Mrs Lalitha Samuel

Friars Hall Nursing Home

Inspection report

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Date of inspection visit: 02 March 2015
Date of publication: 15/04/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 27 and 28 November 2014. A breach of legal requirement was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, safeguarding people who use services.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

Friars Hall Nursing Home provides nursing care for older people and those with physical disabilities and dementia. The service can accommodate a maximum of 54 people. At the time of our visit 41 people were living at the service.

A new manager had been appointed on 26 January 2015, but they were not yet registered. 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.

At our last inspection on 27 and 28 November 2014 we found people were not being protected from abuse, or the risk of harm. Staff lacked knowledge of the provider's policy, and had failed to recognise and respond to incidents of verbal and physical abuse between people who used the service. These had gone unnoticed, and had not been reported to the local authority, safeguarding team. Following the inspection the provider sent us an action plan to tell us the improvements they were going to make.

During this inspection we looked to see if these improvements had been made. Systems had been

Summary of findings

implemented to ensure that risks to people's health, safety and welfare were being identified and managed. Appropriate arrangements were in place to ensure people were protected from abuse, or the risk of abuse. Training had been provided to staff so that they understood and were able to describe types of abuse, and knew who to report concerns to.

A new manager and clinical lead had been appointed; supporting nursing staff to effectively address areas of risk to people's health, safety and welfare. Care plans were in the process of being revised and contained more detailed guidance for staff so that they knew how people's health and social care needs were met.

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?

We found that action had been taken to improve people's safety.

The provider had put suitable arrangements in place to manage risks, and manage safeguarding matters.

Staff understood their responsibilities to report concerns and safeguard people against the risk of abuse.

Inadequate

Friars Hall Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Friars Hall Nursing Home on 02 March 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 27 and 28 November 2014 inspection had been made. The team inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting some legal requirements.

The inspection was undertaken by two inspectors. During our inspection we spoke with one person who used the service and one relative. We spent time observing the care people received to help us understand the experiences of people who were unable to talk with us, due to their complex health needs.

We looked at records in relation to seven people's care. We spoke with three staff including care, nursing and activities staff. We also spoke with the deputy and manager. We looked at staff training records.

Inadequate

Is the service safe?

Our findings

At our last inspection on 27 and 28 November 2014 we asked the provider to take action to make improvements to ensure people who used the service were safe. This was because people were not being protected from abuse, or the risk of harm, in a consistent and positive way that protected their dignity and rights. Staff had lacked knowledge of the provider's policy, lacked training to support this policy and there was a general confusion as to what made a safeguarding concern and how it should be responded to. This had led to incidents of verbal and physical abuse between people going unnoticed, and not being reported to the local authority safeguarding team.

At this inspection we found the provider had taken steps to ensure that staff had been trained in how to identify the possibility of abuse and know how to prevent it before it occurred. Records provided by the new manager showed that combined safeguarding adults, and dignity awareness training had been provided on 11 February 2015. A further session had been booked for 11 March 2015 to ensure that all staff, unable to attend the first training day, had received up to date training. Staff spoken with had a better understanding of safeguarding and what this meant in terms of protecting people from abuse and keeping them safe.

Staff confirmed they had read, or had been asked to read, the providers safeguarding adult's policy and procedure and that this had been discussed at staff meetings and supervision. Posters had also been displayed in the entrance hallway and communal areas of the service providing information to people, their relatives and staff about safeguarding adults and how to contact the Local Authority to report abuse. Staff clearly described the process they would follow to report concerns, through the management team and via the Local Authority Safeguarding helpline, Customer first. Where two incidents of aggressive behaviour had occurred between people who used the service, the deputy manager had taken appropriate action to address these issues, including discussion with the Local Authority safeguarding team.

The atmosphere in the service was calmer and more relaxed than our previous inspection. This was confirmed in discussion with a relative, who told us, "A lot of new people had moved into the service last year, and they had not settled very well. They have settled in now, and the home is a lot calmer. The home is lovely, as are the staff."

The number of people living in the service had reduced from 48 to 41 since our last inspection. The new manager told us they had reorganised the allocation of staff, and had increased the number of nurses on shift, by using agency staff. Staff told us fewer residents and more staff meant they had more time to spend with people, resulting in fewer incidents of behaviours that challenged. One person told us, "It's getting better and better here."

New documentation, including risk assessments, behavioural support plans and behaviour monitoring charts were in the process of being implemented for people identified with complex behavioural needs. These were being completed with input from a community psychiatric nurse and relatives, and took into account people's emotional and psychological needs. These documents provided guidance to staff on how to support people who due to their dementia or mental health may at times be angry, frustrated or confused. Staff spoken with had a better understanding of how to support people's behavioural needs. For example, a member of staff told us where one person became "Aggressive if there was too much noise," they had reduced their exposure to noise by providing additional one to one support to divert their attention during these times.

At our previous inspection we found that the provider had failed to take appropriate action to ensure people were protected against the risk of harm or which placed them at risk of harm. For example, no risk assessment had been undertaken following an initial incident and measures had not been taken to minimise or prevent the risks for anyone else in the future. This had left people at continued risk of harm, and a similar incident had occurred, which could have been avoided. At this inspection the provider had carried out an assessment of equipment to keep people safe. This assessment clearly set out the risks, and measures in place to reduce the likelihood of such an event reoccurring.