Mr Gordon Nuttall

The Keepings

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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on the 1 and 2 September 2015 and was unannounced. At our last inspection on the 15 April 2014 the provider was not fully compliant with the regulations inspected.

We found concerns in April 2014 with how the provider met people's care and welfare. We asked the provider to send us an action plan outlining how they would make improvements and we considered this when carrying out this inspection. All the improvements the provider was required to make were completed.

The Keepings is registered to provide accommodation and support for 23 older adults who may have dementia. On the day of our inspection there were 22 people living at the home and there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act (2008) and associated Regulations about how the service is run.

Summary of findings

The provider had systems in place to ensure people were protected from harm. People told us they felt safe.

Staff were able to give examples of different types of abuse and knew how to keep people safe.

People told us they received their medicines as they wanted. Where people were being administered medicines 'as required' the provider had a protocol in place to ensure staff were clear how these medicines should be administered.

The provider did not use a staffing dependency tool to be able to determine the right levels of staff based upon people needs.

Staff were able to access support and training when needed to be able to support people appropriately.

Whilst we saw people's consent being sought before support was given, the provider did not take the appropriate action to ensure staff had the appropriate knowledge and skills not to restrict people's human rights as is required within the Mental Capacity Act 2005.

People were able to see their doctor, optician or other health care professionals for regular health checks or when they were not well.

People were able to eat and drink as much as they wanted on a regular basis, but choices were limited.

People were supported by staff in a kind and friendly manner; ensuring they were able to make decisions about the support they received.

People's privacy and dignity was respected by staff.

People were able to take part in activities, but these were not always consistently linked to their preferences, likes or dislikes as these were not consistently recorded on their care files.

The provider had a complaints process which people were aware of. However there was no process for recording complaints received.

We found that the recently replaced carpet was not in keeping with what a dementia friendly home would be expected to have in place to support people's perceptual awareness.

The provider had a quality assurance questionnaire in place so people and relatives could share their views on the service.

We found no evidence that quality assurance checks were being completed by the provider on a regular basis to ensure the standard and quality of support to people.

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?

Requires improvement

The service was not always safe.

People told us they felt safe.

Where people were administered 'as and when required' medicines, there was a protocol in place to ensure staff had the appropriate guidance.

The provider did not have a dependency tool in place to determine the levels of staff required based upon people's needs to improve the interaction people received.

A recruitment process was in place to ensure only appropriate staff were recruited to support people safely.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had access to support when needed to meet people's needs.

The provider did not ensure where people lacked capacity, staff had the appropriate knowledge and skills not to restrict people's human rights as is required within the Mental Capacity Act (2005).

While people were able to eat and drink sufficiently, meal choices were not being displayed consistently and choices were limited.

Is the service caring?

Good

The service was caring.

People were being supported by staff who responded as people wanted.

People were cared for in a caring and kind manner.

People were involved in how their care and support was given.

People's privacy and dignity was being respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

People felt confident to raise concerns. While complaints raised by people were responded to. Complaints made were not being recorded so any trends could not be noted and used to improve the service people received.

People's preferences, likes and dislikes were not consistently being taken into account as part of an activity program to ensure people could take part in activities that they liked.

Summary of findings

Is the service well-led?

The service was not always well led.

We found that the recently replaced carpet was not in keeping with what would be expected in a dementia friendly home. The type of carpet being used would lead to people having problems with their perceptual awareness.

We found no evidence to show that the provider carried out quality assurance checks on the service provided to people by the registered manager.

People and relatives were able to share their views by completing a quality assurance questionnaire.

Requires improvement

The Keepings

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.

Our inspection took place over two days 1 and 2 September 2015 and was unannounced. The inspection was conducted by one inspector 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 we asked the provider to complete a Provider Information Return (PIR) which they did. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service, this included information received from the provider about deaths, accidents/ incidents and safeguarding alerts which they are required to send us by law.

On the day of our inspection there were 22 people living at the home. We spoke with six people who were able to share their views with us, one relative, a visitor, seven members of staff, this comprised of care assistants, senior care staff, domestic cleaner and the cook. We also spoke to the deputy manager and the registered manager. We looked at the care records for four people, the recruitment and training records for four members of staff and records used for the management of the service; for example, staff duty rosters, accident records and records used for auditing the quality of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they were happy and able to get support when needed. One person said, "The staff are golden when they come, sometimes you have to wait a while but you can't expect them to see everyone at once". Another person said, "They're good to me, sometimes they're [staff] a bit pushed". A relative said, "There is enough staff ". Staff we spoke with told us there were enough staff. Our observation during the inspection was that there were enough staff; however we were unable to observe the staffing impact during the night time. The staffing rota matched the levels of staff that was planned to be on shift during the inspection, but we saw no evidence that the levels of staff were decided based upon people's needs. The registered manager confirmed they did not use any recognised process to determine the appropriate staffing levels. They confirmed they would implement a staff dependency tool so they would be able to know how many staff they should have based upon people's needs within the home.

