

## All Hallows Healthcare Trust

# All Hallows Nursing Home

### Inspection report

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### Ratings

#### Overall rating for this service

Requires Improvement ●

Is the service safe?	<b>Requires Improvement</b> ●
Is the service effective?	<b>Requires Improvement</b> ●
Is the service caring?	<b>Good</b> ●
Is the service responsive?	<b>Requires Improvement</b> ●
Is the service well-led?	<b>Requires Improvement</b> ●

# Summary of findings

## Overall summary

All Hallows Nursing home provides accommodation and nursing care for up to 50 people. It also provides rehabilitation services and end of life care. When we inspected on 27 October 2016 there were 40 people using the service. This was an unannounced inspection.

There was a registered manager in post. 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.

During this inspection, we found that the registered provider was in breach of two regulations 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

We found that care plans focused primarily on the clinical aspects of people's care, but contained less information to guide staff on how to support people with their emotional and social care needs. Having this information would help staff to tailor individual needs more fully.

A range of risk assessments were in place, but some risks had not been identified, such as those associated with choking. This meant that staff were not provided with guidance on how to reduce risks to people in this event. In addition risk assessments relating to bed rails did not reflect the most up to date guidance to ensure staff followed best practice, and we have made a recommendation about this.

Quality assurance systems were in place, but needed to be analysed more fully to understand its significance and to ensure that the care people were receiving was responsive to their needs. A complaints procedure was in place. However, analysis and oversight of feedback received was not sufficiently robust to ensure themes were identified and lessons learnt.

Best practice was not being promoted or considered fully for people who were most vulnerable, such as people approaching the end of their life, and people who were living with dementia.

People's nutritional needs were assessed, but the service needed to improve how they supported the specialist nutritional needs of people living with dementia. We have made a recommendation about this.

People were supported by staff to take their medicines safely. However, protocols which guided staff on when to offer medicines which were prescribed "As required" were not in place. Guidance was not in place for topical applications, such as creams.

People had access to activities, however, people were not always protected from social isolation. The range of activities available were not always appropriate or stimulating for people. Staff needed further training in

how to provide meaningful activities which support the specialist needs of people living with dementia.

People sought consent from people before providing support. However, some staff did not understand what the Mental Capacity Act meant for people living in the service, and how this could impact on the care they received.

Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

Staff respected people's privacy and dignity at all times and interacted with people in a caring, respectful and professional manner.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

The culture in the service was welcoming, friendly, and person-centred. The management team presented as open and transparent throughout the inspection, seeking feedback to improve the care provision.

## 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** ●

The service was not consistently safe.

People were supported to take their prescribed medicines. However, protocols and guidance were not available for medicines which were taken 'As required', or for topical applications.

Risk assessments were not in place for people at risk of choking. Risks relating to the use of bed rails did not reflect the most current guidance.

Staffing levels were calculated and provided to ensure that people's needs were met.

Staff recognised types of abuse which they could come across in their work, and their responsibility to protect people from abuse.

### Is the service effective?

**Requires Improvement** ●

The service was not consistently effective.

Staff sought people's consent before providing care and support. However, staff knowledge in relation to what MCA meant for people living in the service was limited. Documentation in relation to Best Interest Decisions were not easily identifiable within care records.

People's food and fluid intake was not always monitored effectively.

People were supported to maintain good health and had access to healthcare support in a timely manner.

### Is the service caring?

**Good** ●

The service was caring.

People were treated with respect and dignity by staff who delivered compassionate care.

The atmosphere in the service was relaxed and people were

listened to.

People were supported to see their relatives and friends.

### **Is the service responsive?**

The service was not consistently responsive.

Care plans held large volumes of information, making it time consuming to identify key care requirements. Care plans needed to be developed to fully reflect people's emotional and social care needs.

The range of activities available were not always appropriate or stimulating for people living with dementia.

There was a complaints procedure in place. However, analysis and oversight of feedback needed improvement to identify themes and ensure lessons were learnt.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not consistently well-led.

Quality assurance systems were in place, but not sufficiently organised or analysed to identify where improvement was needed.

Best practice was not being promoted or considered fully for people who were most vulnerable.

There were systems in place to ensure regular feedback from people, relatives and staff.

**Requires Improvement** ●

# All Hallows 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 27 October 2016 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service: what the service does well and improvements they plan to make. We reviewed information we held about the service, such as notifications and information sent to us from other stakeholders for example the local authority and members of the public.

We 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 speak with us, for example, people living with dementia.

