

Countrywide Care Homes (2) Limited

Argyle House

Inspection report

The Avenue
Dallington
Northampton
NN5 7AJ

Tel: 01604 589089

Website: <http://www.mmccarehomes.co.uk/our-care-homes/argyle-house>

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Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Requires Improvement



Is the service caring?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



Overall summary

This unannounced inspection took place on 16 June 2015. Argyle House has four floors providing care for up to 87 people with varying care needs including those living with dementia and those that require nursing care. Two floors provide residential care and two floors provide nursing care.

There was a registered manager in post at the time of our 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 meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People lived on one of four floors, where their experiences differed according to their complexity of needs and the staff team that looked after them.

Summary of findings

Recommendations made by health professionals were not always carried out, which resulted in people not always getting sufficient support to eat and drink enough to maintain a balanced diet.

Risks to people were not always appropriately identified and managed. Staff had received the appropriate training but they did not always carry out care in line with their training.

People did not always receive the care that was planned and people were not always able to summon assistance when they needed, although there were enough staff on duty to provide care and support to people when they needed it.

People were not consistently treated with compassion, kindness, dignity or respect and their experience of care differed depending on their level of dependency and ability to speak up and be heard.

The manager and staff had a good understanding of meeting people's legal rights and the correct processes

were being followed regarding the Deprivation of Liberty Safeguards. However people's ability to influence their day to day care differed depending on which floor of the home they lived and whether they could speak for themselves.

People and their relatives had not been enabled to offer feedback or to influence how the home was run. The culture in the home was predominately task orientated and there was no encouragement from the manager to be creative in planning care. The quality monitoring was not always effective and needed to be strengthened.

We identified a number of areas where the provider was in breach of Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and you can see at the end to this report the action we have asked them to take.

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?

Risks to people were not always appropriately identified and managed.

Staff understood their roles and responsibilities to safeguard people in the home, however they did not always report safeguarding incidents or concerns to the relevant authorities.

There were enough staff on duty to provide care and support to people when they needed it. However people perceived that staff were less attentive at the weekend.

Medicines were stored and administered safely.

Requires Improvement



Is the service effective?

The service was not always effective.

Recommendations made by health professionals were not always carried out resulting in people not always having sufficient support to eat and drink enough to maintain a balanced diet.

Staff received appropriate induction and training, however this was not consistently reflected in the way in which they cared for people in the home.

Regular supervision and appraisal systems were in place for staff.

The manager and staff had a good understanding of meeting people's legal rights and the correct processes were being followed regarding the Deprivation of Liberty Safeguards. However not all people were enabled to have a say in how their day to day care was delivered.

Requires Improvement



Is the service caring?

The service was not always caring.

People were not consistently treated with compassion, kindness, dignity or respect and their experience of care differed depending on their level of dependency and ability to speak up and be heard.

People's belongings were not always well cared for.

Requires Improvement



Is the service responsive?

The service was not always responsive.

Assessment processes and care plans were in place however people did not always receive the care that was planned.

People were not always able to summon assistance when they needed.

People's experience of influencing their care differed depending on which floor of the home they lived and whether they could speak for themselves.

Requires Improvement



Summary of findings

People that found it difficult to communicate did not always receive one to one time with staff or any other opportunities to participate in activities and stimulation.

Is the service well-led?

The service was not always well led.

People and their relatives had not been actively engaged or enabled to influence how the home was run.

The culture in the home was task orientated and there was no encouragement from the manager to be creative in planning care.

Staff were not confident in raising concerns and there was a need to create greater opportunities for staff to be heard.

The quality monitoring was not always effective and had failed to identify the issues and concerns identified as part of this inspection.

There was a registered manager.

Requires Improvement



Argyle House

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 15 June 2015 and was unannounced.

The inspection team consisted of three Inspectors, a specialist advisor who had a background in dementia care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses dementia care service.

Prior to the inspection we reviewed the information we hold about the service such as notifications, which are

events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider and the local authority safeguarding team.

