Care Quality Commission

Sovereign Health Care Associates Limited

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

Overall summary

This inspection took place on 10 March 2015 and was unannounced. We did not have any concerns with the service at our previous inspection in April 2014.

The service provided accommodation, nursing and personal care for up to 40 people. At the time of the inspection there were 35 people who used the service.

The home currently did not have a registered manager, but a person had been recruited for this position and was due to start shortly. 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.

People who used the service experienced delays and had to wait for the care and support they required because there were insufficient numbers of staff.

People were not always kept safe because their health and wellbeing were not consistently identified and managed. People did not always receive their care as planned.

Summary of findings

Medication was managed by the nursing staff. People did not always receive their medications as they had been prescribed by their doctor.

Some people who used the service were unable to make certain decisions about their care. The legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) were being followed. The MCA and the DoLS set out the requirements that ensure where applicable, decisions are made in people's best interests when they are unable to do this for themselves. Arrangements were in place for best interest meetings and decisions to be made when required.

Health care professionals were contacted when additional support and help was required to ensure people's health care needs were met however actions were not always taken following advice and recommendations made by professionals.

People told us they liked the food and had enough to eat. Some people required their daily intake to be monitored in order for them to remain well.

Sometimes people were not treated with the care, compassion and respect they should have received. Peoples' continence needs were not well managed. People experienced institutional regimes and were at risk of skin damage.

Some limited hobbies and recreational activities were available within the home. Some people were at risk of isolation because they stayed in bed and received interaction with staff only when physical interventions were provided.

The home had not had a registered manager in place for a period of time. People told us this has had a negative impact on the provision of care.

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 safe. There were insufficient numbers of staff to meet people's individual needs and keep people safe. Risks to people's health and wellbeing were not consistently identified, managed and reviewed. People did not always receive their medication as it was prescribed.

Requires Improvement

Is the service effective?
The service was not effective. People told us that they liked the food and have sufficient to eat. Some people at risk of dehydration were not always monitored effectively to ensure they drank sufficiently.

Requires Improvement

Is the service caring?
The service was not always caring. People gave mixed feedback about their interactions with staff and we saw that people were not always treated with care, compassion and respect. People's independence was not always promoted and some of the staff's actions disabled and restricted people.

Requires Improvement

Is the service responsive?
The service was not responsive. Recreational activities were arranged for some people, but some people stayed in bed all day and were at risk of isolation. People told us they knew how to complain but that recently their concerns had not been resolved to their satisfaction.

Requires Improvement

Is the service well-led?
The service was not well led. The home had not had a registered manager for a considerable period of time. Staff morale was low because of the staff shortages and the lack of managerial leadership, this impacted on the care and support provided to people.

Requires Improvement

Conifers 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 inspection took place on 10 March 2015 and was unannounced. The inspection team consisted of two inspectors.

We looked at the information we hold about the service. This includes notifications of significant events that the provider had sent us, safeguarding concerns and previous inspection reports.

We spoke with 12 people who used the service and observed their care. We spoke with five people who visited their relatives, the area manager, a registered nurse and five members of care staff. We looked at five people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service, these included staff rosters, the staff training records, three staff recruitment files and the provider's quality monitoring audits.

These records helped us understand how the provider responded and acted on issues related to the care and welfare of people and monitored the quality of the service.

We contacted the local authority commissioning officer for their views on the service. We used this information to support the planning of the inspection.

Requires Improvement

Is the service safe?

Our findings

Without exception people told us the staffing levels were insufficient to meet the needs of people. One person told us: "The staff are always very busy, there is not enough of them and we have to wait until they have finished looking after other people". Another person told us: "Sometimes I have to wait to go to the toilet and it's painful". We heard a person ask a nurse to help them to the toilet. We saw a delay of 10 minutes before the person was offered support because two staff were needed and care staff were busy supporting other people.

A visitor told us: "We visit every day so that we can make sure that [Person's name] has a meal; they need help, and there are never enough staff so we [family] need to be sure that they get the meal". Another relative said: "Staffing is a problem there are never enough of them to do anything but the routine care". Staff told us that all people who used the service needed some level of support with washing and dressing. Some people needed the assistance of two care staff to support them with their daily hygiene needs. One staff member told us: "We are continually under pressure and stressed because we know that we should be doing more, but we just haven't got the time as there is not enough of us".

