Waverley Care Homes Limited

Autumn House Nursing Home

Inspection report

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Staffordshire
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

This inspection took place on 29 November 2016 and was unannounced. At our previous two inspections in March 2016 and July 2016 we judged the service as inadequate and placed it into special measures. Services in special measures will be kept under review and the expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At this inspection we found that minimal improvement had been made and the provider remained in breach of two Regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not safe or well led. The service will be judged as inadequate and continue to remain in special measures. We are considering what further enforcement action is required.

Autumn House Nursing home is a home providing accommodation, personal and nursing care for up to 67 people. At the time of the inspection 60 people were using the service. The service was in administration.

There was no registered manager in post and the manager recently employed was leaving. 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.

The systems the provider had in place to monitor and improve the service had not been fully effective in making the required improvements. Although the staff felt supported by the manager, their morale was low as the manager was leaving and they had had several managers over a short space of time.

People's medicines were not being managed safely. People did not always receive their medicines at the required times and in the way they had been prescribed.

There were insufficient suitably trained effective staff to safely meet the needs of people who used the service. There had been an increase in the use of agency staff and several permanent staff were leaving. New

staff and volunteers had been checked for their suitability to work with people.

Risks of harm to people were not always minimised. Some people could not call for help when they needed it and other people's risk assessments were not being consistently followed by staff who knew them.

The manager and staff knew what to do if they suspected someone had been abused, however abuse in relation to people's medicine management had not been recognised and responded to.

People who required support to maintain a healthy diet did not always have their food and fluid intake monitored to ensure they had eaten and drank sufficient amounts. People mostly received health care support in a timely way when their needs changed or they became unwell.

People were not always treated with dignity and respect as some agency staff did not support people to eat and drink in a dignified manner. People did not always receive care that met their individual needs and preferences due to a lack of available, effective staff.

People's right to privacy was upheld and some people were able to choose to be involved in hobbies and activities that were available, however some people had little quality time spent with them due to a lack of available staff.

The principles of The Mental Capacity Act 2005 were being followed as people were consenting to or being supported to consent to their care by their representatives.

People and their relatives felt they were able to have a say in how the service was run and felt able to complain to the manager. However people expressed concern over the manager leaving due to the lack of a consistent manager for a long period of time.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient suitably trained staff to meet the needs of people. People's medicines were not managed safely and people were at risk of harm due to not having their medicines as prescribed.

Risks of harm were assessed however action was not always taken to minimise the risks.

Incidents of suspected abuse were reported to the local authority for further investigation however abuse in relation to people not having their medicines as prescribed had not been recognised and responded to.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always receiving care from staff who were effective in their role due to an increased use of agency staff.

People mostly received health care support when they became unwell and attended appointments when required.

People who required support with maintaining a healthy diet did not always have their food and fluid monitored to ensure their intake was sufficient.

The principles of the Mental Capacity Act 2005 were being followed to ensure that people were consenting or being supported to consent to their care.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

People and their relatives told us that they were involved in meetings about the care they received.

People's right to privacy was respected and upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their individual assessed needs and preferences.

The provider had a complaints procedure which was followed when a complaint was made, however people were concerned about who would be responsible for any concerns raised when the manager had left.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in post and the manager was leaving.

The systems the provider had in place had not been effective in ensuring that improvements in the quality of the service was made.

People, their relatives and staff were concerned as permanent staff were leaving and there was an increased use of agency staff.

Autumn House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This was a return inspection to look for improvements following our previous inspection in July 2016.

This inspection took place on 29 November 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the action plan the provider had sent us following our last inspection. We looked at notifications the manager had sent us about significant incidents. Statutory notifications include information about important events which the provider is required to send us by law. We had discussions with the local authority to gain their views on the quality of service.

We spoke with 10 people who used the service and five relatives. We spoke with the manager, new interim manager, deputy manager, one permanent nurse and one agency nurse, five care staff and the cook. We fed back at the end of the inspection to the nominated individual.

We looked at five people's care records, staff rotas, training records, two recruitment files and the systems in place to monitor and improve the service. We did this to check that good standards of care were being delivered.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found that the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not receiving care that was safe and their medicines were not being managed safely. At this inspection we found that although some improvements had been made the provider remained in breach of this Regulation.

We checked to see if improvements had been made in the management of people's medicines. We found that people were still not receiving their medicines at the prescribed times. We observed people having their medicines administered at times contrary to the prescribing labels. Some medicines need to be taken before food or on an empty stomach. This is because food and some drinks can affect the way these medicines work. We saw one person was administered their medicine with their breakfast when it should have been given on an empty stomach. We saw two people were administered a particular medicine that should not be given with others as it would affect the effectiveness of the medicine. This was clearly recorded on the prescribing labels. We saw another person should have had a medicine stopped, however staff had continued to administer the medicine for a period of two weeks after being instructed to stop the medicine.

