Uttoxeter and District Old People's Housing Society Limited

Kirk House Care Home

Inspection report

34 Balance Street,
Uttoxeter,
Staffordshire,
ST14 8JE
Tel: 01889 562628
Website:

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We inspected Kirk House Care Home on 19 and 21 May 2015. The inspection was unannounced and in response to concerns raised by other health and social care professionals and relatives of people who used the service. We also checked if the provider had made improvements following our inspection on 24 November 2014.

The provider is registered to provide accommodation, personal and nursing care for up to 35 older people who have physical health needs or are living with dementia.

The provider had two intermediate care beds for people who required short-term support before returning home when they left hospital. At the time of our inspection, 29 people used the service. Fifteen of these people needed nursing care or palliative care.

There was no registered manager in post at the time of the inspection. 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

Summary of findings

meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There was a manager in post who had not yet applied for registration. We refer to them as 'the manager' in this report.

At the last inspection in November 2014, we asked the provider to take action to make improvements in the following areas: How the quality of the service provided was monitored and assessed; how people were protected from the risk of abuse; how people were protected against the risks associated with unsafe use and management of medicines. Ensure that people had adequate food and drink; arrangements for obtaining and acting in accordance with the consent of people who used the service, and ensuring that people's care records were accurate.

The provider sent us an action plan of how they intended to make the improvements. All but two actions were to be completed by 22 May 2015; the others were to be completed on 5 June 2015. We saw that improvements had not been made and the provider continued to be in breach of regulations we inspected against.

Staff did not always take appropriate action when abuse was suspected. This meant that people were not always protected against abuse. We made safeguarding referrals to the local authority about the concerns we identified.

People did not have risk assessments or management plans in place to ensure that they received safe care. Where plans were in place, staff did not always provide care as directed. People's risks were not reviewed as their needs changed.

People were at risk of poor health because they did not always receive their medicine as planned, and staff did not take action when people missed their prescribed medicines. The provider did not have effective systems in place for storing and managing medicines.

Legal requirements of the Mental Capacity Act (MCA) 2005 were not always followed when people were unable to make certain decisions about their care. This meant that people's liberties were at risk of being restricted unlawfully. The MCA and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure where appropriate; decisions are made in people's best interest.

People were at risk of malnutrition because their food and drink intake was not monitored effectively and staff did not did not take action when people were losing weight.

Recommendations made by health and social care professionals were not always followed. This put people at risk of poor care.

People's dignity was not always maintained and their choices were not always respected.

People were at risk of isolation. The provider did not always ensure that people who were cared for in their bedrooms received adequate social stimulation.

People were at risk of harm due to widespread shortfalls in the way the service was managed. The provider did not have effective systems in place to regularly monitor the quality of the service provided. The provider did not maintain action plans for how concerns will be dealt with or improvements monitored. The manager had delegated some responsibilities to staff but did not always ensure that these responsibilities were carried out. We saw that very little progress had been made against the action plan and the provider did not have a system in place of how progress against the actions will be monitored. The provider did not always submit required notifications to us as required.

The provider had introduced meetings to obtain the views of people who used the service and their relatives and had started making some improvements in how services were provided based on feedback received.

People who used the service and relatives told us that staff were caring and they liked living in the home. We saw that staff spoke with people respectfully.

Some people told us and that they had a choice of food and drinks and were given adequate amounts. We observed that the atmosphere in the dining area was pleasurable.

We identified that the provider was not meeting some of the Health and Social Care Act 2008 Regulated Activities Regulations 2014 that we inspect against and improvements were required. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The overall rating for this service is ‘Inadequate’ and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider’s registration of the service, we will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe."

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 always recognise and take appropriate action when people were at risk of abuse. People's risk assessments and management plans were not updated when their needs changed. People did not always receive care as planned. People did not always receive their medicines as prescribed and their medicines were not always stored appropriately.

Inadequate

Is the service effective?
The service was not effective.

The legal requirements of the Mental Capacity Act (2005) and Deprivation of Liberty safeguards (DoLS) were not followed. People's liberties were restricted unlawfully. People were at risk of malnutrition because their food and drink intake was not monitored effectively and appropriate action was not taken when they were losing weight. Recommendations made by other professionals were not always followed.

Inadequate

Is the service caring?
The service was not always caring.

People were not always treated with dignity and respect. People's choices and preferences were not always respected. People and their relatives told us that staff were caring and treated people kindly.

