Dr Rais Ahmed Rajput

Spring Tree Rest 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?	**Inadequate**

Overall summary

The inspection took place on the 2 October 2014. It was unannounced.

Spring Tree Rest Home had opened in January 2014 and this was their first inspection. The service could accommodate up to 30 people. At the time of our inspection 20 people were using the service.

The service had a registered manager. 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 and associated Regulations about how the service is run.

Staff did not know who to contact if they suspected someone had been abused.

Staff were not following the Mental Capacity Act 2005 for people who lacked capacity to make a decision and had not considered whether people were restricted. People's capacity to make decisions for themselves had not been assessed.

Summary of findings

When concerns had been raised about two people's health care, support from external agencies had not been sought.

People who used the service and their relatives told us that they were happy with the care they received from the service, however they felt that they could be more involved in the decisions about their care and day to day choices.

People received their medication at the appropriate times in a safe manner. However there was no audit trail to ensure that people had received their prescribed medication and equipment used was not regularly maintained.

Care plans and risk assessments had not been reviewed and up dated to reflect a change in people's needs. Risk assessments were not always followed and meant that people were at risk of injury.

Staff did not always feel confident to fulfil their role and had not received training to ensure they could fulfil their role.

From our observations and what people told us, people were treated with dignity and respect. People's privacy was maintained at all times.

The registered manager investigated and responded to people's complaints, according to the provider's complaints procedure.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and have made some recommendations to improve. You can see what action we told the provider to take at the back of the full version of this 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?
The service was not safe. Staff did not know how to raise an alert with the local safeguarding team in the absence of the manager and deputy manager. Risk assessments were not always followed to keep people safe. People's medicines were administered safely by staff that had been trained to administer them.

Requires Improvement

Is the service effective?
The service was not effective. The provider did not work within the guidance of the Mental Capacity Act and DoLS to ensure decisions were made in people's best interests where people did not have capacity. Staff did not feel confident and competent to fulfil their role, because the training they had received had not been sufficient. People's health care needs were not always met. People's nutritional and dietary needs were met.

Requires Improvement

Is the service caring?
The service was not consistently caring as people were restricted within their home. People told us they were treated with dignity and respect. Interactions between staff and residents were kind and caring. Relatives and friends were free to visit and they felt welcome.

Requires Improvement

Is the service responsive?
The service was not responsive. The provider did not always respond when people's needs changed to reduce the risk of incidents occurring again. People's views were not gained about the care they received and individual preferences were not always met. National guidance in supporting people living with dementia was not routinely followed.

Requires Improvement

Is the service well-led?
The service was not well led. The provider did not have systems in place to routinely monitor the quality of the service. Staff had begun to receive individual support and supervision however staff told us they did not feel competent to fulfil their role. Care team meetings had not taken place to gain staff's views in how the service was run.

Inadequate

Spring Tree Rest 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 checked 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.

The inspection took place on the 2 October 2014 and was unannounced.

The inspection team consisted of 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 the 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 also reviewed the information we held on the service.

We spoke to the provider, registered manager, deputy manager, four care staff and the cook. We also spoke to 11 people who used the service and five visiting relatives and two health care professionals.

We looked at the care records for four people who used the service. We looked at seven staff recruitment files, the training records and at the systems the provider had in place to monitor the quality of the service including the complaints log.

Requires Improvement

Is the service safe?

Our findings

A large proportion of the people who used the service were living with dementia. Each upstairs corridor was locked and accessed by a keypad. The staff told us that this was to keep people safe and stop people from using the stairs unsupervised. The registered manager and deputy manager told us that people could ring their call bell in their room if they required assistance from staff but some people would be unable to use the call bell due to their dementia and physical health care needs. We saw records that showed on two occasions two different people had been found by staff in another person's bedroom uninvited. This presented a risk to people and staff we spoke with told us they did not know how to raise an alert with the local safeguarding team in the absence of the manager and deputy manager. The provider had not identified that this arrangement had placed people at risk of harm and had not taken action to ensure people's safety.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed people's medication being administered. Tablets were dispensed into pots from a monitored dosage system. They were taken to the person with a glass of water and staff stayed with people whilst they took their medicine. Medication was stored in a secure medication trolley and was locked when not in use. Photographs of the person were on each person's medication records to ensure the correct medication was administered to the right person.

We looked to see if the provider carried out checks on staff's fitness to work with adults. One staff member had most recently worked in a caring environment but the reference the provider had obtained had not been from their past employer. The registered manager told us that they often had difficulty getting references from other care services. Another new staff member had no references obtained prior to employment with the service and they were present and working on the day of our inspection. Other checks had been carried out to ensure people's suitability to work in the service.

People who used the service and their visiting relatives told us they felt the care was safe at Spring Tree Rest Home. A relative told us: "When I leave having visited my mother I am comfortable that she is in good caring hands and that she is safe." A person who used the service said: "I can talk with some of the staff about any concerns I might have and I feel safe here".