During the inspection we spoke with eight people living at the service, and four relatives. We also spoke with the Chief Executive Officer, the registered manager, deputy manager, activities co-ordinator, and five care and catering staff. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met, we looked at records in relation to five people's care. We also looked at records relating to the management of the service, recruitment, training, and systems for monitoring the quality of the service.

# Is the service safe?

## Our findings

People told us they felt that staff supported them well with their medicines. One person told us, "Yes I get them [medicines]. They come round virtually on the dot. You can have pain relief if you need it". Another said, "They ask me if I need any pain relief, I don't take anything unless I really feel I need to take it".

People were supported to take their prescribed medicines. We saw that medicines were stored securely, with appropriate facilities available for controlled drugs and temperature sensitive medicines. Each person had a lockable cabinet in their room which stored their individual medicines. Some people were prescribed topical applications, such as creams. However, there were no body maps or detailed information on where to apply these or why it was being used. This information is important as it ensures that creams are applied correctly and at appropriate intervals.

For people receiving medicines "As required", there were no protocols in place for staff to follow on when to offer these medicines. This information is necessary where people may not be able to verbalise how they are feeling, and would provide staff with information, such as symptoms a person may display if they were in pain. One person was prescribed medicines for agitation, but there was no clear information on interventions which may work to reduce the agitation before the medicines were considered. Having a protocol in place would reduce the risk of medicines being given when they may not be needed.

We discussed the above concerns with the registered manager. Following the inspection the registered manager contacted us to confirm that documentation had been implemented and we will check to see how this is working at future inspections.

There were systems for people who chose to independently manage their medicines. Where this was in place, a risk assessment had been completed which determined if this was safe, and the person had signed to agree. We observed good practice when medicines were being offered and given to people. The service had recently been visited by the local pharmacist to review their current procedures; their report showed that generally systems were working effectively. Where advice had been given by the pharmacist, action had been taken to follow this.

People's care records included risk assessments and guidance for staff on the actions that they should take to minimise risk. These had been reviewed to ensure any needs which had changed were updated. These included moving and handling, falls, nutrition, skin integrity and the use of bed rails. However, the bed rails risk assessment being used was not in line with the most current guidance. We discussed this with the registered manager, who confirmed they would implement a strengthened risk assessment framework promptly.

We recommend that the service explores current guidance from a reputable source [Such as the Health and Safety Executive] in relation to ensuring the safe use of bed rails, and the associated risks which should be considered when assessments are completed.

We also found that some people had thickened fluids prescribed, which would indicate they were at risk of choking. However, there were no risk assessments in place to provide guidance to staff on how to minimise the risks associated with choking, such as positioning people in a safe position when they are eating or drinking. We brought this to the registered managers' attention, and following the inspection they informed us that risk assessments were now in place for all people at risk of choking.

Personal Emergency Evacuation Plans (PEEP) were not recorded within people's care records. These show the support people require to evacuate the building in an emergency situation and should be available to staff. The registered manager told us they would review this in line with their fire procedures.

Risks to people injuring themselves or others were limited because equipment, including electrical equipment and hoists had been serviced and checked so they were fit for purpose and safe to use. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria.

Staff had been provided with training in safeguarding people from abuse. They understood their roles and responsibilities regarding safeguarding, including the different types of abuse and how to report concerns. One staff member said, "I have reported concerns before to the matron [Registered manager] and it got sorted". Another said, "Any issues we see get reported, it's not brushed under the carpet". We had received notifications from the service which identified that they had raised safeguarding referrals with the local authority, who were responsible for investigating safeguarding concerns, when staff had been concerned about people's safety.

People's comments on staffing levels varied. One person told us, "Oh yes, enough staff, they're always there to help". Another said, "Sometimes the staff are rushed". A staff member said, "When we are at full complement it's fine, but if training is on and staff have to attend it makes it a bit short". Our observations were that staff responded to people's requests for help in a timely manner, and that people were not rushed when being assisted. Staff on duty carried pagers, which alerted them when a person needed assistance, or in the case of an emergency. This system ensured that resources were used effectively and people's safety was monitored. The registered manager told us that they calculated staff based on the dependency needs of people but did occasionally use agency staff if needed. They did however try to use regular staff so they were familiar with the service and got to know people's needs.

People were protected by robust procedures for the recruitment of care workers. Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.



## Is the service effective?

### Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager was aware of the DoLS authorisations in place and when these needed to be reviewed.