Two care staff members had failed to turn up for work, so this added to the workload of the remaining staff. The area manager arranged for an agency care staff to work and they arrived late morning. The agency staff told us this was their first time at the home and did not know the care and support needs of people. They were allocated to work with existing staff. We saw they provided support to people with supervision from other care staff. Care staff although appreciative of the additional help told us that this created further delays as they had to spend time explaining the work that was needed to the agency care worker.

People had to wait for long periods of time before staff were available to support them with their daily personal hygiene requirements. We saw people waited for long periods of time to be helped from the dining room to the lounge areas. When in the communal areas people sat in their wheelchairs for a further period of time before staff were available to help them into more comfortable seating.

The evidence above meant that people were experiencing delays and at risk of not receiving the care and support they required because there were insufficient numbers of staff. Therefore there had been a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that some people needed support to decrease the risk of them coming to harm. Risk assessments were in place but people were not encouraged to be independent. For example some people who could walk with support were in wheelchairs when moving from area to area. Another person was at risk of falling due to immobility. We saw two different walking frames were in the person's bedroom. Staff were unable to tell us which frame the person used when they needed support with walking and to reduce the risk of them falling.

Staff told us and we saw that most people needed help with transferring from area to area.

We saw care staff supported one person to move from an arm chair into a wheelchair. We observed that the person was lifted up by staff holding on to the back of the person's trousers. The person's risk assessment and management plan for moving and handling indicated that the person required a standing aid hoist to stand. This had not been used. This meant that the person had been at risk of harm because they had not received care as planned.

We saw a person was given two biscuits in the lounge and they were then left alone and unsupervised, and at lunchtime we saw they were provided with a pureed meal. Staff confirmed and their risk assessment recorded that a soft diet was required. The risks of harm to this person was not consistently identified or managed to promote their safety.

The evidence above meant that people were not in receipt of safe care and were at risk of harm. Therefore there had been a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with explained how they would recognise and report abuse, they were clear on the actions they were required to take. One staff told us they would report any concerns to the most senior person on duty but would follow it up and report further if they felt that it hadn't been responded to appropriately. Information on the safeguarding procedures were displayed in the main staff office. Staff had access to the information should they need to refer to it.

Requires Improvement

Is the service safe?

Medication was managed by the nursing staff. They told us and we saw how they stored and administered medication to people. Some people required medication that can be given on an 'as required' basis. Staff told us they were aware of when these medicines could be given. One person who suffered with anxiety problems had been prescribed medication that could be given on "as required basis" to help them with their anxiety. Staff told us and records showed that they had been given this medication on a regular basis. Staff said they gave the medication to pre-empt the feeling of anxiety. However, this regular administration of the medication had not been reviewed or agreed by the doctor.

Care staff told us that some people required creams and lotions to help reduce the risk of sore skin. We saw that the nurses signed the medication administration records to indicate care staff were applying these creams. The nurses confirmed they had not witnessed the care staff apply the creams but were confident that the care staff completed the task. We spoke with one member of care staff they told us they would check with the nurses if they were unsure of which cream to use

Requires Improvement

Is the service effective?

Our findings

Staff told us they received sufficient training for them to do their job. The provider employed an in house trainer to roll out the training to staff. One staff member commented they found the face to face training sessions useful. The Mental Capacity Act 2005 (MCA) and the Deprivation of liberty Safeguards (DoLS) set out the requirements that ensure where applicable, decisions are made in people's best interests when they are unable to do this for themselves. Staff we spoke with had knowledge of the MCA and DoLS. The staff demonstrated they understood the principles of the Act and the DoLS and we saw them seeking people's consent before they assisted them with the needs during the day. The area manager told us no one at the home currently required a DoLS application and people were not subject to any restrictions.

We saw mental capacity assessments had been completed which indicated the level of support an individual needed with decision making. One person was able to make decisions about their everyday life but would find it difficult understanding and making more complex decisions. We saw people's representatives had been involved in making decisions in their best interests when they were unable to do so themselves.

