were supported to access their General Practitioner and health and social care professionals.

Is the service caring?

Good

The service was caring.

People told us the staff were caring. We saw staff used a variety of approaches depending on the situation. We saw staff use a friendly manner when they were encouraging people and a kind and gentle approach to help people become calm.

Summary of findings

Staff had developed positive caring relationships with people living in the home. They made efforts to respect people's privacy and dignity

Is the service responsive?

Requires improvement

The service was not always responsive.

People told us there was a lack of activities. We observed the staff in Gainsborough Unit were not able to provide meaningful activities because they were not able to interact with people.

People's needs were assessed but care plans were developed to meet the assessed needs. For example, mental health and aggression. Where people's needs changed their care plans were not always updated. Records of interventions such as positional changes and food and fluid charts were not always being kept or were incomplete. People at risk of malnutrition may not be receiving appropriate nutrition or hydration.

People said the staff delivered people's care and treatment the way they liked. The staff showed a good understanding of person centred care.

People knew who they could talk to about any concerns. Staff told us where they were able they resolved simple complaints. Where more serious complaints were made they were passed to the clinical lead for investigation.

Is the service well-led?

Requires improvement

The service was not always well-led.

A registered manager was not in post. People and relatives told us the management of the home was improving but more improvements were needed. They said more activities and social stimulation was needed.

Staff said there was a "caring culture" and the area manager told us the priority was to bring stability to the home for staff to focus on a "caring" culture.

The views of people and their relatives were sought through surveys and at residents meetings. People told us they were able to make suggestions and raise concerns.

Audits such as medicine and care plans were taking place monthly to ensure people care and welfare needs were met.

St Teresa'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 the 5 and 12 of March 2015 and it was unannounced. It was undertaken by two inspectors..

Before the inspection we spoke to and looked at information from commissioners of the service, previous inspection reports and notifications. Services tell us about important events relating to the care they provide using a notification.

During the inspection we spoke with people, their relatives, the staff on duty, the area manager, the clinical lead and the provider. We interviewed staff, and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the interactions between people and staff and we reviewed records.

We looked at the care records of people, policies and procedures, quality assurance system, schedules and monitoring charts, audits of systems, reports of accidents and incidents and medicine administration records

Good

Is the service safe?

Our findings

People said they felt safe and were treated well by the staff. Relatives said their family member was protected from abuse. One relative said "I have never heard any raised voices or anything.'' Another relative told us that they had not seen anything to concern them during their visits.

Staff were aware of how to report any abuse and received safeguarding training. Staff were able to describe the forms of abuse and who to report suspected abuse. A registered nurse told us the statutory bodies to be contacted if senior staff in the organisation did not respond to their allegations of abuse. Staff told us it was their duty to report any forms of abuse they may witness by other members of staff towards people. This is called whistleblowing.

Where risks to people's safety and welfare were identified, risk assessments were developed to inform staff how to lower the level of risk. Risks were assessed on the potential of people developing pressure ulcers, malnutrition and for people with mobility needs. For example, the risk assessment for one person with moving and handling needs included the healthcare professionals involved in the assessment, the techniques and the equipment to be used. Also included was the number of staff needed to assist the person with transfers. People told us the staff helped them with transfers and they used the correct equipment. Staff confirmed they followed the risk assessment in place.

A member of staff told us accidents and incidents were analysed. We were told from the analysis of accidents action was taken which had reduced their reoccurrence. For example, the action taken following falls had reduced their reoccurrence. Accident forms included management plans to prevent falls and were reviewed two weeks following a fall.

Emergency plans were developed to ensure the staff knew how to help people evacuate the property in the event of an emergency. Individual emergency plans described the support needed from the staff to help them evacuate the building.

Systems were in place to ensure the premises were safe for people who lived in the home and for staff. Assessments were undertaken on the potential of a fire in the premises and included the actions needed to reduce this potential. For examples fire alarm checks, tests and training for staff.

People said there were enough staff on duty to meet their needs. Some staff said in Gainsborough Unit staffing levels needed to increase because the people in this unit had higher levels of dependency. For example, people living with dementia with nursing care needs. A relative told us the manager had informed relatives the staffing levels were to increase and they had improved recently. Staff on Bartlett Unit said there were enough staff but there was a vacancy for an activities coordinator to provide activities and stimulation to people. A registered nurse described the arrangements for deploying staff to ensure people's needs were met in a timely manner. A member of staff said outside peak periods there was time to sit and chat with people.