People's care records made reference to their mental state, including decisions made in a person's best interests. However, where best interests meetings had taken place, these were not easily identifiable as they were recorded within the daily notes, which included a range of general information. Important information such as best interests meetings should be formally recorded, detailing who was present and what decision was being made in the person's best interests. This information needs to be known and understood by staff providing care. We discussed the importance of this with the registered manager, who told us they would implement a separate form so it was clear when these were in place.

We observed staff asking people for consent prior to assisting them with tasks such as administering medicines, assisting people to eat, and deciding where to spend their time. One person said, "[Nurse] knew that I had to go to hospital, but still asked me if I was happy to go. They always make sure they have my consent". Some staff knowledge around the MCA indicated a lack of understanding about what the MCA actually meant for people living at the service. The registered manager told us that all staff attended mandatory MCA training [75% compliant] but they had also planned more advanced MCA training in December 2016 to further underpin staff knowledge and application of the Act.

Where people required assistance, they were supported to eat and drink enough and maintain a balanced diet. This included keeping records of their food and fluid intake when there were risks, preparing and providing food and drinks and encouragement of drinks. However, some fluid charts had not always been totalled to establish the total fluid intake for each day and to monitor that the intake was adequate for their needs. This meant it was not consistently clear how concerns in relation to fluid intake were escalated or addressed.

Where people were at risk of losing weight, food supplements were used to support weight gain. However, the use of nutritional snacks between meals were not documented and was a missed opportunity to

support weight gain. Where people had needed the specialist advice of dietician's or speech and language therapy, referrals had been made to the appropriate professionals.

We recommend that the service explores current guidance from a reputable source [Such as the Social Care Institute for Excellence or the Alzheimers Society] in relation to supporting the specialist nutritional needs of people living with dementia, and the range of options which can be considered in meeting people's individual needs.

We observed the lunchtime meal. The atmosphere was relaxed, and people were seen to be chatting to one another. People said they enjoyed the food, but sometimes the meat was hard to chew. One person said, "Food is always good, but the pork is so tough you can't chew it", and, "Yes, it's always the meat that's the problem". Another commented, "I can't say anything bad about it, it's one of my passions, I love my food. I think it's because it's all done 'in-house', all fresh".

Several staff were available at all times throughout the meal, offering a variety of drinks and discreetly supporting people who required assistance with eating and drinking. This was not rushed, and staff assisted people at the pace needed to eat safely. One person said, "They cut my food up for me, they know, I don't have to ask them. They kept me on a soft diet, now they've gradually returned me to normal food".

Staff were provided with the training that they needed to meet people's needs. This included an induction before they started working in the service consisting of mandatory training such as moving and handling and safeguarding. The induction lasted over a period of three months, and each staff member had an induction on commencing employment at the service and shadowed staff to gain knowledge of the role. Staff received an "orientation" booklet, which was signed off as the staff member became competent. The Human Resources department provided us with information relating to the training records of staff. Where training was due to be undertaken, we saw that staff had been booked to attend. Other more specialist training included palliative care [care of the terminally ill], first aid, and dementia awareness. However, staff needed more knowledge of supporting people with dementia to have access to stimulating activities. For example, we saw one person who spent the day restless in bed. A picture had been placed on the ceiling for the person to look at whilst in bed. However, we observed that the person was not aware of it even being there.

The service was up to date with current best practice guidelines in relation to training in health and social care, including the introduction of the Care Certificate, which we saw had been completed by three new members of staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work. Records showed that staff were provided with one to one supervision meetings. This showed that staff were provided with the opportunity to discuss the way that they were working and to receive feedback on their work practice.

People were supported to maintain good health and have access to healthcare services. A GP visited the service twice weekly, which enabled staff to raise concerns about people's health in a timely manner, and for the GP to monitor people's progress. Staff were guided in care records about what actions they were required to take when they were concerned about people's wellbeing.

## Is the service caring?

### Our findings

People told us that the staff were kind and caring. One person said, "Wonderful staff, they're marvellous, they never say no to anything, nothing is too much trouble for them". They [staff] take their time in what they do for me, they don't make me feel rushed, they're very good, even though I know they're busy". A relative said, "I must say outstanding staff, they are really wonderful. Everyone, even the maintenance man, are all lovely". It really is like one big family, if you feel a bit down you get a cuddle".

Staff communicated with people in a caring and respectful manner and spoke about them in a respectful way. They communicated in an effective way by making eye contact with people and listening to what people said. People appeared relaxed in the presence of staff. Where people responded well to humour, staff joked with people and there was lots of laughter.