Some people had a Do Not Attempt Cardio Pulmonary Resuscitation order (DNACPR) on file. This is a legal order which tells a medical team not to perform Cardio Pulmonary Resuscitation (CPR) on a person. Where people were unable to make this decision we saw that their doctor and representative had been involved in the decisions. This meant that in the event of a medical emergency, people's preferences would be upheld.

Most people told us the food was good. One person who used the service said: "I have enough to eat and drink, in fact I have too much sometimes". Another person commented: "No one asks me what I would like to eat, I have what is given, and I don't have a choice". Staff told us a selection of food was provided each meal time and people were offered a choice. We saw that the heated trolley used at lunchtime contained various options.

Most people had their meals in their bedrooms; care staff served the meals to them. Staff told us that some people liked porridge for breakfast and they served them as needed. We saw a large uncovered bowl of porridge on an open uncovered trolley in the corridor on the first floor. A skin had formed on the top of the porridge which indicated that it had gone cold. The midday meal was served to people on the first floor from a heated trolley to ensure that the food was at a suitable temperature for the people to enjoy. Staff were unable to tell us why the heated trolley was not used at breakfast times.

Staff told us that they monitored the food and drinks people had each day because people were at risk of malnutrition and dehydration. Some people remained in bed all day and required staff to provide them with refreshments. We saw that monitoring records were completed by staff each day. These were totalled at the end of the 24 hour period to record the amount of fluid people consumed each day. There was no information in the care plans or risk assessments of the amount of fluid each person needed to consume daily for them to remain well hydrated. Staff were unable to tell us how much fluid each person needed to consume each day. Effective systems were not in place to reduce the risk of people becoming dehydrated.

Some people who used the service had complex needs requiring specialist care and support from the nursing staff. External healthcare professionals were contacted if additional help and advice was needed. For example a doctor and district nurse had been contacted for advice regarding the use of catheters. We saw there was a delay in actioning the advice from the health professionals. Staff offered a reasonable explanation as to the cause of the delay and confirmed that follow up action had been taken.

Requires Improvement

Is the service caring?

Our findings

People were not always supported to maintain and preserve their independence. No-one was independently walking about; people were either in bed, sat in the communal areas or in wheelchairs. We saw a person being transferred manually into a wheelchair by two care staff. We saw that they had a walking frame close by them. The mobility record for the person identified that they should be offered support to take a few steps each time they wished to move. We did not hear staff ask the person if they wished to take a few steps when they wanted to move to another area of the home. They were not given the opportunity to mobilise independently.

People told us that care was rushed and care was not personalised. Staff told us they did not have the time to spend quality time with people. One person who used the service said: "I am a human being and feel I could be treated better". A visitor commented: "They [care staff] are always so very busy, they never have enough time they are always rushing about. I feel sorry for them". A member of staff told us they did not have the time to spend with people to find out how people were feeling or to do the 'extras' that were needed. We observed staff were very busy throughout the day.

Some people told us staff treated them kindly. One person remarked: "They [the staff] are nice to me when I am not nice to them. Whatever I ask they would help me". We saw that staff were considerate and thoughtful when they interacted with people. We saw a kind and caring interaction between one member of care staff and a person living at the home. The person was a little unsure of where they were, staff knelt down to the person's eye level and offered an explanation and reassurance.

People's privacy was respected, staff were careful to ensure bathroom, toilet and bedroom doors were closed when people required support with their hygiene needs. Two people shared a bedroom, both were in bed for the duration of the inspection, a visitor was asked to leave the room when one of the people required staff support. Privacy curtains were provided between the beds to afford each person some degree of privacy.

Requires Improvement

Is the service responsive?

Our findings

People told us that each week day morning some sort of recreational activity was arranged for them to participate in. A member of staff was employed to arrange recreational and leisure activities each weekday morning. During the morning we saw two people participated in arranging some flowers and a small group of people played ball. During the afternoon no staff were available to arrange or facilitate any activity. One person told us they liked to receive Holy Communion each month and they looked forward to this certain time when the local clergy visited.

