Mr & Mrs N Nauth

Credenhill Court Rest Home

Inspection report

Credenhill Court
Credenhill
Hereford
Herefordshire
HR4 7DL

Tel: 01432760349

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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**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 10 November 2015. A Breach of legal requirements was found. They also required improvement in the safe, effective, caring and well led domains of the inspection. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this comprehensive inspection to check that they had followed their plan and to confirm whether they now met legal requirements.

This inspection took place on 5 and 7 July 2016 and was unannounced.

Credenhill Court Residential Home provides accommodation and personal care for up to 35 people, some of whom are living with dementia. At the time of our inspection there were 33 people living at the home.

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 and associated regulations about how the service is run.

At this inspection we found that the registered provider was no longer in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However we found breaches in Regulation 17 in relation to the management and governance of the service, Regulation 13 in relation how people were being deprived of their liberty Regulation 10 in relation to dignity and respect and Regulation 9 in relation to person centred care. These shortfalls in the service are described throughout all sections of this report.

There was no effective leadership in the service. There were no quality assurance systems in place and the registered manager had not identified the concerns that we identified during the inspection. There were no clear actions planned or taken to improve the care and treatment that people received. We had concerns in relation to how the service was managed.

People were not always kept safe from harm. Staff were not deployed in a way to keep people safe or to respond to people's health needs at the times when they needed support.

People were not always treated with dignity and respect.

People did not receive the appropriate support to maintain healthy nutrition and people's specific dietary needs were not always catered for.

People were not always supported to access health and social care services to maintain and promote their

health and well-being when needed.

People did not have opportunities to engage in their hobbies and interests.

Staff did not start working with people until checks had been made to make sure they were suitable to support and care for the people living in the home.

People did receive their medicines safely. Medicines were ordered, stored administered and disposed of safely.

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 not always protected from harm or abuse because risks to people's health and care had not been identified and managed appropriately.

Staff were not deployed effectively to keep people safe and meet their health needs. There were no systems in place to determine how staffing levels were identified and deployed.

People received their medicines safely as there were systems to ensure that medicines had been given as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive the support and training they needed to meet people's individual needs.

People did not always have access to other health professionals to maintain their health and wellbeing.

People did not have the appropriate care and support to ensure that they had adequate nutrition.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

People were not involved in planning and reviewing their care and support.

People did not always get the care and support that they needed.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not receive care that reflected their own individual needs or preferences.

Staff did not always respond and act appropriately to concerns that people raised.

There was not a system to listen to and respond appropriately to people's concerns or complaints.

Is the service well-led?

Inadequate

The service was not well led.

There was no effective leadership

There were no governance systems in place to assess, monitor and to address risks to people.

The provider had not identified the concerns and risks identified during the inspection.

Credenhill Court 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 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.

The inspection took place on 5 and 7 July 2016 and was unannounced. The inspection team consisted of two inspectors. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law. We also asked the local authority for any concerns or information relating to Credenhill.

We looked at the information we held about the provider and this service, such as incidents, unexpected deaths or injuries to people receiving care, this also included any safeguarding. We refer to these as statutory notifications and providers are required to notify us about these events. This information was used in the planning for the inspection.

We used the Short Observational Framework for Inspection (SOFI) because some people were unable to communicate with us verbally. SOFI is a specific way of observing care to help us understand the experience of people living at the home.

We also spoke with 11 people who lived there, four relatives, one healthcare professional, one Deprivation of Liberty Safeguard assessor, six care staff, two team leaders, the deputy manager and the registered manager. We looked at the care records of four people, including nutritional risk assessments, assessments of people's needs and daily records. We also looked at the systems for monitoring the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection staff did not always know how to keep people safe and reduce the risk of harm as they did not always have a good understanding of people's needs. At this inspection we found that some areas had not been improved.