Staff rotas recorded how many care staff were on duty in the morning, afternoon and night. There were cooks who covered the seven day period and domestic staff. The registered manager and deputy manager worked over the seven days. People who used the service spoke well of the staff however some people commented that staff did not have much time to spend with them. One person told us: "The staff are very nice people but we just don't see much of them", they went on to say: "It seems the only time I see the staff is at mealtimes". Another person told us: "They could do with some more staff on duty at times but they are pretty good". We observed that there were sufficient staff to meet people's needs however consideration to the deployment of staff within the home had not been considered. People were at risk at night due to staff not being available to them at all times and some people who required constant supervision was seen to be alone for long periods of time.

Requires Improvement

Is the service effective?

Our findings

We observed that people could not go outside the home or to different parts of the building without staff support. We saw that people were confined to bedroom areas without the ability to call for assistance or move from the locked areas. Staff confirmed that some people did not have capacity, but assessments had not been completed to determine this and the provider had not considered what may be in people's best interests. The Mental Capacity Act (MCA) is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so and the Deprivation of Liberty safeguards ensures that people are not unlawfully restricted. Staff told us they had not received any training in the Mental Capacity Act 2005 [MCA] and in the Deprivation of Liberty Safeguards [DoLS]. We saw that people may be unlawfully restricted and the provider had not taken action to ensure that people were not being deprived of their liberty.

One person's GP had advised that a person was admitted to hospital. The staff had informed the person's relative of this advice and the relative had requested that they did not admit the person to hospital. The staff had followed the relative's advice. We saw an incident of a similar nature where a relative had requested that medical intervention was not gained for their relative and the staff had again followed the relative's advice. They informed us that they had taken the advice of the families although they had been concerned about the person's welfare. The registered manager had not considered people's capacity to decide for themselves and had not carried out a best interest decision where people were not able to make a decision for them self.

These issues meant a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There had been a recent incident where external agencies had to be called in an emergency to support the care staff with a person who had exhibited behaviour that challenged. The registered manager told us that the person's community psychiatric nurse [CPN] had been contacted for support following the incident. Care plans and risk assessments for this person had not been up dated and reviewed following the incident. We spoke with four care staff who were unable to tell us how they would manage a similar incident and had not received training to support this person with complex needs.

This was a breach of Regulation 23 of The Health and Social Care Act 2008. (Regulated Activities) Regulations 2010.

All the staff we spoke to told us that they had attended a one day training event which covered safeguarding procedures, medication, first aid, health and safety, food hygiene, infection control and moving and handling practise. Staff told us they did not feel that there had been enough time designated to each subject for them to be competent and confident in the subjects.

We observed breakfast and lunch time. At breakfast people had what they chose. Some people had cereal, others had toast with preserves and someone else had egg on toast. At lunchtime we did not see that people were offered a choice. People were presented with a roast beef dinner. The food itself looked appetising and people were supported in a patient and caring manner when they required help. One person told us: "The food is alright I suppose, I would like some dishes like curry and rice but we don't get this. There is enough choice on the menu and I get enough to drink throughout the day". Another person told us: "The best meal of the day is breakfast in my opinion". Another person told us the food was 'ok' but said 'there isn't much choice'. We spoke to the cook who showed us a four weekly menu. In the kitchen we saw that there was a list of alternatives for people if they didn't want the meal that was on offer. We were told that there was no one on a special diet apart from two people who required reduced sugar due to their diabetes.

Requires Improvement

Is the service caring?

Our findings

We observed that care staff completed their duties in a caring manner. Interactions between people were friendly and relaxed. When someone had become disorientated we saw that staff guided them back to a place of safety in a calm and kind manner. However, people were restricted within the home and people were not always supported to leave when they wanted to.

People who used the service and their relatives all told us that the staff were kind and caring. One person told us: "The staff couldn't be any better, they treat me with respect and observe my dignity", another person said: "The staff are very good and they are very attentive to us".

From our observations staff treated people with dignity and respect. Staff were kind and patient allowing people time to take their medicines. We also observed one person being moved with a hoist. The staff were kind and considerate and provided the person with reassurance. At lunchtime we observed people being supported to eat in an attentive, caring and compassionate manner.

Staff we spoke with talked about people in a respectful way. One care staff member told us: "I love my job, I am building up nice relationships with the residents". Staff demonstrated that they knew people's needs and preferences.

People who used the service chatted and laughed among themselves. One person danced to music and this entertained the others in the lounge area.

The deputy manager showed us that they had begun to give people who used the service and their relatives a 'patient survey'. They told us that they were still in the process of collating the information from these.

Bedrooms were personalised to meet people's individual tastes. One person told us: "I'm very happy with my room, it feels like home. I am able to do my own cleaning even though the cleaner comes in".