During our inspection we spoke with nineteen people who used the service, eight relatives, and sixteen staff including the registered manager, quality assurance manager, two clinical leads, one chef, five support staff and six care staff. We also looked at records and charts relating to fifteen people and four staff recruitment records. We also spoke with a visiting district nurse.

We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and the arrangements for managing complaints.

Is the service safe?

Our findings

People and their relatives had access to systems through which they were supported to raise any concerns about their safety. Staff had received training and understood their roles in safeguarding people from harm. They demonstrated an understanding of the types of abuse and there was a safeguarding policy in place which guided staff in the process to follow if they had any concerns. Most safeguarding concerns had been raised where necessary however we found some examples of incidents that had not been identified as safeguarding issues and had not been reported as required by the Commission. For example grade three pressure ulcers had not been reported under these procedures.

The risk management infrastructure in the home required closer oversight in order to ensure that risks to people were appropriately identified and managed. There were a range of risk assessments tools in place and these were being regularly utilised to inform people's care plans. However we found that at times these failed to accurately identify people's level of risk which had the potential to delay people receiving appropriate medical / professional input. For example we found that staff had failed to revise people's body mass index (BMI) in response to changes in their weights and therefore their malnutrition (MUST) assessments were misleading and may have impacted upon timing of seeking professional input. We found similar failing in relation to accurately calculated risk in other assessment tools such as those used to assess depression in people living with dementia.

People felt that there were some inconsistencies in staff availability, although they felt that there were enough staff during the week days they found they waited longer for care over the weekends. One person told us "I do wonder if they're short staffed at weekends" as they had to wait longer for care. Staff reported that they felt under more pressure during weekends due to unexpected sickness levels. The manager used a staff planning 'model' that calculated the numbers of staff required to meet the dependency requirements of people using the service. Records demonstrated that there was a consistent pattern of staffing with no changes to the number of staff on duty over weekend. However the management team should explore the reason why both staff and people perceive a difference in staffing levels at the weekends

There were appropriate recruitment processes in place. Staff were only employed at the home after all essential pre-employment checks and evidence of their good character had been satisfactorily established.

There were appropriate arrangements in place for the management of medicines. Staff had received training in the administration of medicines and passed competency tests that demonstrated they were knowledgeable. People told us that they received their medicine when they needed it. We observed staff administering medicines to people and heard them explain what the medicines were for. Staff followed guidelines to give medications that were prescribed just in case of pain or other symptoms, such as Paracetamol.

Is the service effective?

Our findings

People's risk of not eating and drinking enough had been assessed and individualised care plans were developed. Where indicated relevant health care professionals were involved in people's care, however we were concerned to note that the instructions of health professionals were not consistently followed.

People did not always receive the recommended support they required to eat their meals. For example, one person had been referred to the speech and language team for their problems with swallowing, the staff had been advised to ensure that the person sat upright to have their meals to prevent them from choking; however, we observed staff attempting to spoon feed the person with their lunch whilst they were lying flat. This person was at risk of choking as staff were not following the recommendations of the speech and language therapist.

People did not always receive the food they required to meet their needs. For example one person had been assessed by a health professional as requiring soft finger food, such as banana or cooked carrots, however, their relative told us that they often found that they had been given sandwiches which the person could not cope with, they were concerned enough to regularly bring in milkshakes which they helped their relative to drink. There were no charts to show what they ate and drank over the last week to ensure that they had had a balanced diet. This person was at risk of not eating enough to maintain their weight as staff were not providing food in a way that had been recommended by health professionals.

People did not always receive recommended fortified drinks. For example staff had sought dietitian input for one person who no longer had a good appetite and regularly only ate very small amounts of their meals. The dietitian had recommended they were offered a fortified drink after their meal or at any time in the afternoon. We observed that this person only ate a small amount of their meal however they were not offered a fortified drink. We asked the member of staff what they would offer the person now they had not eaten their meal, they told us that they would let the person sleep. Food charts from previous days also showed that they had only eaten a small amount of their

meals yet there was no evidence that they had been offered a fortified drink. This person was at risk of losing weight as staff were not following the recommended guidance of the dietitian.