We observed a senior member of staff apply eye cream to one person without using any gloves for protection. This put people at risk of infection due to poor infection control measures being used. We saw a tablet on the floor by the medication trolley, we asked the senior staff whose it was and they did not know. We found medicines that needed to be returned to the pharmacy in the home's clinical room. We looked to see why they were being returned and found that several people's medicines had been signed as having been administered. This meant that it was recorded that people had had their medication when they had not. We found that the provider had run out of some people's medicines including a prescribed food supplement. This meant that people's medicines were not being managed safely as people did not have their medicines administered as prescribed. This put people at continuing risk of being unwell due to the unsafe management of medicines.

Some risk assessments had been up dated since our last inspection, however not all staff were aware of people's risks. We were made aware of an incident that had involved a member of agency staff who had given someone a drink who was 'nil by mouth' which means they should not eat or drink anything. They had not been handed over the information about the person's needs. This had happened two days prior to our inspection however medical advice was not sought until the day of our inspection. This put this person at risk of aspiration due to unsafe care and treatment.

We visited people in their bedrooms and saw that some people were reliant on the use of the call bell to call for staff support. We saw several people's call bells were out of reach of people. One person's whose call bell was out of reach told us: "I have to buzz if I want anything. I have a frame but I am not supposed to walk independently with it because of the risk of falling and I need someone to walk with me". This put this person at risk as they were unable to call for assistance if they needed it". We saw records that showed another person whose call bell was out of reach had recently fallen in their room. This meant that risks of

harm to people were not always being minimised.

We saw fluid monitoring charts had been implemented. We saw that the charts were not always completed and the total amount of fluid intake was not recorded. One person was at risk of becoming unwell in if they drank too much. We saw this person's records were not always completed and they were not checked to ensure the person was not having too much fluid. We saw this person's records had not been up dated to reflect an increase in the amount of fluid they could drink. Staff told us that the person could drink a certain amount now however the records did not reflect this. This meant this person was at risk of not being encouraged to drink enough or to drink too much.

On the nursing unit several people were being cared for in bed. We saw that a member of staff had been allocated to specifically check that records had been completed in relation to people receiving their care. For example several people required regular repositioning in their beds to relieve pressure and prevent sore skin. The member of staff was checking that the record had been completed, however they were not checking or observing that the actual care task had been carried out. We saw one person's records showed that they had been repositioned three times, however we observed that the person was in the same position and had not appeared to move. We asked the member of staff how they could be sure that the care had been carried out and they were unable to tell us. This put people at risk of harm as the records did not evidence that care was always carried out.

This was a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that the provider was in breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient suitably trained staff to safely meet the needs of people. At this inspection we found that the provider was still in breach of this Regulation.

People and their relatives we spoke with told us that there were still not enough staff to care for them safely and they were concerned as several staff were leaving. A relative told us: "It's safe here as long as they are not short staffed because of illness or something and I worry then because of the number of agency staff coming in who do not know my relative". Although many agency workers are now regular, and there are one or two top notch agency staff who are top of the job, it's the continual change of night staff that really worries me as they all treat my relative differently until they know her". Another relative told us: "I am not sure about my relative being safe at present because of the many changes. Nine managers in two years and so many agency workers. The problem is continuity and agency staff who don't know my relative. I wish those leaving would just go because I feel their heart is not in it. That is why I come in every day".

Staff we spoke with told us that there was not enough staff to be able to meet people's needs. One staff member told us: "No there is not enough staff. It'd be ok if it had the right balance but the agency staff don't know the residents and it puts pressure on the permanent staff. We need extra permanent staff". On the residential unit there were three members of staff to support 30 people. Out of those three staff one was an agency member of staff who did not know people's needs. We observed a person asking for a bath and initially whilst we were present, they were told they could have one that evening. Later a staff member told us that the person would not be able to have the bath as there would not be enough time due to the staffing levels. This meant that there were insufficient staff to meet this person's needs.

We were informed that the manager, unit manager, a nurse and some care and maintenance staff were leaving. The provider had a plan to recruit to these positions however there would be a period of time when

there would only be one permanent nursing staff. People we spoke with were worried about the staffing levels.

This was a continuing breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they felt safe from harm. The manager and staff knew their responsibilities in relation to safeguarding people from abuse. Referrals to the local authority had been made for further investigation when there had been an incident of alleged abuse. However abuse in the form of neglect and poor medicine management had not been recognised and acted upon.

At our previous inspection we found that the provider was in breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they were not always following safe recruitment procedures. At this inspection we found that improvements had been made and they were no longer in breach of this Regulation.