Requires improvement

Is the service responsive?
The service was not always responsive.

People who were cared for in their bedrooms or who needed support to access communal areas were at risk of isolation. The provider had a system in place for dealing with complaints and kept a record of complaints made. People who used the service and staff told us that the manager was approachable and always available to deal with their concerns.

Requires improvement

Is the service well-led?
The service not well-led.

There was no registered manager in post. People were at risk of harm due to widespread shortfalls in how the service was managed. The provider did not have effective systems in place for monitoring the quality of the service provided. The provider did not always notify us of incidents that occurred.

Inadequate

Kirk House Care 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 19 and 21 May 2015 and was unannounced and in response to concerns raised by other professionals about the service. Two inspectors and an expert by experience who had personal experience of using or caring for someone who uses this type of care service undertook the inspection. A specialist adviser, with experience of care for people living with dementia or receiving palliative care was also involved.

We reviewed the information we held about the service. Providers are required to notify us about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We refer to these as notifications. We noted that the provider did not always notify us of these incidents. We reviewed additional information we had requested from the local authority safeguarding team and local commissioners.

We asked the provider to complete 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. They did not return a PIR and we took this into account when we made our judgements.

We observed how care was provided and also carried out a lunchtime observation to see how people were supported during meals. We spoke with nine people who used the service and five relatives. We spoke with two nurses, six care assistants, the activities coordinator, one ancillary staff member and the service manager. We also spoke with two professionals who went to the home regularly to obtain their views about the care people received.

We looked at nine people's care records to see if their records were accurate and up to date and conducted an audit of 21 people's medication administration records (MAR). We looked at records relating to the management of the service. These records helped us understand how the provider responded and acted on issues related to the care and welfare of people and monitored the quality of the service.

Inadequate

Is the service safe?

Our findings

At the last inspection the provider was in breach of Regulation 13 of the Health and Social Care Act 2008, (Regulated Activities), Regulations 2014 because staff did not always identify and report abuse when it was suspected. Wesaw that improvements had not been made and people were still at risk of harm.

We heard one person shouting to be let out of their bedroom. The person was saying, "I want to get out of here. I'm going mad just lying here looking at that wall all day long. I'm in here 24 hours a day, please get me out it's like a prison". A nurse told them, "It's not safe to sit you out. We're doing the best for you". A district told us the person used to walk independently and they did not know why the decision had been made for them to be cared for on their bed because they wanted to get out. We checked the person's records and noted that it had been recorded over several days that the person was shouting, screaming, throwing various objects in their bedroom and trying to get out of bed. Their records showed that they often tried to get out of bed but were stopped by staff. We did not see any assessments as to why the person should be cared for in bed with bed rails. The person's shouting and screaming was also discussed during staff handover but staff had not recognised that they were not supporting the person in the way they wanted to be.

One person who was at risk of choking and could only drink thickened fluids had been given a cup of tea by another person who used the service. A member of staff intervened and explained that the person couldn't have the drink because they were at risk of choking. They recorded this incident in the person's daily records; however, they did not recognise their responsibility to report this as a safeguarding concern so that appropriate action could be taken to protect the person from harm.

Staff we spoke with told us they had received safeguarding training and gave us examples of types of abuse and what action they would take if abuse was suspected. However, a professional who visited the service told us staff did not always recognise abuse and take action. They had found that safeguarding concerns had not been reported for several months. A recent incident had gone unreported until the manager was told by a health professional that it had to be reported. Another professional told us that incidents of abuse had been brought to their attention by a relative and that staff were aware of these but had not recognised the incidents as safeguarding. We also identified concerns that had not been identified by staff and had to raise them with the local authority.

The concerns above showed that the provider had failed to recognise and take appropriate action when people were at risk of harm. This meant that the provider continued to be in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities), Regulations 2014.

At the last inspection the provider was in breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities), Regulations 2014 because people's medicines were not always managed safely. We saw that improvements had not been made and people were at risk of harm.

We found that people did not always receive their medicines as prescribed. We checked a total of 21 medication administration records (MAR) and found that people were regularly missing medicines because they were asleep. For example, we checked the MAR records for two people who had high blood pressure, heart problems and were at risk of blood clots. We found that people did not always receive their prescribed medicines because they were sleeping. A review of the people's medicines had not taken place so that they could have their medicines at a more suitable time. We brought this to the attention of staff and made a safeguarding referral.