People were at risk of not receiving enough to drink. Where there were charts in place to record people's drinks, the staff had not been consistent in recording what people had drunk. For example one person's care plan stated that staff needed to ensure that a person had adequate drink, although the plan did not state how much they should drink in one day. We saw that for one week the charts recorded that they had drunk less than 440mls per day, and as little as 170mls (a cup full) in one day yet staff had recorded in the daily record at the end of the day that the person had 'ate and drank well'. There was no evidence to demonstrate that this person had received adequate fluids daily.

People's mealtime experience was not always positive. We observed mealtimes on two floors. One person did not eat their main course as they were falling asleep; we noted that the staff had not encouraged that person to eat their meal. On the first floor one person sat alone in the dining area, whilst all the other people sat in armchairs in the lounge to have their meals. There was no sense of occasion for the meal, the tables were not set and there was no repositioning from the lounge to encourage social interaction. One person had spilt food on their lap and this went unnoticed by staff.

People did not often have their choice of food. The chef told us that they had provided meals for people who preferred West Indian or Chinese foods, however, when we spoke with people they told us that this happened very occasionally and was not a regular occurrence. One relative said that their family member enjoyed spicy foods but that this was not often on the menu.

This is in breach of Regulation 14 (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's experience of the way their health was monitored varied. Those people who were able to speak for themselves were aware that the GP visited regularly and they knew they could ask to see the GP if they wanted to. However, where people could not speak for themselves they relied on staff accurately assessing their health needs and referring them to health professionals. We were concerned to find that some of the assessment tools that

Is the service effective?

staff used to calculate people's health had not been used correctly as the information on the assessments were inaccurate. There was a risk that people may not always be referred to healthcare professionals in a timely way as the information available to staff to indicate people's health needs were not always correct.

However, staff did not always rely on the assessment tools and where they noticed a change in a person's condition, they did refer people, this was confirmed by a visiting healthcare professional who confirmed that the staff had identified people that needed to be seen during their visit as staff had recognised when their condition had changed.

The manager provided training records that demonstrated that all staff received regular training that would help them to provide for people's needs, for example caring for people living with dementia. We observed that some of the training had not been used in practice when helping people with their meals or calculating people's risks.

Staff were supported in their role by regular supervision and appraisals. Staff had supervision meetings every two months and annual appraisals took place in the summer months. Staff felt supported by their line managers; "I am happy with the support I get from the clinical lead, they are easy to contact." New staff underwent a period of induction and received mandatory training such as moving and handling before working with people. New staff then worked closely with more experienced members of staff until they were deemed competent; the length of this time depended upon their experience of care work.

Not all people had access to the available resources that would help to encourage and maintain their

independence. People who were living with dementia lived on the ground floor, they had free access to a large lounge and garden area which observed was used regularly. Relatives told us that people enjoyed using these areas. People who lived on the other three floors also had access to these areas via the lifts; however, people did not use the space regularly although they were encouraged to do so by the activities co-ordinator. The provider had partitioned the garden to try and encourage people from all parts of the home to use the outside space, but the information had not been relayed effectively to all the people who used the service.

The manager and staff understood their roles and responsibilities in ensuring that people are involved in decisions about their care and how this is delivered. They had received training and had policies to guide them how help people to participate in decisions that affected their care and how to act if people were not able to make decisions for themselves. The manager understood their responsibilities and was clear on the action that they would take if it was necessary to deprive or restrict people's liberty. Some people that lived at the home did not have the capacity to make decisions for example, to the use of bed rails. While one person had been unable to consent to bedrails, the family members were able to tell us that they had been consulted and 'trusted the professionals'. A DoLS application had been made and 'best interests' decision had been taken in line with legislation and guidance

People had also given their consent for example for influenza vaccinations and for photographs to be taken of them during activities.

Is the service caring?