One person, who stayed in bed for the majority of time, told us: "I stay in bed as it is too much trouble for the staff to get me out. I need the hoist and two staff to move. I like music and seeing the singer that comes in. I asked someone if I could go down [into the communal areas] when he was next on. No one told me when he last performed so I wasn't able to see him or join in". People told us they did not go out unless with relatives or to hospital appointments.

Staff told us that most people needed help with continence and as such incontinence aids were used. Each person had an allocated number of continence pads for the 24 hour period. Staff told us that 'care rounds' were made routinely each day, where staff would change the incontinence pads. They went on to say that 'sometimes people were washed and creams applied but not always'. We saw instances where people experienced sore skin because of incontinence and the lack of basic care. One person told us that currently they had a 'sore bottom'. We looked at their records and saw that 'moisture lesions' had been identified, staff were instructed to 'monitor for two days'. Staff were unable to tell us what the current regime for this person was in regard to skin care. Continence care was not managed properly and people were at risk of developing sore skin and being uncomfortable.

We saw that 26 people who used the service stayed in their rooms all day. Some people told us that they would like to sit out of bed more often. One person said: I don't like to bother the staff as they have so much to do". Staff told us that the lack of suitable seating was one of the reasons that people stayed in bed. We met one person who told us they did not get out of bed very often but would like to do so when they felt well enough. Their care plan instructed staff to use a certain type of chair that would 'hold legs in a comfy position'. This certain chair was not in the vicinity of the person and staff confirmed that there were none available.

The failure to provide care in a manner that promoted people's welfare and safety meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All people had a plan of their care and support needs; however we saw very little involvement of people or their representatives in the care planning and review process. One visitor told us they had spoken with staff about the care of their relative but had not seen any paperwork. The area manager told us that the relatives of two people who used the service had recently been involved with a care review. We saw that arrangements were made to invite relatives to these meetings so that people could be more involved with discussing and agreeing their care and support needs in the way they preferred.

People told us they would speak to their families and relatives if they had concerns regarding the service. One person did not have relatives that visited; they told us they would speak with staff. Visitors told us that they would speak with staff and someone in 'the office' if they had concerns. They told us that the nurses and care staff tried to help them when they had concerns with the care of their relative.

Requires Improvement

Is the service well-led?

Our findings

The home did not have a registered manager. Four people had been appointed within the last two years as the acting manager but had left for various reasons. Another person had recently been recruited; the area manager told us they would be starting work shortly. Staff told us that the lack of management has had an impact on the running of the home and the constant changes had been difficult. They said: "Morale is low because of the staff shortages and the lack of managerial leadership". Visitors told us that there had been 'no clear leadership' and that 'someone needs to come and see what is really going on' for the benefit of people who used the service and the staff. An area manager had been allocated to oversee the home and had been in the post for three months.

Relatives said the care has 'gone down over 12 months'. One person said: "It's not as nice as it used to be". There has been a lack of consistency in how the service has recently been managed and led; this has impacted on the quality of the care provided to people.

Checks and audits were completed on a regular basis and an action plan completed when shortfalls were identified. A recent 'residents quality survey' had been analysed following comments received from people who used the service. People commented on the food, activities, environment, staff and support. People said they liked the food but they were not always asked their choice, staff did not always answer the call bell in a timely way and more activities would be good. The area manager commented that the lack of a manager has had an impact on implementing the changes needed in a timely way. They told us they had been working with the nurses and staff to make improvements to the way the service operated.

Staff meetings were arranged for all staff when needed. Minutes of the meetings were available for reference. A meeting in 2014 with care staff identified the need for a member of staff to be in the lounge area after 6pm. Relatives and 'residents' meetings were held, at the most recent one the staffing levels and the availability of staff in the lounge areas were discussed. Two relatives told us that they had attended the meeting in January 2015 where it was discussed that that more staff supervision was required in the lounge area. The area manager provided us with a copy of the 'lounge protocol' which was a record for the monitoring of the lounge on a regular basis. They told us this had not been implemented and was unsure when it would be.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of service users must be appropriate, meet their needs, and reflect their preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements.**