One person said, "If I am in pain I do get tablets". A relative we spoke with said, "I don't have any concerns about the medication for [person's name]". Staff we spoke with told us they were not able to administer medicines until they were trained. One staff member said, "I have had medication training and my competency is checked, the manager does carry out visual checks". We saw evidence to confirm that competency checks were taking place to ensure staff administered medicines appropriately and safely.

The provider had a medicines procedure in place to guide staff on administering medicines. However, we found that the procedures were not always being followed as per the provider's guidance. Where people were administered medicines the appropriate record was not always being kept on the Medicines Administration Record (MAR) chart. Where this took place no action was taken to offer staff further support, notify the appropriate authorities or raise a safeguarding with the local authority. We saw evidence that where people had medicines 'as required' there was a protocol on each person's MAR to guide staff appropriately. While observing staff administering medicines we did not see any direct risks to people. The staff member we observed knew when 'as required' medicines were to be administered. There was however a potential risk to people that staff would not all administer 'as required' medicines in a consistent way without proper guidance. We discussed our findings with the registered manager who acknowledged that the appropriate processes were not followed or in place to ensure any risks to medicines were reduced appropriately and action would be taken to rectify this.

People we spoke with told us they were happy within the home. One person said, "They [Staff] make you feel its home", whilst a relative we spoke with said, "I do feel people are safe here, it's the best choice ever". Staff we spoke with knew how to keep people safe. They were able to explain the actions they would take where they felt people were not safe. They gave examples of different forms of abuse and told us they had completed training in safeguarding. A member of staff said, "If someone here was being abused I would report it to the manager" and another staff member said, "If it was the manager I would ring CQC [Care Quality Commission]". We saw evidence to confirm staff had received training and there was information on display in the home identifying how people should be kept safe.

We saw evidence that risk assessments were being carried out. Where risks were identified with how people were being supported we saw that the appropriate documentation was in place to guide staff as to how risks should be managed and where possible reduced. Risk assessments were in place for equipment that was being used to support people, for example, hoists and wheelchairs in order to ensure they were being used appropriately and safely. Staff we spoke with knew what the individual risks were to people and how they should be managed or reduced while supporting them. We saw that risk assessments were also being carried out to ensure the environment in which people lived and the external areas of the home were safe enough to ensure people's safety.

Staff we spoke with were able to explain the process they would follow where an accident or incident took place. This involved them speaking and checking people's alertness where they were found on the floor, and or seeking medical support from a paramedic. One member of staff said, "I would record any accidents in the accident book and on people's daily records". We saw evidence to confirm this was taking place and that where accidents took place the

Requires improvement

Is the service safe?

appropriate monitoring was being done. The registered manager told us that accidents and incidents were regularly checked as part of the quality audits that were carried out.

The staff we spoke with all told us they were required to complete a Disclosure and Barring Service (DBS) check as part of the recruitment process before being appointed to their job. This check was carried out to ensure that staff were able to work with people and they would not be put at risk of harm. We found that the provider had a robust recruitment process in place which also included all newly appointed staff to provide two references. Staff confirmed they were able to shadow more experience staff as part of an induction process and their experiences, skills and knowledge were checked before an appointment was made.

Requires improvement

Is the service effective?

Our findings

We saw people's consent being sought before any support from staff was given. People who were unable to verbalise their consent due to a lack of mental capacity used other ways to communicate their consent which staff demonstrated to us that they were able to understand. For example non-verbal communication and body gestures. A relative said, "My mom does give consent".

We found that the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) were not always being implemented appropriately where there were concerns about people's human rights being deprived due to their lack of capacity. We saw evidence where covert medicines were being administered with the approval of a doctor to someone who lacked mental capacity, but the appropriate procedures were not followed to meet the Mental Capacity Act (MCA) in terms of DoLS. We saw no evidence of people's mental capacity being assessed, best interest meetings, appropriate advice being sought or any authorisation from the supervisory body to ensure that the MCA was being adhered to. Some staff we spoke with were able to explain MCA and DoLS and told us they had received training, while other staff could not tell us what MCA and DoLS were and the impact this may have on people. The registered manager acknowledged that training was not being offered to staff consistently and action was taken by the manager by the end of the second day of our inspection to set up appropriate training so staff would have the skills and knowledge necessary. We have also had confirmation from the registered manager since the inspection that the appropriate advice was sought from the local authority in respect of the concerns identified with the administering of the covert medicines. However we have not been back to the home to confirm this.