Our findings

People were not consistently treated with compassion, kindness, dignity or respect and their experience of care differed depending on their level of dependency and ability to speak up and be heard. Where people had challenging behaviours we observed staff treat people in an inpatient manner and to become frustrated. For example where one person was shouting, we observed one member of staff express their frustration verbally. Some staff expressed concern to us that where people had challenging behaviours that other staff did not seem to cope and ignored some people's cries for help. We fed this information back to the provider.

The approach to maintaining people's privacy and dignity within shared rooms could be improved.

For example two people that shared a room did not have any privacy from each other, even whilst receiving personal care. Staff had the provision of a screen they could use, but it was evident that the screen had not been used for some time as it was covered in dust and stored in the bathroom. When we asked the staff how they ensured that people were afforded their privacy, they were not aware that there was a screen in the bathroom.

Staff providing care for people with limited physical abilities were not always considerate with the positioning of people within their rooms. For example one person who was cared for in their bed and could only see out of their left side, had their television and table with drinks on placed to their right side. This person could not see to reach for their drink or see the television. Their relative told us that it was awkward for their relative to reach their drink as they could not see it.

People's belongings were not always respected or well cared for. Relatives we spoke with were concerned at the number of items of clothing and footwear that had been lost in the past year. The manager had placed a notice in the home to ask relatives to collect any unclaimed or unmarked laundry on a specific date; however some relatives had not seen the notice and were not aware of this. There had been a very large amount of clothing that

had not been claimed that had recently been sent to a local charity shop. This meant that some people and their relatives had not been given adequate opportunities to claim their clothing that had been misplaced by staff in the laundry.

People's experiences of staff interaction differed depending upon which floor they lived on. Most of the positive feedback came from people living on the residential floor (third floor); people were looked after by staff that had developed positive caring relationships with them. People told us that the staff were very kind. One person said that they really enjoyed chatting to [staff member]. They said "[staff member] is always cheerful and they make me feel better after they have been in for a chat, sometimes they take me out and I really enjoy that."

Some staff responded positively to people's changing needs. We observed one person appearing anxious, we saw that staff approached them and encouraged them to move to a different environment; staff told us that the person needed staff to talk to them in order to reduce their anxiety and make them feel calm.

We saw activities staff approach people in a kind and caring way taking time to allay one person's anxieties and then to encourage another person to come and take part in an activity as they were unsure if they wanted to take part. We heard the staff member suggest that the person could come and watch the activity [board games] and didn't have to join in if they didn't want too. This encouraged the person to go to the room where the activity was taking place.

We observed staff when they were talking with people who had good communication skills, most of them were courteous and respectful and clearly had good relationships with those they cared for. We also observed that some staff members were communicating with a resident using their native language. They had phrases translated into English to enable them to do so. We saw that the person was enjoying this contact with staff as they were smiling and laughing, their relatives stated that all the staff are lovely and friendly.

Is the service responsive?

Our findings

People were assessed before they went to live at the home, to ensure that their individual needs could be met. A relative of a person that had recently come to live at the home said that the transition to the service had been “really good”; they were pleased that the member of staff that had completed the assessment of their relative prior to admission had come in on their day off to greet their relative.

People were continually assessed for their physical and emotional needs. People had individualised plans of care to meet their needs. The care plans were instructive to staff, for example the plans explained how people required help to mobilise and how to prevent falls. The care plans were reviewed on a monthly basis, where needs had changed, we saw the plans of care had been updated.

People’s daily records and charts recorded that staff had provided care as detailed in the care plans. However, we observed that for two people the staff had recorded over night that their position had been changed to relieve their pressure areas, whereby other staff and relatives informed us that these people could not be moved into the position the staff had indicated. These people were at risk of developing pressure ulcers as they may not have been receiving care at night to relieve their pressure areas.

Some people were not always able to summon assistance when they needed as they did not always have access to their call bells. Systems were in place for staff to check regularly that people had access to their call bells, these systems relied on staff ticking off a checklist, however we saw at times the checklist was ticked even when people did not have access to their call bells.

