Rockley Dene Homes Limited

Cherry Hinton Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced focussed inspection of this service on 7 December 2016. During that inspection four breaches of the legal requirements were found.

One breach was because the provider had failed to notify the local authority of safeguarding incidents as per safeguarding protocols. Another breach was because people were placed at risk of avoidable harm. The provider had failed to report to relevant external authorities of incidents that affected the safety and welfare of people. The third breach was because there was a failure by the provider to have robust quality monitoring systems in place to enable them to identify where quality and safety was being compromised. The fourth breach was the failure of the provider to notify the Care Quality Commission (CQC) in a timely manner of all incidents that happened within the service that they were legally obliged to do so.

After the focused inspection in December 2016, the provider wrote and told us what they would do to meet legal requirements in relation to the breaches. They said they would meet these requirements by 14 February 2017. We undertook another focused inspection on 7 April 2017 to check that they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Cherry Hinton Nursing Home' on our website at www.cqc.org.uk.

Cherry Hinton Nursing Home is registered to provide accommodation, nursing and personal care for up to 60 people. At the time of our inspection there were 37 older adults, including adults living with dementia living, at the service.

At the time of this inspection there was no registered manager in post. A new manager was working at the service and they were currently applying to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this focused inspection on 7 April 2017 we found that the provider had followed their plan, and legal requirements had been met.

The provider had notified the local authority of any safeguarding concerns as per safeguarding protocols. Staff had received training and refresher training in safeguarding and had an understanding that they had a duty to report concerns around suspicions of harm and poor care.

Applications had been made to the local authority (supervisory body) to lawfully restrict a person's liberty

when the person had been assessed as lacking capacity to make their own decisions.

Risks to people's health and safety had been assessed and actions identified to mitigate such risks. Incidents that affected the health, safety and welfare of people living at the service were, where appropriate, referred to external healthcare agencies such as the falls team for additional and specialised guidance and support.

There were robust systems in place to monitor and identify areas where the quality and safety of the service provided may be compromised. Actions were in place to respond appropriately to any areas of improvement required in a timely manner.

The CQC had been notified by the provider of all incidents, including safeguarding incidents that they were legally obliged to inform us about.

Although we found that improvements had been made we have not revised the rating for the four key questions: to improve the rating to 'good' would require a longer term track record of consistently monitoring the quality of the service and delivery of high quality care.

We will review our ratings at the next comprehensive inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Action had been taken to improve the safety of the service.

People were protected from unlawful restrictions.

People were protected from harm because incidents of suspected harm and poor care had been reported to the local authority safeguarding team.

Risks to people's safety were being managed. Referrals to external healthcare professionals were made for guidance and in a timely manner.

Although improvements have been made we have not revised the rating for this key question: to improve the rating to 'good' would require a longer term track record of consistently monitoring the quality of the service and delivery of high quality care.

We will review our rating at the next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

Action had been taken to improve how well-led the service now was.

The provider had effective systems in place to assess and monitor the quality of the service provided. Where improvement was required, action was taken in a timely manner.

The provider had notified the CQC of all the incidents that they were legally obliged to inform us about.

There was no registered manager in post.

Although improvements have been made we have not revised the rating for this key question: to improve the rating to 'good' would require a longer term track record of consistently monitoring the quality of the service and delivery of high quality care.

We will review our rating at the next comprehensive inspection.

Cherry Hinton Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focussed inspection of this service on 7 December 2016. During this inspection four breaches of legal requirements were found. This was because the local authority safeguarding team were not informed of all safeguarding incidents that had occurred. Referrals had not been made to external health care professionals, where appropriate to help manage and give guidance on a persons deemed risk. There was not a robust system in place to identify and manage people's assessed risks in an appropriate, safe and timely manner. The provider had not notified the CQC of all incidents they were legally obliged to notify us about.

After the comprehensive inspection on 7 December 2016, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook an unannounced focused inspection visit to Cherry Hinton Nursing Home on 7 April 2017. This visit was carried out by an inspector and inspection manager. This inspection was to check the provider had made the necessary planned improvements to meet legal requirements.

We inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led. This was because the service was not meeting legal requirements in relation to Regulations 12,13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and Regulation 18 of the Care Quality Commission (Registration) Regulations (part 4) 2009.

Before the inspection we looked at the information we hold about the service, including statutory notifications. A statutory notification is information about important events which the provider is required to tell us about by law. We also looked at whether we had received any other information in relation to the four breaches, including complaints and information shared by other health and social care organisations. This information aided us with our inspection planning.

During the inspection we spoke with the nominated individual, home manager, deputy manager and two

nurses. We observed people's care to assist us in understanding the quality of care people received.

We looked at three people's care records in relation to their risk assessments, including staff guidance for 'as required' medication and the management of their deemed risk. We also looked at staff training records; safeguarding records; health and safety meeting minutes; incident and accidents records and quality monitoring records and corresponding action plans.