People's medicines were managed so that they had received them safely. They said their medicines were administered by the staff.

We reviewed the arrangements regarding the management of medicines on the Gainsborough Unit. The interim manager told us they were just introducing a system to check the competency of staff to administer medicines. This would be carried out annually

Registered nurses and associate nurses were responsible for the administration of medications in the home. We observed part of a medication administration round and observed safe practice . The nurse demonstrated knowledge of the needs of the people they administered medication to. Medication administration records (MAR) were signed by staff to indicate administration of the medicine. People's photographs were attached to their MAR sheets to aid identification and other important information. A record was kept when people had refused or not received a medication.

We found that individual protocols for the use of 'when required' medicines were not always available. For example; we found that one person had been prescribed a medicine to reduce anxiety, to be used as required. The MAR recorded that the person was receiving this on a nightly basis. There was no protocol available to guide staff on its use. This is seen as good practice as it directs staff as to when, how often and for how long the medication can be used and improves monitoring of effects and reduces the risk of misuse. The interim manager informed us that protocol forms were available for use.

Good

Is the service safe?

We reviewed the storage and control of medications and found that satisfactory measures were in place to store and record their receipt, administration and disposal.

Requires improvement

Is the service effective?

Our findings

New staff received an induction to prepare them for the work they were to perform. Staff told us the induction programme covered training and shadowing more experienced staff. However, not all staff had the opportunity to shadow more experienced staff. One member of staff said some of their induction was theory based which included watching DVD and their knowledge was tested. Another member of staff said the induction was over two days and they watched DVD on specific topics. This member of staff said they shadowed more experienced staff. Staff on Gainsborough Unit said new staff were not always counted as supernumerary when they first started. Another member of staff on this unit said "induction training could be better; need more time and support. If we are short we will use them on the floor."

Comments received indicated that some staff's ability to communicate clearly was compromised by their English language skills. One member of staff told us their understanding was good but their communication in English was difficult. This member of staff told us how they were improving their language skills. A relative told us communicating with some staff could be a problem. One person we spoke with told us that they felt that some staff members spoken English was ''not good'' and that people could not always understand them."

Staff told us they attended training which covered safeguarding adults, moving and handling, dementia awareness and behaviours which staff found difficult to manage. A member of staff said there were in house trainers. Staff were able to describe the training provided and how it was implemented. The training matrix showed staff had recently attended mental health awareness and Mental Capacity Act 2005 (MCA) training. A manager told us they had planned refresher training for staff in safeguarding adults, medicines and understanding and managing difficult behaviours.

Registered nurses and associate nurses (qualified nurse not yet registered with the Nursing and Midwifery Council)) had one to one and group meetings with the clinical lead. The clinical lead told us there was a combination of one to one meetings and group meetings to discuss staff concerns and cascade information. The area manager told us conduct and performance monitoring were addressed separately as the emphasis on one to one meetings was to offer support.

A nurse associate said at one to one meetings concerns were discussed and group meetings were used for in house training. Three of the five caring staff we asked were not aware of having one to one meetings with their line manager. The fourth member of staff said 'I've had a couple and an appraisal'' and the fifth said supervision was "not very often now.'' The minutes of group supervision which took place on the 17 and 21 February 2015 were held to cascade information on the Care Quality Commission (CQC) new methodologies. We saw that on the 19 February 2015 one member of staff had a one to one meeting with the clinical lead. We recommend the service find out more about providing appropriate support to staff, based on best practice, to enable staff to carry out the duties they were employed to perform.

Members of staff showed a good understanding of the principles of the Mental Capacity Act 2005 (MCA). They explained most people were able to make simple decisions relating to their everyday care, but where more complex decisions were required families or advocates, social and health care professionals helped make best interest decisions. One member of staff told us some people were able to make decisions when the choices were shown to them. Another member of staff said some people were able to make decisions when the information was simplified.

MCA assessments were in place for some people but the outcome of the assessments were not made clear in the forms. This meant staff were not informed about the decisions people were able to make, the support needed to help them make decisions and who helped the person make more complex decisions.