Another person had diabetes and needed insulin. Insulin is meant to be stored in the fridge at the recommended temperature in order for it to be effective. We saw fridge temperatures were not being monitored to ensure that medicines stored were within the recommended temperature levels. There had been a continuous breach of Regulation 12 of the Health and Social Care Act (Regulated Activities), Regulations 2014 because people's medicines were not managed effectively.

People did not always have up-to-date risk assessments and management plans to reflect the care and support they required when their needs changed. Staff members told us that two people had to be weighed weekly because they were losing weight; We saw records which indicated that that this was not happening. A professional who visited the person told us they had informed staff to

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Is the service safe?

monitor the person's weight and keep them informed of any changes, but this had not happened. This person was at risk of poor health because they did not receive care as planned.

Another person had to sit in a special chair for limited time periods each day due to their back problems. They were not being supported to do this; instead they received care in bed. A professional had made recommendations for staff to review and manage risks related to the person but we found that this had not happened. A staff member and the manager told us the person was to be cared for in bed, however, a professional who knew the person told us this was not correct. These people did have not risk assessments and management plans in place to guide staff of how they should be cared for. This meant that their individual need were not being met.

One person who had recently been discharged from hospital was at risk of harm because they did not receive care as directed by the doctor. The doctor had recommended for them to be weighed weekly. We saw that the person's care plan had not been reviewed and risk management plans were not put in place to minimise the risks. We saw that the person had not been weighed as advised. The care assistant we spoke with told us the person could not be weighed because they were cared for in bed. Professional advice had not been sought on how the person should be weighed. The person was at risk of poor health because they did not receive care as directed and care plans and risk assessments were not updated to reflect the care and support they required. A professional we spoke with told us people's care plans and risk assessments were not always updated. They said, "It makes me nervous when people say they want to go there for respite (temporary) care. I just won't send them there".

The failings above showed that the provider had not provided care in a way that met the individual needs of people. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities), Regulations 2014.

People told us that there were sufficient numbers of staff on duty to provide them with support when they needed it. One person said, "If they hear me call, they just come. They are very good". We saw that call bells were responded to quickly and people did not have to wait long before they received assistance from staff. We saw the provider followed recruitment procedures which checked that potential staff were safe to provide care before they started work. Shift patterns had been changed recently to ensure that there were always enough staff on duty. Staff told us that the provider no longer used as many agency care staff which meant that continuity of staff was maintained. The staff duty rosters confirmed this.

Inadequate

Is the service effective?

Our findings

At the last inspection the provider was in breach of Regulation 14 of the Health and Social Care Act 2008, (Regulated Activities), Regulations 2014 because people were not always supported to eat and drink adequate amounts. We saw that improvements had not been made and people were still at risk.

One person, who had a stomach condition which meant that they could not eat certain foods, was not always given foods that met their individual needs. The person told us the stomach condition had made them very selective of what they ate and we saw that this had been recorded in their care records. However, the person had been given a dessert which contained foods they could not eat. They told us, "I have to pick at every meal and it's terrible. I get worn out by the time I get to eat. It's exhausting, you see?" We brought this to the attention of a nurse. This person's preferences had not been respected.

We saw that people who had been prescribed food supplements to prevent malnutrition were at risk of not receiving the supplements as prescribed. This was because information provided on how the supplements were to be administered were not always consistent. For example, one person's MAR showed that they had to be given food supplements three times daily. The nurse we spoke with told us there was a chart in the kitchen to guide staff of what supplements people were required to have and how often they should be given. We checked the chart in the kitchen which did not accurately record information about prescribed dietary supplements. Their food and drink monitoring chart showed that they were not receiving the food supplements regularly. We checked their weight monitoring records and noted that they had been losing weight.

We found that people were at risk of malnutrition because their eating and drinking was not monitored. One person who was cared for in bed was not having adequate amounts of food and drink. The person's care records showed that the person had drunk very little on most days and had refused to eat. We saw staff had not taken appropriate action to ensure that the person was supported to eat and drink sufficient amounts. We looked at weight monitoring charts and saw that three people had lost a significant amount of weight in the last six months. A staff member told us two of these people had to be weighed weekly and the other had to be weighed monthly. We saw that this was not happening. When we spoke with staff staff had not made appropriate referrals for these people's food and drink to be reviewed and management plans put in place for how they will be supported to remain healthy. We spoke with a professional who knew one on these people. They told us, "[Person's name] has lost a considerable amount of weight and I've asked them [staff] repeatedly to weigh them and they haven't done it. They haven't let me know [person's name] has lost so much weight". The failings above showed that there was a continuous breach of Regulations 14 of the Health and Social Care Act (Regulated Activities), Regulations 2014.