People told us they were involved in creating their care plans. One person told us, "They usually discuss it with me [care plan] if they are going to make any changes and I have an opportunity to say what I think". They allow my [relative] to be involved, they check it with [relative]". A relative told us, "[Relative's] care plan was reviewed this year, and we were involved".

Daily care plan summary sheets were included in care plans, and were written in a way that demonstrated that people had been involved. Statements were constructed by people, for example, "I will ring the bell if I need assistance. I am able to ring the bell and ask staff when I need help". Care plans also included information on how people liked to spend their day. In one case, a person expressed a wish to see their pet daily as this was important to them. The service made the necessary arrangements and this was put in place.

People's privacy and dignity was respected. A nurse told us, "We always do eye drops when they [people] come back from lunch [to their bedroom] so they can be done in private". One person said, "When they're [staff] washing you they cover you up with a towel, they're [staff] very good. They knock on the door, every time. It's their values". We also observed that when people were given their medicines in a communal area, this was carried out discreetly, so others were unable to see.

There was a yearly resident forum where people and relatives could raise any issues. The last meeting in February 2016, was attended by the Chief Executive, the registered manager and other support staff from the service. It was well attended by people and their relatives, and discussed general matters that people raised, alongside action which should be taken, and who was responsible for each action. This meant that actions would be discussed and reviewed at the following meeting. There was also a six monthly resident survey, which enabled people to feedback their views. The survey in August 2016, showed mainly positive scores relating to the care that people received.

Staff ensured that people's views were also heard on an individual basis. For example, in one care plan for a person receiving rehabilitation, we saw that relatives felt that the person needed another month of rehabilitation before returning home, but medical professionals felt that the person would be able to

manage. The person themselves had expressed a wish to return home. Staff had recorded that the person had a right to take risks if they wanted to return home. This demonstrated that staff were advocating on the person's behalf and ensuring their views were heard.

## Is the service responsive?

### Our findings

People's care records included care plans which guided staff in the care that people required and preferred to meet their needs. Each person had two care plans; one held in their room which staff wrote in, and another held in the nurses' office, which contained confidential information including medical reports, assessments, and nurses' progress notes.

Care plans contained a large volume of information, making it difficult and time consuming for staff to identify the important aspects of people's individual care needs. They were not person-centred or fully focussed on a person's whole life, including their emotional and social care needs. For example, some care plans provided little information about how the person wanted to live their life and how they could be enabled to do so. This extended to their social wellbeing as well as emotional and physical needs.

For example, entries did not provide details about the quality of the person's day and how they had spent it, but more on the clinical aspects of their care. Where information about a person's life was included, it was not informative enough. For example, one care plan said, "Worked in a cinema", and "I have grandchildren that live abroad". There was no further information to build on or which might support staff to have meaningful conversations with people about their lives and what was important to them. There was limited information about what brought wellbeing to people's lives, particularly for people living with dementia, or for people who may spend most of their time in bed. Improvements were also required because the service had not considered the impact and risks to prevent social isolation. This is particularly important where people are developing, or living with dementia.

Displayed on the main notice board was a list of activities available for people to participate in Monday to Friday. These included various board games, craft making, quiz, knitting, painting, movies and music and movement. We spoke with the activities co-ordinator who told us, "I love my job, I just love making people happy. We do music and movement, play instruments, get them singing, it makes people feel at ease. Even if they're not participating, they're aware and involved in their own way".

We observed the records kept of people's participation in activity. Several of the entries did not demonstrate that activity had been completed. For example, one person's activity plan for the whole of October consisted of entries such as, "Up in chair", "Retiring in chair", and "Relaxing in bed". This did not indicate that activity had been encouraged by staff, or if the person had chosen not to take part. A relative had commented in a recent questionnaire, "Staff need more time to just sit and talk with residents. Need more interaction and stimulus. Care is excellent, but I think the social side needs improvement". Therefore the activity provision needed to be reviewed to ensure it was meeting the needs of everyone.

People's records provided guidance to staff on the areas of care that they could attend to independently. However, in some cases we saw areas where this could be improved upon. For example, one person's care plan stated that when providing personal care they, "Require assistance", but it was not clear about what assistance was required, to ensure the person retained their independence as much as possible.

Where people were receiving rehabilitation in the service, their care plans contained information received from community professionals, the GP and relevant medical history. However they had not been developed to demonstrate people's goals for their rehabilitation and how they would be supported to achieve this. It was not clear when people were being supported by occupational therapists and physiotherapists and how this linked in to their overall care plan. The outcome of their interventions were written within the daily notes, making it difficult to demonstrate how people were changing, improving and working towards their rehabilitation and return home.