A person said, "I can make myself some tea whenever I want", another person said, "The food is nice, there is enough" and a relative said, "The food is good, but choices limited". People were generally very complimentary about the food and told us they were able to have a hot breakfast if they wanted one. We observed people being offered hot and cold drinks throughout the day to ensure they were not dehydrated. We spoke to staff who were able to explain that the cook went round daily to checked with people what they wanted to eat. We saw that at lunch time people were limited to a cold lunch as they were able to have a hot meal on the evening. People were observed all eating their meal and we saw no one complaining or having something else to eat. People told us they all enjoy their lunchtime meal and were complimentary of the food. Staff told us that having the main meal of the day in the evening had a favourable effect on people, their nutrition and their sleeping patterns had improved.

A member of staff told us that someone who they had concerns about their weight loss had the dietician involved, and since having their main meal on an evening the person had gained weight and was eating much better. The cook told us that information about people's nutritional or dietary needs were passed to her by senior staff. She was unable to show evidence of how this information was kept as it was not written down, which meant when she was not at work there was a risk that this information may not be known by staff preparing meals in the cook's absence. We found that a menu was not being displayed consistently to show the choices of meals available to people or what alternatives there may be, but people told us they were given a choice by staff and able to make choices at meal times. We found that a pictorial menu was available in the kitchen to aid people understand the meals on offer, but this was not being used.

The staff we spoke with told us the registered manager was supportive and they could approach the registered manager for support when needed. Staff told us they received supervision every month, they were able to attend regular staff meetings and they had a yearly appraisal. All the staff we spoke with told us they had to go through an induction and as part of the induction they shadowed staff who were more experienced in the role. We saw evidence of the induction process used and documents to verify that staff received supervision and appraisals. We saw that a program of training was also in place to support staff skills and knowledge. We saw that service specific training like dementia awareness was made available alongside other more mandatory courses. For example, food hygiene, manual handling and health and safety. A staff member we spoke with said, "I have learned about the effects that dementia has on peoples' visual perception", while another told us the registered manager was proactive in seeking out extra training and a number of staff had recently attended a specialist dementia course at a local college.

People told us that the GP visited regularly. One person told us they went to hospital regularly for treatment to their

Requires improvement

Is the service effective?

eyes. A relative said, "[Person's name] is able to see a dentist, physio and opticians when needed". We saw evidence that where people were seen by a health care professional this was recorded on their care notes. Our observations of people were that they were dressed appropriately for their age and looked relaxed. Where people needed to see a dentist, a doctor, a chiropodist or an optician this was made available. Staff were able to explain how people's on going health needs were catered for, and where people needed to see an health care professional how this would be done.

Good

Is the service caring?

Our findings

When we last inspected this service in April 2014 we found breaches in Regulation 9 of the Health Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This was because there were concerns that people were not being supported when needed due to staff using their mobile phones. People's dignity and privacy was not being appropriately respected as people using the stair rails at nights could be seen from the street in their night clothes. We asked the provider to send us an action plan outlining how they would make improvements.

We saw evidence that the provider had made the appropriate improvements so staff no longer used their mobile phones during their working shift. One member of staff told us that they were now able to lock their bags and phones away in a secure area, which they were unable to do at our last inspection. None of the people we spoke with told us that they had to wait to receive care and support for any reason. The registered manager told us the action they took to ensure mobile phones were not used during staff working times and the staff meeting minutes were produced to show the discussion that took place with staff.

We saw evidence that the window area over seeing the stairs area had curtains to ensure people's dignity and privacy was respected during the night time when the stairs were being used by people in their night wear. People were dressed respectfully and wore clothes that suited their age group. A relative told us that people's dignity and privacy was respected by staff. Staff we spoke with were able to explain how people's dignity and privacy was respected in how they supported them. One member of staff said, "People are covered over when we support them with personal care". We saw that a dignity champion was in place to ensure staff had the knowledge they needed to know how to respect people's dignity.

We found that people we spoke with had difficulty in giving specific examples to demonstrate whether staff met their needs. Overall people's comments were positive, one person said, "They [staff] are so kind and they listen", while other people described staff using the following phrases, 'I like all the staff', 'They're lovely', 'They are good to me'. A relative told us that they were able to visit the home whenever they wanted and were made to feel welcome. Our observations were that the home was friendly and had a homely atmosphere throughout. Staff knew people well and spoke to them with respect and kindness.