People felt that there were enough staff to meet their individual needs. One person told us, "There are staff around and if you really needed them they would help." One relative we spoke with told us their relative was safe at the home because, "Staff respond in no time at all." However we found staff were not deployed in a way that ensured that people's needs would be met. In one area of the home we saw a person was agitated and was using offensive language. At the same time another person also became upset by this and started using offensive and threatening language. Staff were in other areas of the home and no staff came until after 20 minutes. When they arrived they were able to talk and redirect the person. Later during the day we observed the same person trying to poke and pull at an electrical socket in the hallway. No staff were visible so we alerted them to this and they redirected the person to another area.

We found one person was at risk of falling and had recently had three falls in a month. There was no risk assessment in place and when we asked staff how they managed this person safely we did not have a consistent response to how they managed this risk. The registered manager told us that there had been no risk assessments relating to falls even though they knew that the person was at times at risk of falling. This meant that nothing had been done to identify any factors that may have increased the risk of falling or any action identified or taken to prevent further falls. This left the person at risk of further falls. The registered manger told us that there was no consistent approach to identifying, assessing and managing risk for people, and accepted that this meant that at times risks to people's safety was not managed effectively.

Staff were able to tell us what they would do if they suspected abuse and showed us that they had a good understanding of the different types of abuse. They also told us what they would do and who they would contact if they suspected abuse. The registered manager showed us examples of recent safeguarding referrals they had made. We could see that there were systems in place to protect the people that lived in the home and to make sure that the relevant authorities were informed and action taken to keep people safe.

People told us that they had the support they needed to take their medicines safely. For some people they needed prompting and observing to make sure they were taken safely, whilst other people needed more support in taking their medicines. We saw staff support people to take their medicines. For example, a member of staff held a person's inhaler for them so they could use it. We saw that staff knew what support to give to make sure people their medicines safely. We observed how medicines were administered and found the right medicines were given at the right time to the right person. Only staff that had received training in the safe management of medicines were able to administer medicine. Medicines were stored safely and appropriate systems were in place for the ordering and disposal of medicines.

Staff told us that checks were made to make sure they were suitable to work with people before they started

to work for the provider. These included references, and a satisfactory Disclosure and Barring Service (DBS) check. DBS helps employers make safer recruitment decisions by preventing unsuitable people from working in care.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 10 November 2014 we found that there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The principles of the MCA were not followed and people's rights were not protected. At this inspection we found that some improvements had been made and they had met the requirements of the law. 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 made on their behalf must be in their best interests and as least restrictive as possible. The deputy manager told us that people were given choices and we saw staff gave people choices of food and drink, where they wanted to be sat and also before providing support around personal needs. People told us that they felt staff asked them before providing any care or support. The registered manager showed us examples of where best interests meetings had happened for people that did not have capacity. We saw that these meetings had included the relevant people including professionals and people that knew the person best.

We had other concerns in how the principles of the Deprivation of Liberty safeguards were being applied. 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). We checked whether the provider 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 could not tell us how they identified and supported people consistently and in the least restrictive way. The registered manager could not assure us that they had a system to consistently identify when a person's liberty may be restricted.