All of the above constitutes a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they knew how to complain. One person told us "I can honestly say, in the five and a half years I've been here there's been nothing I would say that made me want to make a complaint". A relative said, "They [staff] bring questionnaires, they're straight to the point, we always fill them in".

There was a complaints procedure in place for people to access. However, the log of complaints was not well organised, and was filed with incident and drug error forms, making it difficult to analyse the information held. Actions taken in response to complaints were also not clear. We had to speak with the registered manager to provide further explanations to us. Whilst actions had been taken, there were no lessons learnt logs which identified actions that the service were taking to minimise the risks of similar events happening again. Following the inspection the registered manager told us they had separated the complaints and incidents folder and made the action points clearer. This will help the management team have more effective oversight of recurring themes.

## Is the service well-led?

### Our findings

Quality assurance systems were in place which monitored the safety of the service, but were not sufficiently robust or analysed to identify where improvement was needed. Records showed that checks and audits were undertaken, including medicines and daily care records. However, the analysis of these audits had not identified shortfalls in quality or information which staff needed to ensure people's care was of a good quality. For example, risk assessments relating to choking and the assessment of bed rails. We also noted in several of the care plans we reviewed, that writing at times was illegible, which could cause difficulty for people and professionals to read. They had therefore failed to identify these issues independently, or any recurring themes which could be used to improve the provision of care. Due to the volume of information held, it was not easy to quickly identify where improvement was needed or what action had been taken. Whilst the registered manager was able to explain what was happening, the records did not always reflect this.

There was a call bell audit in place which monitored how long people waited for staff to respond. Some people had waited over 15 minutes to have their call bell answered. When we discussed this with the registered manager, they told us the call bell system had been faulty, and they had called the service engineer in to fix this. However, they were not clear about whether it was now working and asked the maintenance personnel to enquire further. It was not clear from their explanation whether or not people had been waiting for support, whether the issue had been fixed and/or what the system was in place to ensure this was effectively monitored.

We also noted areas where best practice was not being promoted or considered fully for people who were most vulnerable. For example, although the Gold Standard Framework for end of life care had been accredited, it was not being effectively used to ensure people's views were known and understood by all staff caring for them. The registered manager told us that this can be a difficult subject to broach with people, and this was usually addressed when people's health started to deteriorate. There was therefore a risk that people who may deteriorate suddenly, may miss the opportunity to have their wishes and preferences clearly documented in advance. Additionally, many people were living with dementia but the approach to their care was not clearly set out for staff to ensure they lived their days with meaning and as they wished as far as possible.

All of the above constitutes a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection the management team demonstrated an open and transparent manner, actively seeking feedback to improve the service, and a commitment to address any shortfalls. Following the inspection they contacted us to confirm that changes were already being implemented in response to our feedback. The registered manager told us that they were supported in their role by their deputy manager and the Chief Executive Officer [CEO], who communicated regularly with them. They told us they could contact the CEO at any time and they would always respond.

The culture in the service was welcoming, friendly, and person-centred. Staff showed a good understanding of their individual roles and spoke to each other throughout the day as to what was happening and what needed to be done. They were kind and compassionate towards people who used the service, and supported people in a patient manner. Staff told us they felt able to speak up and raise concerns with the management team. However, some staff felt undervalued. One staff member said, "Staff always thank each other at the end of shift. I feel if management adopted this way, it might boost morale. A thank you would be good". Another said, "Good relations between staff, but not as much support from the management as we would like". The registered manager told us that following the staff survey this year, they had already identified that staff wanted communication to improve from the management team and was working on this. Following the feedback they put a board up in the staff room where staff could add agenda items they wanted to be discussed and hoped that communication would start to improve.

People were asked for their views about the service and these were valued. The "residents" questionnaire in August 2016, showed mainly positive responses from residents and relatives in relation to the care they received. Comments received were discussed in the staff group forum meeting so everyone was aware. One person told us "Absolutely fantastic, well led and a lot of hard work to have it running like this". A relative said, "Our family have been very impressed by the care they have shown for my [Relative] and ourselves since [their] transfer".

The registered manager told us how they were planning to improve areas of care provision. For example, linking in with the National Activity Providers Association [NAPA] which is a skilled and specialist activity provider. This could benefit the service by changing how it delivers activities, by looking more closely at the life history of people and how they socialise. They also told us they were planning to implement a new computerised records system which will help to share information about people [with their consent] with NHS staff and multidisciplinary teams involved in people's care. This will provide more effective oversight of people's care and improved communication between professional staff.