Requires Improvement

Is the service safe?

Our findings

At our focussed inspection of Cherry Hinton Nursing Home on 7 December 2016 we found that people were placed at risk of avoidable harm and risk of harm. This was because the provider had failed to assess the risks to people's health and safety and there was a failure to report on-going concerns to relevant external healthcare professionals for specialised guidance and support. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 7 April 2017 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12.

We looked at accident and incident records since the last inspection and found that there were people who had experienced a number of falls. Records we looked at showed that people were being monitored on the number of falls they were experiencing. Where appropriate, we saw that referrals had been made in a timely manner to external healthcare professionals. These included referrals to the falls team for specialised guidance and support on how to manage the risk safely and where possible reduce the risk of recurrence. This is now in line with the providers falls prevention policy.

Records showed that there were recurring incidents of people with behaviour that could challenge themselves or others. Documents designed to assess and monitor a person's behaviour over a period of time were being used and where appropriate a referral had been made to the community psychiatric nurse for guidance. A staff member told us, "[We] do everything we can to keep people safe."

At the last inspection we noted that there were a high number of bedrails in use throughout the service. Bed rails are used to reduce the risk of people falling out of their bed. People should only use bedrails when it has been risk assessed that it was safe to do so and that the person was at risk of falling from their bed. During this inspection, records showed that staff had re assessed the risk and people with bedrails in place were deemed as needing them in situ for their safety. A staff member said, "We don't use bedrails as much as we used to. These are a restriction. We will use the alarm mats where we can. [We] will use crash mats [padded mats] and alarm mats at night for some people as safer." This demonstrated to us that staff assessed and monitored people's risks and took action in a timely manner to reduce the risk of unsafe care and avoidable harm.

At our focussed inspection of Cherry Hinton Nursing Home on 7 December 2016 we found that the provider had failed to notify the local authority of all safeguarding concerns as per safeguarding protocols. This was a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 7 April 2017 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 13.

On review of accident and incident forms we found that the provider had notified the local authority of all

potential safeguarding concerns as per safeguarding protocols. Staff had received either training or refresher training in safeguarding since our last inspection and were aware of their duty to report suspicions of harm and/or poor care. This training was attended by all staff including non-care staff. Records we looked at, evidenced to us that staff had reported any concerns that they had to the home's manager and that these concerns were listened to, referred to the local authority safeguarding team and investigated.

People had been safeguarded against the risk of having their liberty unlawfully restricted. Records showed that people assessed as lacking the mental capacity to make their own decisions had applications made to the local authority supervisory body to lawfully restrict their liberty.

Requires Improvement

Is the service well-led?

Our findings

At our focussed inspection of Cherry Hinton Nursing Home on 7 December 2016 we found that there was a failure by the provider to have systems and processes in place that enabled them to identify where quality of care and safety was being compromised and to respond appropriately and without delay. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 7 April 2017 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 17.

We looked at how incident and accidents were managed and responded to. We found that there were robust systems in place to monitor and analyse information to identify where action was needed. We saw that the provider's representative and the home's manager took action to make the necessary improvements to reduce the risk of the incident/accident recurring.

Incidents and accidents were discussed at the health and safety meetings held quarterly and actions to reduce the risk of recurrence were implemented as a result of learning from these incidents. One staff member told us, "Communication is better, as what is talked about at meetings gets seen through [done]." Organisational visits were undertaken by the provider's representative to monitor and report back on the quality of the service provided.

We saw that the provider had a quality assurance framework tool in place which monitored the service being provided. Part of this included monitoring falls. This collated the number of falls people had, whether there was any patterns around these falls and actions taken including notifying the CQC of any serious injuries sustained. This demonstrated to us that there were now systems in place to assess and analyse information gathered to identify where action was required to reduce the risk of recurrence. These actions taken were now carried out in a timely manner.

At our focussed inspection of Cherry Hinton Nursing Home on 7 December 2016 we found that there was a failure by the provider to notify the CQC of all incidents that they were legally obliged to when carrying out the regulated activity. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

At our focused inspection on 7 April 2017 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 18 (Registration) Regulations.

At this inspection we found that the provider had notified the CQC, without delay, of all incidents that they were legally obliged to notify us about.

There was no registered manager in place. The provider had appointed a new home manager who was currently going through the application process with the CQC to become the registered manager. The manager was supported by care staff and non-care staff. Staff spoke highly of the new home manager and

the management team. A staff member said, "The home is moving forward in the right way, management is a lot stronger, they know what is going on and are not just stuck in their offices."

During our visit we noted that the provider had not displayed their previous CQC inspection rating within the service. They had displayed their rating on their website. It is a legal requirement for a provider to display the rating of their most recent CQC inspection within a communal area of a service and on their website. During this inspection the ratings display template was downloaded and displayed within the reception area of the service.