We found staff did not understand the legislation regarding DoLS and how this impacted upon their role in supporting people's rights. The registered manager told us that seven people were subject to DoL authorisations, but the records showed that only two people had a DoLS authorisation in place. Other people's DoL authorisations had expired. The registered manager could not assure us that there was a system in place for identifying when people needed assessing to see if a DoL was still required. None of the staff we spoke with including the senior staff who were responsible for leading the shifts could demonstrate to us any knowledge of the DoLS. We discussed with senior staff about how they managed a person who had a DoL in place to protect them from falling on the stairs. We did not receive a consistent response to how they did this, and what we were told was different to what was detailed in their care records and didn't match what was detailed in the person's DoL authorisation. We spoke with a professional assessor from the DoLS team who were responsible for assessing and authorising DoL applications. They told us that conditions and recommendations set at the time of approval were not always met by the home. Staff were not working in line with the requirements of the MCA and DoLS.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they did not always get enough to eat or drink. We found that people were given two choices of food when they were seated, but people's choices were not always catered for. For example, one person wanted beer with their lunch and their request wasn't listened to by staff, despite them telling us they knew the person liked beer with their meal. Staff could not tell us the reason that the person did not get the drink they requested. We saw one person have their food taken from them after only eating a little of what was on the plate. We spoke with staff about this and some staff said the person liked to take their time to eat, whilst other staff told us that the person often left their food. We spoke with this person and they told us they were vegetarian, they did not eat meat. At mealtimes we saw that there were no meat free meals provided. We asked the cook about this and they told us that meat free options were not routinely available. We looked at the person's care records in relation to food and drink and we saw that they had lost weight each month from March 2016. Additionally the person had ill-fitting dentures that made eating and drinking problematical for them. We spoke to the registered manager about this, they could not tell us why action had not been taken to address the person's weight loss or ill-fitting dentures.

People did not always receive care and support that was effective in meeting their health and welfare needs. Staff told us that they felt they had adequate training and support to carry out their roles safely and effectively. Staff said that they had regular supervision and good levels of support from the registered manager with their roles. However we found that staff were unable to demonstrate to us that they had understanding and training on areas important to their roles. We saw that the responses from staff did not reflect best practice in understanding the MCA and DoLS and also about supporting people with dementia. For example staff were unable to demonstrate an understanding of dementia and how to provide best possible care. Staff could not tell us about people's individual needs and what support people needed to maintain their health and wellbeing for as long as possible. There were no checks by the provider or registered manager to make sure that any training that staff received had provided the necessary information to change and improve the care and support that people received. The registered manager told us that this had been an oversight and they had not thought about measuring the effectiveness of training.

Some people told us that when they were unwell staff were quick to respond and involve the doctor and other health professionals. One relative we spoke with told us, "Recently, there were concerns about [person's name] and the fact they kept falling asleep in the day. The staff sought medical attention and blood tests were carried out. The registered manager kept us informed throughout". However, we found that at times when we would expect other professionals to be involved in people's care they were not. We had examples of falls and weight concerns that were being monitored but no involvement from the doctor or other health professionals such as dietician had been sought. A health professional told us that actions they raised with the registered manager were not always carried out. The registered manager could not tell us why they had not taken the appropriate action to respond to changes in a people's health and wellbeing.

Requires Improvement

Is the service caring?

Our findings

At our last inspection people were not always treated with dignity and respect. At this inspection we found that some concerns remained about how some people were treated.

We found there were times when people were not treated with respect or dignity. We heard staff discussing people's personal continence care in communal areas. We raised this with the registered manager who said, "I know work is needed to improve staff knowledge and understanding of dignity and respect." One person who told us they were a vegetarian was regularly given meat based meals without the opportunity of observing their wishes. We spoke with the registered manager who told us they knew they were a vegetarian, but because they were living with dementia it didn't matter as they would eat meat if it was offered. This did not respect the person's beliefs and wishes. We saw a person who was living with dementia sat in a communal lounge with a blood stained top on. We asked staff about this and they told us the person had a nose bleed earlier on and they did not want to move them due to the risk of a further nose bleed. However no attempt had been made to provide a change of clothing or to cover up what was a heavily stained item of clothing, even though there were other people in the lounge including external visitors. This did not provide the person with dignity or respect.

People did not always receive an approach from staff that was caring. For example where a person displayed behaviours that made other people feel upset, no action had been taken to alleviate the distress caused to people. One person told us, "I find this very uncomfortable at times. [Person] can become even more aggressive, they have never hit out but it's not very nice." When we spoke with staff they did not give us consistent responses as to how they supported this person and how they made sure that other people did not feel upset or intimidated by this person's behaviour. The registered manager told us that this person, "Does this a lot." They could not tell us how they ensured that people felt safe and comfortable in the home.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they had not been involved in planning their care and support and had not been involved in discussing or reviewing their care. One person told us, "I've not been asked how I want to be looked after." We reviewed two care plans and saw that people had not been involved in the process of making decisions about their care, treatment and support. The registered manager could not tell us why people were not actively involved in decisions about their care, but said that they would look at ways with the staff that they could start to make this happen.