All the relatives we spoke with told us they were free to visit at any time and were always made to feel welcome. One relative told us: "I'm always made welcome when I visit and staff keep me fully informed about any issues, including helping me decide what toiletries are needed for my mother's personal care". Three relatives told us that they had heard that relatives meetings were being arranged but as yet had not been invited to one. One relative told us: "I've never heard of any relatives meetings and if I had I would have attended".

Requires Improvement

Is the service responsive?

Our findings

One person was at high risk of falls. We saw a falls risk assessment that stated they should be observed at all times, and that they should use a walking frame. We saw a large proportion of the time they were left alone. Staff were in the vicinity but we saw that they were not actively observing this person who was walking without the use of their frame. Records showed that this person had recently had a fall which had resulted in a serious injury. Care records and risk assessments had not been reviewed to reflect the recent fall. The deputy manager told us they were going to refer the person for support from the falls team and confirmed that they should be supported whilst mobilising. This had not been completed and it was eight days since the fall had taken place. The provider had not responded to reduce the risk of further falls.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service and their relatives told us that there was not enough for them to do. One person told us: "There's nothing to do except sit and watch the TV". Another person told us: "There is not a lot to do except sit and natter although I do like to sit in the garden when I can". Another person told us: "There's not much to do during the day, it would be nice if we could go to the local town every now and then to have a look round". Another person told us: "There's not much to do during the day. I like to spend time in the garden but am unable to do so because the door is locked ". We saw that people spent their time in the lounge area, with little or no stimulation throughout the day.

A large proportion of people who used the service were living with dementia. Some people required support to move freely around the home however others were able to be more independent. There were no visual prompts or sensory materials around the service to help people to orientate to time and day. Good practice regarding the design of environments for people with dementia includes incorporating features that support spatial orientation and minimise confusion, frustration and anxiety, such as better-quality environments, reality orientation cues and high light levels.

People who we spoke with told us they did not know of their care plans. One person told us: "I don't know about my care plans and I have never had a discussion about my care". Another person told us: "I don't know of my care plan and I have not had regular discussions with staff about my care. I've got no particular religious or cultural needs although I would like some meals that are native to my country of birth". However one relative told us: "We all sat together and completed my mum's assessment including my mum".

People's care plans did not give comprehensive details of how to best meet the needs of people in a personalised way. Care plans in place had not been reviewed or up dated following changes in people's needs. The registered manager and deputy manager confirmed that information within the care plans needed to be more in depth.

Relatives we spoke with knew how to make a complaint if they needed to. A copy of the complaints procedure was on the wall in the reception with contact numbers of the appropriate people to complain to. We saw records that confirmed that complaints had been dealt with and we saw evidence of action taken. For example we saw a drinks trolley had been put in the reception area following a complaint. This meant that people could make drinks for themselves and their visitors.

Inadequate

Is the service well-led?

Our findings

The provider had not implemented any systems to routinely monitor the quality of the service. The registered manager told us that since they service started they had been concentrating on recruiting staff and admitting service users and had not reviewed how the service was being managed. Records and equipment for the storage of medication were not maintained appropriately. Care plans were not reviewed to ensure that people received the appropriate care and treatment they needed. The provider did not have systems in place to identify this.

These issues constitute a breach of Regulation 10 The Health and Social Care Act 2008. (Regulated Activities) Regulations 2010.

The provider told us that the management team met every week to discuss any issues and identify improvements. We asked to see records of these meetings but they could not be provided and staff could not identify where improvements had been identified and made.

When the registered manager and deputy manager were not on duty, there was no senior staff member in charge. Staff told us that they shared the tasks out between themselves including who was going to administer medication. They told us that they used the on call system if they had any concerns they felt they couldn't manage. We discussed this with the manager as some staff had told us that they didn't feel competent in their role and this may impact on the quality of care that was being delivered. It also meant that there was no one person accountable during the absence of the manager and deputy manager.

Staff told us that there had been no staff meetings, however we saw that the deputy manager had started to complete individual supervision sessions with staff to discuss their personal development. Staff told us they felt supported although they were not satisfied with the quality of the training being provided.

People who used the service, relatives and the staff told us that the management team at Spring Tree Rest Home were approachable.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse (1) The registered person did not make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of (a) Taking reasonable steps to identify abuse and prevent it before it occurs (b) by responding appropriately to any allegation of abuse (2) Where any form of control or restraint is used in the carrying on of the regulated activity, the registered person must have suitable arrangements in place to protect service users against the risk of such control or restraint being (a) unlawful; or (b) otherwise excessive

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services 1. The registered person did not take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of (b)the planning and delivery of care and where appropriate treatment in such a way as to – (i)meet the service user's individual needs, (ii)ensure the welfare and safety of the service user (iii)reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff (1) The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purpose of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by – (a) receiving appropriate training, professional development, supervision and appraisal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered manager must protect service users, and others who may be at risk against the risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to - (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity

This section is primarily information for the provider

Action we have told the provider to take

(b)identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.