We found that systems to gain and review consent from people were not in place. This was in breach of regulation [18] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found people's liberty was restricted as codes were needed for keypads on entrance and exit doors but people did not have access to these codes. Staff told us people were not able to leave the property without their support. Deprivation of liberty Safeguards (DoLS) applications were made to the supervisory body for people who required continuous supervision and lacked the option to leave the home without staff supervision. DoLS provide a process by which a person can be deprived of their liberty when they

Requires improvement

Is the service effective?

do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom

People were supported to eat and drink. We asked people on the Bartlett Unit what they felt about the meals. One told us ''they're alright; I get enough food and drink. I like the faggots.'' Another said ''we have lovely dinners here and I have a little drop of port at dinner time. Since lunch time today, this is my third cup of tea.'' A third person told us ''the food is excellent and I get plenty of drinks. '

We observed staff offer people a choice of refreshments. We observed members of staff address people by name and as staff placed the meal the person was told what was served. Staff used a variety of methods to communicate with people. For example thumbs up and showing the meal. Staff asked people if they had finished before they removed the meal.

The chef told us they catered for people's dietary needs which included vegetarian, soft and diabetic diets. We were told with the exception of people with diabetes, high calorie meals were served to help people maintain their weight. It was explained people had a choice of meals and were served with their preferred meals. We were told people were asked about their preferences each month which included information about foods to be avoided.

People were supported to access their General Practitioner and health and social care professionals. Relatives told us the staff kept them informed about GP visits. Records of visits from social and healthcare professionals were maintained. We saw staff had recorded the nature of the visit and the outcome of the visits. At staff handover members of staff were informed of the visits by health care professions.

Good

Is the service caring?

Our findings

One person told us “This is lovely [the staff]. I am thoroughly enjoying myself. I couldn’t wish for better, them (the staff) are really nice.’’ Another person said ‘’I’m very impressed. Staff are very kind, very caring. I needed my nails to be cut and I asked about who could do it for me and a carer came the next day.’’ A relative told us they were supported to arrange a family party in the home for their relative and they commented on how friendly the staff were. Another relative told us their family member was able to choose to have their meals in their bedroom.

Members of staff used a gentle and sensitive manner towards people. They told us “caring” approach was used towards people. One member of staff said “we try our best to give people everything they need. The job is about the relationships with people. Treat people well. It’s like a family. It’s important to make them feel at home.” We saw one person was sitting by themselves at lunchtime. A care assistant asked the person if they wanted to come and join some other people at another table.

A relative told us the staff respected their family member’s privacy. They told us staff always knock before they enter bedrooms. A member of staff gave us an example to describe the way people’s rights were respected. For example respecting people’s decisions.

Requires improvement

Is the service responsive?

Our findings

Relatives told us there was very little social activity or stimulation on Gainsborough and at one time had witnessed “about twelve people sitting in the lounge and one staff member, who was on the phone.”

We were informed activities were not taking place as the staff activity coordinator and activity assistant had recently left. We saw that many people were sat in the lounge on the top floor of the Gainsborough Unit. We observed staff trying to interact with people with limited success. One person was being encouraged to paint, but not being supported to do so. Another person had a set of pictorial cards, but was not being supported by staff to experience any meaningful activity using them. Similar music CD’s were playing throughout the day in the lounge which could become intrusive to some people. A television was on with the sound muted and sub titles shown, although people were not watching. There was limited conversation between staff and the people other than to offer them drinks.

We spoke with one person in the morning, who said that they would like to go for a walk outside. Staff members were present during this conversation but the person remained in the lounge area throughout the morning. We spoke with three people on the Bartlett Unit who were complimentary about some of the social activities they had attended. One said "I have been down to several things and enjoyed them.” Another said "I join in most things.” One person voiced that they were upset about not having any activity staff at the moment.

People’s needs were assessed and care plans were in place, but these did not always accurately reflect the care and support given or required. For example, care plans were not reviewed following a fall or following GP's visits. Care plans were variable in the guidance they gave to staff on how to meet people’s assessed needs and on how they liked their needs met. We saw care plans were not devised for all aspects of the person’s care and welfare needs. For example care plans were not developed for people with mental health care needs. This meant staff may not be aware of the impact people's medical condition may have on the way their care and treatment needs to be delivered.
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Where people were reluctant to accept support the care plans did not say how staff were to encourage people to agree to staff assistance. We saw care plans were not updated following review meetings. For example, the review notes told staff to give people time when they were resistant to personal care but the care plan did not give this guidance. This meant staff may not be responding to people in a consistent manner.

A nurse associate told us there were people who at times expressed their frustrations or emotions using aggression or violence. We were told staff managed these behaviours by identifying the source of aggression, sitting with people and speaking with people until they became calm. However, a care plans to reflect this information was not in place.