We saw that care was not always provided to people in a manner which demonstrated that they were actively involved in decisions about how their care was provided. For example we observed that the television was on loudly in the main lounge areas. When asked, people told us that they did not want the television on and they had not been asked what they wanted to watch, or whether they wanted to sit in front of the television.

Staff did not have time to talk to people unless they were undertaking a care task. When the task was completed staff left the person to undertake other duties. One person told us, "There are enough members of staff, but they are all a bit 'Here you are, move here' and off they go". Time was not spent with people to enrich their time with conversation and company.

Requires Improvement

Is the service responsive?

Our findings

People did not have any activities to reflect their own hobbies and interests and staff could not demonstrate to us that time was given to individuals to pursue any interests they may have. All of the people that we spoke with told us that they were bored and had nothing to do. We observed that people were left without appropriate stimulation or support. We spent time in a communal area where eight people were sat .From what people and staff told us and from our observations we were not assured that care reflected people's individual needs. We saw that when people requested to do what they wanted this was not always carried out by staff. For example, one person told us repeatedly they wanted to go for a walk. We mentioned this to three separate members of staff, who told us the activities coordinator was not in work this week and that he normally 'did things like that' We raised this with a team leader and the registered manager. However, the person was still not accompanied out on a walk. This person told us, "I cannot bear not doing anything. I have always been such an active person." One person said, "I am fed up and bored. It is boring here there is nothing to do." Two other people told us how they enjoyed ball room dancing but had not done it since living in the home. They told us that no one had ever asked them what they liked to do. When we spoke with staff they were unaware that these people enjoyed dancing.

People's records did not reflect people's life history or the things and interests that were important to people. Staff and the registered manager could not demonstrate to us that they had an approach that appreciated people's individuality and was person centred. We spoke with one person who told us that they used to enjoy gardening when they lived independently but had never done gardening at all since living at the home. We asked what she had done on the day of our inspection they told us, "Absolutely nothing, and it is horrible." When we spoke with staff and the registered manager they acknowledged that more needed to be done to reflect people's individual interests and needs.

Relatives we spoke with told us they were unaware of any reviews of people's care needs at the home and that they had not been involved in any care plan reviews. Reviews of people's care did not happen regularly or always when needed. Where people had shown changes in their health, people had not always had their health reviewed when they needed. For example when people had shown signs of weight loss or an increase in falls. This did not show an approach which responded to individual's changing needs or health care needs.
People were not involved in shaping their care and support. They had no involvement in their support and treatment plans. The people that we spoke with told us that they did not feel involved in their care. A person told us, "There is no one to listen to how I feel here."

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

People told us that they did not know how to complain or who to raise concerns with. We could see that there was a procedure for responding to complaints and relatives told us they knew how to complain. We saw that there had been no recent complaints. However the people that lived there told us that they did not know how to complain or who to raise concerns with. Some people that we spoke with told us that they were unhappy with aspects of the care and support they received. When we informed the registered

manager they told us that they did not know that people were unhappy, and they couldn't demonstrate to us that they had a system to capture people's comments and concerns.

Inadequate

Is the service well-led?

Our findings

At our last inspection there were no effective systems of measuring trends in falls or incidents. We also had concerns that there were no effective governance systems in place. At this inspection we found that no improvements had been made. Concerns remained about the management, leadership and governance of the home.