People's freedom was restricted. One person told us, "I like walking but I can't go off on my own, so I just sit in the lounge and I go to different places where you can sit, but I'd rather go walking out. I used to love walking". The person told us that they could only go out accompanied by staff because they had mobility problems. The manager told us that that person could not always make safe decisions about their care. However, the person did not have any capacity assessments in place to guide staff of the decisions that could be made in their best interest. The manager had not made a Deprivation of Liberty Safeguards (DoLS) application although they were under constant supervision by staff and could not leave unless they were accompanied by staff.The Mental Capacity Act (2005) and DoLS set out requirements that ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

Staff told us that they had received training in MCA; however, they did not demonstrate an understanding of the Act (2005) or DoLS. The manager had not made any DoLS applications. They said, "I'm looking at doing capacity assessments of everybody and possibly two or three would met the criteria for DoLS. I think [Person's name] would meet the criteria but they are happy, the others are happy to stay." The failings above showed that the provider was a continuing breach of Regulation 13 of the Health and Social Care Act (Regulated Activities), Regulations 2014.

People told us that staff knew them and supported them well. We observed staff communicating well with people when they supported them. We saw that staff had received recent training in a variety of health related topics. They told us the knowledge acquired supported them in how they provided care to people. However we found that the

Inadequate

Is the service effective?

training was not always effective as people were at risk of malnutrition and were not always protected from harm. We spoke with three newly employed care assistants who told us they received an induction, training and were required to shadow another member of the care staff for a period of time before they provided care unsupervised. They told us this enabled them gain confidence and skills in care provision before they started working unsupervised.

People we spoke with told us, and we saw that the meal time experience for those able to have their meals in the dining area was pleasurable. People told us that they enjoyed their food and a choice was always available if they did not want what was on offer. One person said, “The food is excellent, they will find something if you don’t like what’s on the menu”.

Requires improvement

Is the service caring?

Our findings

We spent time in the lounge and observed that staff did not always respect people's dignity. A staff member went to the corridor and called out to another staff member to bring a hoist because a person needed assistance to go to the toilet. Staff noticed just before the person was to be transferred that the battery to the hoist needed to be changed. Whilst the person waited, staff did not cover their legs to keep them comfortable and maintain their dignity. Staff had not communicated discreetly with the person or between themselves when they supported them to go to the toilet.

One person told us they were always in their nightie. They said, "I like to get dressed and sit up". We saw they were in bed in their nightie on both days. The person's wishes to get dressed were not respected or acted upon.

We saw that some people had been involved in planning their care. We saw that some people's opinions about how they wished to receive care and those of their relatives were taken into consideration when care was planned. We saw that staff explained things to people before they engaged in any activities with them.

People told us that staff were nice and treated them kindly. One person said, "I'm well looked after here. The staff are so kind. I don't know anyone who's nasty. They look after me very well". Another person said, "If they [staff] hear me rolling around in bed, they just come to me". Relatives told us that staff were nice and polite to people. They told us they could visit people at any time and staff respected and treated them nicely. We observed staff talking to people politely.

People's religious beliefs and preferences were supported. An activities coordinator arranged an interdenominational church service each month at the service. People were supported to see leaders of their faith beliefs if they expressed the desire to. We saw that the activities coordinator maintained a record of these activities to demonstrate how people's needs were met.

We saw that people's privacy was maintained when staff supported people with their personal care. We saw that bedroom doors were shot when staff were supporting people in their bedrooms. We observed that staff knocked on doors and waited to be invited in or called to alert the person in the room that they were about to go in, if the person was unable to communicate.

Requires improvement

Is the service responsive?

Our findings

We found that people who were cared for in their bedroom and needed support with all aspects of their care were at risk of isolation. We noted that these people had limited social interaction with other people who used the service. One person told us they would like to sit in communal areas and to have lunch with other people. The person said, "I haven't sat out for lunch for over a month. They don't ask me but I will go if they ask me to. There isn't anybody to chat with unless when relatives visit me". Staff told us the person was awaiting an assessment for a more suitable chair. However, a professional who knew the person told us that a suitable chair had been provided already but staff were not using it. A recent assessment and treatment plan from another healthcare professional identified a lack of stimulation as one of the concerns. The report stated, '[Person's name] would like to sit out of bed and engage with residents. [Person's name] reported this verbally'. This had left the person feeling isolated as staff had not responded to the person's needs.