The staff said they did not always read the care plans, they said handovers when shift changes occurred kept them informed of people’s needs. We were told care assistants mainly read care plans during induction and from then on relied on handovers where they were told about people’s changing needs. This meant staff may not be fully informed of changes in people's care and treatment which occurred during their time off.

People’s level of dependency and potential of them developing pressure damage and malnutrition was assessed. Risks were also assessed for people at risk of falls and where people had mobility needs moving and handling risk assessments were devised. Staff sought advice from health care professionals for people assessed at risk and used appropriate equipment. For example, a pressure relief mattress was used for people at risk of pressure damage. Staff told us people were weighed monthly and their weights were recorded in their care plan. We saw from the records some people had sustained progressive weight loss but the care plans were not updated.

Records of interventions such as positional changes and food and fluid charts were not always being kept or were incomplete. Malnutrition Universal Screening Tool (MUST) guidance was not always followed for people at risk of malnutrition. Fluid charts in place gave the daily fluid intake guidance for each person. However, some people were not reaching the minimum daily fluid intake and staff had ticked that the care plan was not for updating. Staff

Requires improvement

Is the service responsive?

may not identify signs of deterioration because intervention charts were not consistently completed. This meant people at risk of malnutrition may not be receiving appropriate nutrition or hydration.

We found that [the registered person had not protected people against the risk of receiving inappropriate care or treatment]. This was in breach of regulation [9] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation [12] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Members of staff had a good understanding of person centred care. A nurse associate (a qualified nurse not yet registered with the Nursing and Midwifery Council.) told us there was a person centred approach to care. This nurse said "It's what people want, its important here." One member of staff gave us an example of person centred care. They said it was knowing people's preferences. Another member of staff told us person centred care was knowing how to addressed people, and their food preferences.

A relative told us if they had complaints they would approach the clinical lead. Staff told us they passed complaints to the manager for investigation. Another member of staff said depending on the nature of the complaints as some they were able to resolve promptly. For example if people complained about the food they could offer an alternative. We looked at the complaints log and eight complaints were received from relatives and these complaints were resolved.

Requires improvement

Is the service well-led?

Our findings

A registered manager was not in post. The area manager had taken day to day management control of the home with the clinical lead. The provider told us recruitment for a manager was taking place. 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.

A person living in the home commented ''Staff couldn't be better, but management could." A relative told us that they thought the staff were "poorly managed, they need training and support.'' Staff told us the culture was "caring." They said ''It's caring, all the staff here are good.'' Another relative told us the care people receive had improved since more staff were recruited.

The area manager told us there was a caring and respectful culture. Putting people in the middle was the approach used to meet people's needs. We were told the priority was to bring stability to the home and to introduce strong structures so that staff could focus on a "caring" culture.

A nurse associate (qualified nurse not yet registered with the Nursing and Midwifery Council) told us there had been a period of instability. We were told the area manager was approachable but in the absence of a registered manager the clinical lead was approached with concerns. Another member of staff told us there was team work and staff were respectful towards each other. A third member of staff told us there were high expectations and the staff team worked well together. A fourth member of staff said ''There isn't any [management]. It's been a rough year but it's starting to get better.'' The fifth member of staff member described the management as ''good'' but said they did not know who the new manager was.

Staff said team meetings kept them informed about policy changes and about the running of the home. We saw a staff meeting had arranged to discuss staff pay and conditions, introduce new staff and activities during the recruitment of new activities coordinators.

The views of people were sought about the care delivered and the staff who delivered their care and treatment and they comments received about the home were positive.

Audits were monthly and conducted by the clinical lead. A sample of four care records were audited each month to assess the quality of care received by people. The clinical lead told us these audits were to identify people at high risk were having their care needs met. For example people at risk of malnutrition, falls, pressure areas and behaviours staff found difficult to manage. Action plans were devised to ensure people's needs were met but we found a lack of monitoring. For example, care plans were not updated from the intervention monitoring such as food and fluid charts and positional change to reflect people's current needs. For example care plans were not updated for people with progressive weight loss. A staff member confirmed that the clinical lead carried out monthly audits relating to subjects such as infection control, falls, incidents, wound management.

The area manager was recently assigned this service and was visiting two weekly to undertake monitoring visits. This area manager was aware the quality of service needed improving and told us some issues related to not having a registered manager in post. We were told at these visits people assessed at having high dependency needs, complaints investigations and staff vacancies were discussed with the clinical lead.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Suitable arrangements must be in place to assess people's capacity to make decisions and to ensure they have the support they need to make these decisions.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for people and reasonable steps must be taken to mitigate risks.**