During the last inspection in November 2014, there was one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified four breaches of regulations. The registered manager was unable to identify where improvements were needed during the inspection. They had not identified the concerns we had found. At the inspection in November 2014 staff did not always know how to keep people safe. We found similar concerns during this inspection. People who presented a risk to themselves and others were not effectively supported. Risks to the health and wellbeing of people were not addressed appropriately. A person who had an increase in falls had not had their risk assessed or any action taken to prevent further falls even though the registered manager knew they were at risk of falling. People's diet and nutrition needs were not managed even when there were concerns over their weight. People were voicing that they were unhappy and bored and there was no system for them to raise their concerns. The registered manager could not show us what improvements had been made following the last inspection. There was no evidence that the most important actions had been prioritised. They could not show us that any improvements had been made to the care and support that people received.

Staff told us that they felt supported by the registered manager and felt listened to in the staff meetings that they had, but some staff told us they were unaware of what the management structure was. We spoke with the registered manager about the support that they had. They told us that they were not always able to manage staff in the way that they would have liked to. The provider had commissioned a consultancy firm to manage the human resources of the service. The registered manager told us that at times they felt undermined and unable to autonomously make decisions regarding the management of staff. They gave us an on-going example of a member of staff who they had concerns over regarding their work performance and conduct. They told us that due to the consultancy arrangements they had been unable to address the issues and this person continued in their role with no system of performance management in place. Staff and the registered manager told us the on-going situation with the member of staff had created an unpleasant atmosphere for staff and people. One member of staff told us, "People do pick up on the atmosphere and are affected by it". We spoke with the provider about this situation and the impact it was having on people. They informed us they were in the process of taking action, but could not adequately explain to us why the situation had been allowed to continue for a period of eight months.

Although the registered manager told us that there were regular meetings for the people that lived there, people did not feel that their views or concerns relating to their care were listened to. We could not see that there was a system to record people's views on their care and to then take the appropriate action. Staff told us that they did not feel involved in how the service was run. Other members of staff told us changes had been made to their roles without discussion with and explanations from the registered manager and provider. One member of staff told us, "They took duties away from staff without explaining why, or asking

for our opinion. Some staff feel deskilled as a result". Another member of staff told us, "We were told only team leaders could give people their medicines from now on. There was no discussion with us as a team". The registered manager could not tell us how they were able to monitor the quality of the service and the experiences of the staff and the people that lived there.

There were no regular audits or checks on the safety and quality of the care being provided. We were not assured that adequate governance and quality assurance systems were in place to ensure that the provider was able to identify, address and monitor any concerns or risks relating to care. There had been a lack of progress in improving the service since the last inspection and there was no evidence of any lessons learnt from incidents, concerns or previous failings. We asked the registered manager what they saw as the main challenges faced by the service. They told us, "Modernising the service and ensuring we have the right staff who work here". However, they could not explain to us the plan in place for modernising the service and making sure it was in-line with best current practice.

This was a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities).

Staff were aware of the whistle blowing policy and told us that they would feel comfortable to whistle blow if they felt that this was needed to ensure people's safety. Staff told us that they would not allow any abuse to happen and would report any concerns they had straight away. They told us that they would report concerns initially to the registered manager but if they felt that this was not being dealt with appropriately they knew to report it to the appropriate agencies.

The provider had when appropriate submitted notifications to the Care Quality Commission. The Provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. This means that we are able to monitor any trends or concerns.

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 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 People were not involved in shaping their care and support. People did not receive care that was person centred. Regulation 9 of the Health and Social Care Act (2008) Regulated Activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10(1) of the Health and Social Care Act (2008) Regulated Activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The principles of the Deprivation of Liberty Safeguards were not always followed. The registered manager could not assure us that they had a system to consistently identify when a person's liberty may be restricted. Regulation 13(5) of the Health and Social Care Act (2008) Regulated Activities.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider did not have any effective system or processes to assess, monitor and drive improvement in the quality and safety of the service provided.

Regulation 17 of the Health and Social Care Act (2008) Regulated Activities.