Since the last inspection the provider had improved their recruitment processes. Previously a volunteer who regularly visited the service had not had a disclosure and barring service check (DBS) to ensure they were fit to work with people. At this inspection we found that DBS's had been completed for the person and new staff employed at the service. Previously the provider could not be assured that agency staff used at the service had the skills and training required and that they were eligible to work. At this inspection we saw that the agency was sending information about the agency staff's training and relevant documentation.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found the provider in breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated activities) Regulations 2014 as the provider was not following the principles of The Mental Capacity Act 2005 (MCA) and ensuring people consented to their care. The 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. At this inspection we found that improvements had been made and they were no longer in breach of this Regulation.

Previously one person who had been assessed as having mental capacity to manage their own finances, had been stopped from looking after their own money and this was causing them anxiety and stress. We found that this had now been discussed and a plan had been agreed with the person and they were now managing their own monies. All the staff we spoke with knew the principles of the MCA and that where possible consent should be gained at all times. We saw where able to people were consenting to their care and support and where they lacked mental capacity, they were being supported by a legal representative.

Previously the manager was not aware of who had a Deprivation of Liberty Safeguard authorisation in place. 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 are called the Deprivation of Liberty Safeguards (DoLS). At this inspection we found that the manager had contacted the local authority and they were now aware of who was had been referred and who had an authorisation in place.

Previously staff had told us that they were not supported to fulfil their role. The manager was not able to tell us if staff were trained and competent in their roles. At this inspection staff we spoke with told us that since the new manager had been in post they felt supported. Individual staff supervision had taken place and training was being delivered dependent on staff's individual training needs. However staff told us they were concerned that due to the manager and other staff leaving that the support would not be there for them. A member of staff told us: "The morale is flat again as several staff are leaving".

People generally felt that the permanent staff were effective in their roles, however some people did express concerns about some of the agency staff. One relative told us: "The regular carers are very knowledgeable about my mum's needs, are well trained and on whole very supportive". At this inspection we had concerns about the effectiveness of some of the provider's staff and agency staff the provider was employing. We observed a trained member of staff apply cream to a person without the use of gloves. We also observed several agency staff caring for people in an undignified manner. We had also been made aware of two other incidents where the ineffectiveness of the agency staff had put one person at risk of harm and another in an undignified position.

People generally received health care when they needed it. One person told us when asked about health

care: "I was not well a couple of weeks ago and they got the GP out to see me straight away". However we saw that one person had waited two days for GP advice following an incident that put their health at risk. We saw that people had health support from other agencies such as the speech and language therapists, district nurses and consultants. Staff supported people to attend health appointments when required. On the day of the inspection we saw one person being supported by staff to attend an appointment to a skin specialist and one person who had become unwell was escorted to hospital by ambulance.

People had mixed views on the quality of food they were offered. One person told us: "The food is good and there is a choice at all meals. At lunch there are two hot dishes and a salad and if you don't like them they will do you something else like an omelette or cheese and crackers". However another person told us: "The food can vary and is sometimes better than other times. My main complaint is the vegetables are overcooked and choice can be limited". Some people required their food and fluid intake monitoring and we found that the monitoring charts were not always up to date and accurate. They were not checked daily to ensure that people had enough to eat and drink. Some people required food supplements to increase their calorie intake, however we saw one person had been without their food supplement for two days as the service had run out of stock. People were supported with special diets if they required one such as pureed or percutaneous endoscopic gastrostomy (PEG) which is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection people told us that the staff didn't have enough time to spend quality time with them. At this inspection people told us that the staff were kind and caring and treated them with respect however they still wished staff would be able to spend more quality time with them. A person who used the service told us: "A member of staff was getting me up this morning and they had to leave me half way through. I was half in and half out the bed and I went cold". Another person told us: "The staff don't have time to sit with you but the door is usually open and they ask if you are alright regularly and pop in to check", another person said: "They never rush you but they are always so busy. They chat as they do things and ask if I am okay, but it's not really quality time".

Some people told us that on occasions the agency staff that were used by the provider were unable to understand them due to language barriers. One person told us: "I can't make my needs known as they [a member of agency staff] doesn't know what I'm trying to say". Another person said: "There are so many of them from all over the world and most are lovely but I have heard them say to other residents and staff on several occasions "I'm sorry I don't understand you" but what can you do if that's the only staff you have". A relative told us: "The agency staff are being caring but I can't always tell what they say and I don't like to keep asking them to repeat it".

We observed lunchtime in the nursing unit and saw that three members of agency staff were helping people to eat. We saw they all stood up over the people whilst supporting them to eat and drink and one agency staff member was supporting two people to eat at the same time. No one informed the agency staff to support people in a dignified manner. This did not offer people a dignified mealtime experience and did not demonstrate respect for the people they were supporting.