We saw that people were able to attend regularly meetings to discuss the care they were receiving. The minutes of a recent meeting showed that menu planning was an item on the agenda and that people and their families had some involvement in deciding the menus. We saw that an advocate service was also available in the home to support people to be able to share their views on the service. People told us they felt listened to and staff acted on their wishes. We saw people's independence being promoted as they were encouraged to do as much for themselves as they could. For example, People told us staff supported them to get dressed rather than do it for them. People were able to make choices and generally have control over their lives by the way they were able to do things for themselves and staff doing what people wanted. A relative said, "My mom has flourished in the home since she left hospital".

Requires improvement

Is the service responsive?

Our findings

People we spoke with told us they were happy. A relative said, "I was involved in the assessment and care planning process for my mom and I do attend reviews". Staff we spoke with told us that their approach to meeting people's support needs were person centred and reviews were carried out regularly to ensure people received the support they needed. We saw evidence of care plans and assessment documentation being used to identify the support needs of people and how staff should meet people's needs. Evidence was also available to confirm that the support people received was being reviewed.

One person was able to explain how they enjoyed painting and we saw several of their works displayed throughout the home and in their bedroom. They told us that staff would support them to the shops when they needed to replenish their supplies. Another person who we saw doing some gardening told us they enjoyed doing the gardening and odd jobs around the home to support staff. Staff told us that a number of people liked to get involved in supporting staff for example, in the kitchen. One person said, "I like to do the dusting" and staff confirmed this. We saw other activities taking place for example, a ball throwing exercise and care staff engaging people in ad hoc activities. These activities were not part of a program of activities that we could see and people's care records did not consistently identify what their preferences, likes and dislikes were to ensure they were able to take part in the things they liked most. People therefore from what we saw had access to limited interaction from staff and spent a lot of their time just sitting in the lounge when there was no planned activity being carried out by an external entertainer.

Two people told us that they did not have any complaints but if they did they would speak to the staff. Another person complained to us about how cold the dining room was and made her feelings known to staff when they went to lunch. But staff did not respond or take any remedial action. Our observations were that the dining room was much colder than the rest of the home; it was small and cramped and needed to be decorated. We raised this with the registered manager who told us this was a concern that had already been noted and there were plans in place to decorate the dining area and look at why the area was so cold in comparison to the rest of the home. No action had been taken to rectify why the area was cold compared to the rest of the home.

The provider had a complaints process in place that was displayed and everyone was aware of how to complain. A relative said, "I would complain to the manager but I have never had cause to". All the staff we spoke with knew about the complaints process and told us they would report any complaint made to them to the registered manager. We found that there was no process in place to record complaints and ensure the complainant would be responded to timely. This meant the provider was unable to analyse any complaints being received and use the information to help improve the service people received.

Requires improvement

Is the service well-led?

Our findings

Everyone we spoke with told us the home was well led and people knew the manager. We found that the atmosphere in the home was inclusive, friendly and people were relaxed around staff.

We discussed the recently replaced carpet in the lounge with the registered manager as we identified concerns. A dementia friendly home who understood dementia care and how to support people would have a plain carpet so as not to cause perceptual problems to people with dementia.

We found that there was a registered manager in post as is required to meet legislation. The registered manager had a clear management structure that staff knew. Staff we spoke with were able to explain who they would contact if the manager was not in the home. They were able to tell us that the manager was available when needed and constantly walked around the home checking on how people were being supported. Our observations were that people interacted well with the registered manager throughout the inspection and that people knew the registered manager well.

We found that a whistleblowing policy was in place to enable staff to raise concerns they may have with the service people received anonymously. Staff we spoke with confirmed they knew about the policy and its purpose, but no one had used the policy to date.

We found that the registered manager carried out regular quality checks on the service people received. For example, medication audits were carried out monthly, regular checks on the environment both in and outside the home, health and safety checks and checks on the quality of support people received. The manager told us the provider carried out audits but we saw no evidence to confirm this, to ensure the standards and quality of the service people received.

A relative said, “I have received a questionnaire to complete. Staff confirmed that questionnaires were being used as a way for checking the service quality, however staff told us they did not complete questionnaires they were only given to people and relatives. Staff confirmed that questionnaires had recently been sent out and they had not yet received them all back from people and their relatives. The registered manager told us that questionnaires were analysed and used to improve the service people received. They also compared the home to other homes locally by visiting the Care Quality Commission (CQC) website as a way to improve the service.

We found that accidents and incidents were being monitored for trends as a way of reducing them and making improvements to the service.

We found that the provider did not return their completed Provider Information Return (PIR) as we had requested. We were informed by the registered manager that the form was not received for this service.

The registered manager knew and understood the requirements for notifying us of all death, incidents and safeguarding alerts as is required within the law.