People’s interests and information about their past lives were recorded. Some staff demonstrated that they knew the people they cared for. For example, a member of staff made reference to a person’s skill as a shorthand typist; ‘I wish I could do shorthand like you’. The person smiled and told us they were proud that they did pitman shorthand at night school to learn this.

People did not always have the opportunity to take part in activities. Where people spent time alone in their rooms for most or all of their time, there were no arrangements in place to encourage regular social interaction or to follow their hobbies and interests. However, social interaction and activities which involved people were available in group settings. We observed activities taking place and we noted that these were attended by the same groups of people daily. For those people that were able to express their interests and needs we saw that arrangements were in place to take them out for example, shopping.

People’s experience of influencing their care differed depending on which floor of the home they lived and whether they could speak for themselves. Some had good experiences, where they had discussed a change in the timing of their care, and others had not had the opportunity to engage so well with staff. People were aware that they could raise a concern about their care and there was written information in each person’s room on how to make a complaint. Some relatives said that the manager was approachable and that if they had any concerns they would also be happy to talk to the staff that provided the care to their family member. Some of the people were not so confident that their concerns would be listened to as they had been continually complaining about the lack of access to the garden for over a year and they perceived that their voice had not been heard.

Is the service well-led?

Our findings

Although there were opportunities for people to have a say in the way that the service was run as meetings were held every other month, however there was limited uptake of this option; records showed that in the last meeting no relatives attended. We noted from the minutes of the previous meetings that items such as lost property, activities and staff changes were discussed but there was little evidence that people had influence over the way the home was run.

The service had not been able to engage with relatives to gain feedback about the service despite using different avenues of communicating with them. We asked for the satisfaction survey but the manager was unable to provide us with this for 2014, however the 2015 survey was about to take place. People who used the service told us that they had not been asked to complete a survey, although some people expressed a wish to provide feedback.

The culture was not always positive. We observed that the culture was task orientated and there was no evidence of encouragement from the management to be creative in planning care. Some staff told us they felt excluded, they described the teams as being a clique and did not feel part of the team. The service did not promote an open culture; although most staff were aware of the service's whistle blowing policy and had signed to say that they had read the policy; not all the staff felt confident enough to approach the manager with their concerns. Some staff raised concerns during the inspection that they had not raised at the time of the incidents. The provider gave an undertaking to explore why staff lacked confidence to raise concerns and to look at how more opportunities could be made available to them.

Regular staff meetings were held and included day and night staff. The minutes demonstrated that the manager had discussed issues with staff such as updates on training opportunities, safety of the premises and confidentiality. However there was no evidence that staff had been involved in developing the service or encouraged to raise ideas about improving care.

Although the provider measured the quality of the service regularly; senior quality control staff visited the service to audit the care that had been provided and the quality of the care records, the provider did not have insight into the issues about nutrition and hydration as the manager's quality monitoring had failed to pick this up.

Not all the quality monitoring was effective, as the manager had not noticed that some of the risk assessments and turn charts were not accurate and that fluid charts were not completed.

This is in breach of Regulation 17 (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service had learnt from incidents and safeguarding alerts. Following a review of falls that had occurred within the home, there had been changes made to the environment in the areas where some of the falls had taken place. The environment was now clear of some furniture which gave people more space to walk and to reduce the 'bottleneck' in some areas where falls had occurred.

The registered manager had notified the Care Quality Commission (CQC) about most events that happened in the service; such as accidents and incidents and other events that affected the running of the service. However we found that they had not notified CQC about some safeguarding concerns that had arisen in the home such as the development of grade 3 pressure ulcers.

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

Accommodation for persons who require nursing or personal care
Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

How the regulation was not being met:

The nutritional and hydration needs of people who use the service were not always being met. Regulation 14 (4a and d).

Regulated activity

Accommodation for persons who require nursing or personal care
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Sufficient systems and processes were not in place to assess, monitor and improve the quality and safety of the services provided to people who used the service. Regulation 17 (2 a).