People told us that their right to privacy was respected. One person told us: "They make sure the door is shut and encourage me to do what I can for myself but they have to help me wash and dress as I have balance issues. They make sure I have a towel handy to cover myself as well". We observed that staff knocked on people's doors before entering and we saw nothing that compromised a person's dignity throughout the inspection.

People's relatives and friends were free to visit and they were encouraged to have a say in how the service was run. There were regular meetings for people to contribute their views. However one relative told us: "We have meetings but no manager is here long enough to see any ideas and suggestions through"

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had concerns that people were not always receiving care that reflected their individual needs and preferences. At this inspection we still had concerns that people did not always receive care that met their needs.

Most people told us they were offered choices about their care. One person told us: "The staff come on at 8am and usually come to get me up at about 8.30am. I leave it to them to come to me as I will be lying in bed watching TV so it does not matter if they come half an hour later. It's the same at night, no set time. They put me in bed around 8.30pm to 9pm and I watch TV till midnight". However some people told us they were not always able to make requests of choices about their care. We observed that one person had asked for a bath and they were initially told they could have one and then told they couldn't have one due to a lack of staff. They told us: "In a perfect world I'd like a bath every day but I know that can't happen, so once a week would be ok. I can't remember when I last had one but it's within the last two weeks." A member of staff told us: "[Person's name] has asked for a bath but they will be unlikely to get one as there is not enough staff". Another person told us: "I understood I could choose things like what time I get up but this is not the case. This morning the staff woke me at 10 to10 and I told them 'Leave me alone, I want to stay here and sleep'. But they showed me the clock, told me it was time to get up and got my clothes out for me. I asked why they were getting my clothes as I usually choose my own but I got no answer. Could it be because you are here?"

Most people were offered hobbies and activities of their liking. There was a planned activity schedule which many people who were able to attend enjoyed. We saw people enjoying a game of bingo and pets for therapy had brought in some dogs for people to have contact with. A Christmas fayre was planned and the activity coordinator showed us that they had held themed days and evenings dependent on the time of year and occasion. We asked about people who were being cared for in bed and the activity coordinator told us that they did what they could to spend a small amount of time with people but they needed more staff to be able to spend more time with people. They said: "I like to know that people have spoken to someone else other than the care staff". We saw records that showed that the activity coordinator offered people in their rooms a ten minute chat when they could.

The provider had a complaints procedure and we saw that the manager had receieved and responded to one formal complaint according to the procedure. People and their relatives told us if they had concerns they would speak to the manager and they were confident that they would respond. However people expressed concern as the manager was leaving and this left them unsure as to who would be responsible if issues arose.

Inadequate

Is the service well-led?

Our findings

At our previous inspection the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems the provider had in place to monitor and improve the service had been ineffective. At this inspection we found that the provider was still in breach of this Regulation.

There was no registered manager and the manager in post was leaving. We were informed that several members of staff were also leaving. Staff morale was low and one member of staff told us: "We were getting things in place and now it feels like its falling apart". Another member of staff told us: "No manager will succeed here".

Previously we had found that the management of people's medicines was unsafe. The provider had implemented weekly medication audits; however the manager told us that these were not being completed. At this inspection we found that people were still not always receiving their medication or they were not having it at the prescribed times. Medication systems in place were ineffective as there were several medicines that could not be accounted for. The medication administration sheets were not audited to check for missing signatures.

Previously other records within the service such as food and fluid monitoring records were not audited to ensure people had the required amount to eat and drink. We found that there had been no improvement and the lack of effective record keeping was putting people at risk of harm.

Staff performance was not always being observed to ensure they were delivering good quality care. We observed a member of staff apply cream to a person without using gloves and some agency staff were seen to treat people in an undignified manner whilst supporting them to eat. There was no clear leadership evident and no one explained to the agency staff that this was not appropriate. We were also made aware of two further incidents involving agency staff that had compromised people's health and welfare. The manager told us that they were completing competency checks, yet staff we spoke with told us they hadn't been observed. This meant the quality of care being delivered to people by staff was not always being monitored to ensure it was safe and appropriate.

These issues constitute an on-going breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is required to notify us of events that affect the delivery and quality of the service. We were told that the people at the service had recently had a sickness outbreak which had affected the way they were being cared for. We had not been notified of this event.

The manager and staff had updated people's care plans and risk assessments, since our last inspection however these were not always being followed by staff. This meant that some people were not receiving good quality care that met their individual assessed needs and their preferences.

People and the staff spoke well of the manager, but expressed concerns as they were leaving. One person told us: "It just doesn't feel right at the moment, I am worried, the staff are always leaving, it's just gone downhill". A member of staff told us: "The residents don't know if they are coming or going with the amount of managers and staff".