One person regularly asked to leave their bedroom. A member of staff told us the person liked to be in the company of other people and liked somebody to be with them because they enjoyed talking, but this did not always happen. We heard a member of staff offering to switch the television on for them when the person asked to leave their bedroom, but the television was not working. A professional who knew the person told us, "[Person's name] is completely abandoned there. They begged me not to leave them once when I visited and I just stayed there holding their hand ". This showed that the person was not receiving support that was responsive to their needs.

Another person told us, "There are quizzes and activities to exercise your brain. If there's anything going, you can put your name down to take part, or not if you don't want to, I've been to Alton Towers". The provider had an activities coordinator who told us they worked four half days a week but said that the manager also expected care assistants to encourage people to take part in activities. There was a programme of scheduled activities which the coordinator followed. The activities coordinator told us bakery sessions had been organised recently and those who participated had enjoyed it.

People told us they knew who to speak with if they had any problems. One person told us they had raised a concern with the manager about another person who used the service and this was resolved. Relatives told us they had raised a number of concerns with the manager when their relative first started using the service and the concerns were resolved. There was a complaints policy in place. We saw that complaints made were acknowledged, investigated and responded to.

The manager had introduced relatives and resident's meeting where people were encouraged to raise concerns. The manager had introduced staff name badges and uniforms to identify staff based on their roles. This was in response to comments made by relatives about not always knowing the staff who provided care and support.

Inadequate

Is the service well-led?

Our findings

At the last inspection the provider was in breach of Regulation 17 of the Health and Social Care Act 2008, (Regulated Activities), Regulations 2014 because they did not have effective systems in place to regularly assess and monitor the quality of the service provided and did not always keep accurate records in relation to people's care and treatment. We found improvements were still required.

There were widespread shortfalls in how the service was managed. For example, safeguarding concerns were not always recognised and acted upon. Some people were restricted unlawfully and others were at risk because the manager and staff did not always follow MCA (2005) and DoLS requirements or demonstrate an understanding of these principles. The manager did not always ensure that people's care was reviewed in a timely manner when there were concerns and appropriate action taken to protect them from harm. The manager did not always ensure that professional advice was followed to ensure that people received care and support in line with identified needs.

The manager had introduced residents and relatives meetings where various aspects of care and quality related issued were discussed. We saw that people had raised a number of concerns but the manager did not have an action plan in place to manage these issues and monitor these improvements. We asked them how they reviewed the progress against previous actions and they told us they discussed each point during the next meeting with the residents and confirmed if the action was complete. This showed that the systems in place for monitoring improvement were not effective.

The service had not had a registered manager for a substantial period. Having a registered manager is one of the registration requirements for the service.

We found that the provider did not always notify us or the local authority of events and incidents that happened in the service. For example, staff told us that someone had scalded their hand and some people had fallen and sustained injuries, but we had not been notified of these. Staff informed us that some people had died, but the provider had not notified us of these deaths as required.

Staff told us they had not received individual supervision. The manager told us that they planned on putting individual staff supervision in place but had started holding staff meetings to discuss concerns.

Staff did not always understand their roles and responsibilities. For example; we asked the manager if MAR audits took place. The manager told it was the responsibility of the clinical lead to complete MAR audits but we saw that this was not happening. The manager said "I can't find anything that has been completed. I don't comprehend why these [the audits] haven't been done". Staff did not raise safeguarding concerns or whistleblow when people when people were at risk of harm.

Following the last inspection, the provider had submitted an action plan showing how they intended to make improvements. We saw that there were still breaches in all the areas we were concerned about in the last inspection. The concerns above showed that there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008, (Regulated Activities), Regulations 2014.

People told us that they knew who the manager was and felt comfortable approaching them if they had any concerns. One person said, "The manager's a nice person. You can knock on their door and they will invite you in". Staff told us that the manager was approachable and supported them to carry out their roles and responsibilities. They told us they the manager had introduced staff meetings where they could discuss issues and raise concerns about services. Staff told us, and minutes of staff meetings showed that the meetings were also a means to keep staff informed and involved in the way the service was run.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were at risk or poor health because they were not always monitored to ensure that they received adequate nutrition and hydration.