Fishponds Care Limited

Quarry House

Inspection report

Adelaide Place
Channons Hill
Bristol
Avon
BS16 2ED

Tel: 01179654466

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20 July 2017

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out a focused unannounced inspection of Quarry House on 20 July 2017. Prior to this inspection, we had received concerns about the health, safety and welfare of people living in the home. The concerns related to staffing levels, the deployment of staff within the home and the impact this had on the care and support people received. Concerns had been received from local authority safeguarding and quality monitoring teams and from staff working in the home.

We undertook this focused inspection to ensure that people living in the home were safe, and that there were sufficient staffing arrangements in place to make sure people's care needs were being met. This report only covers our findings in relation to these areas. When we last inspected Quarry House, in September 2016, we found that staffing was insufficiently deployed and did not always meet people's care and treatment needs. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Quarry House on our website at www.cqc.org. The current overall rating for the home is 'Requires Improvement.'

Quarry House is registered to provide accommodation for up to 65 people who need nursing or personal care. At the time of our visit, 61 people were living in the home.

There was no registered manager in post at the time of our visit. The current manager had commenced in post in January 2017. They were leaving Quarry House on 21 July 2017. Another manager had started one week before our visit. They told us they would be applying to the Care Quality Commission, (the Commission), to be the registered manager for the service. 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 who used the service and their relatives provided mixed feedback about staffing. Staff were not always confident they could meet the care needs of people living in the home. Staff were also concerned that further changes in management would affect the support they received.

Staff were not always sufficiently deployed to provide the care and support people needed and when they needed it.

We found there continued to be a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that we had identified at our last comprehensive inspection undertaken in September 2016. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Sufficient numbers of suitably qualified staff were not always deployed to make sure people's needs were consistently met.

People were not always provided with care when they needed it.

We could not change the rating for this key question from requires improvement. During the last comprehensive inspection we identified shortfalls in other areas of care provision in the safe domain, for example, management of medicines. These were not reviewed during this focused inspection. We will review our rating for safe at the next comprehensive inspection.

Quarry 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out a focused inspection of Quarry House on 20 July 2017 following safeguarding concerns being raised. These concerns related to the staffing of the home.

The inspection was unannounced and undertaken by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of this type of service. The inspection involved inspecting the home against one of the five questions we ask which was, 'Is the service safe?'

Due to the number of individual safeguarding concerns, this service has been under a process of 'organisational safeguarding'. This is a process initiated by the local authority as a result of the number and/or severity of concerns raised with them. The Commission has been closely involved with other health and social care professionals regarding the service.

During our visit we spoke with 15 people who used the service and five visitors.

We spoke with the representative for the provider, two home managers, the deputy manager and 17 staff including registered nurses, care staff, activities staff, housekeeping and agency staff. We spoke with two visiting health professionals.

We observed how staff provided support and interacted with people using the service in each of the eight areas of the home. We checked the timeliness of staff responses to people when they called for assistance from staff.

During the inspection, we conducted a Short Observational Framework for Inspection (SOFI 2) assessment. SOFI 2 provides a framework for directly observing and reporting on the quality of care experienced by people who cannot describe this for themselves.

We looked at peoples' care and monitoring records and records relating to the monitoring and management of the home.

Requires Improvement

Is the service safe?

Our findings

Most of the people and visitors we spoke with told us they had concerns about staffing levels in the home. The feedback about staffing on two floors of the home was consistent in that everyone we spoke with told us there were not enough staff on duty to meet people's care needs. Comments included, "There is absolutely not enough staff. Sometimes I would like to get up but I have to wait. It's the same at night. I have to wait", "I think they really need another carer to be on the floor when the other two [staff] are helping people", "You have to wait and wait" and, "There used to be lounge assistants to help people, but they appear to have got rid of them".

The feedback from people and visitors on the other two floors was mixed and we received comments such as, "I'm not rushed and sometimes I get up very early. Nobody tells us what to do and I'm not rushed at night", "It seems a little short sometimes. There's not a lot of them [staff] around, but I'm independent, they don't really do anything for me" and, "Sometimes my relative does have to wait if staff are busy with someone else. Once or twice they may have had to wait for some time, but it's not too bad. It usually only happens if one carer is on break, then they have to wait for the other to come back".

However, people who were able to express their views told us they felt safe in the home. Comments included: "I do feel safe living here, I'm not afraid of anything", "Yes I do feel safe. There's always someone here and the doors are locked at night and during the day" and, "I think we're safe enough in here".

We also received mixed responses from people about staff responses to calls for assistance. People told us, "I don't like to use the buzzer. They [the staff] say to use it, but they're so busy", "No, they [the staff] never come quickly when you ring the bell", "I have a wait for them to come when I press the bell" and, "I used the call bell when I first came here, and they always seemed to come quickly".

The provider had submitted an action plan to the Commission following the last inspection. The action plan that was sent to us in November 2016 stated 'Home Manager / Nurses / Team Leaders to monitor nurse call bell response times.' We received an update to the action plan in July 2017, prior to our inspection visit. The update stated that a call bell audit had been completed in June 2017 and that spot checks were being undertaken. Records of the audit or the spot checks were not available during our visit. We asked for this information to be sent to us after our visit. We did not receive it and we were told it could not be located. This meant the provider could not demonstrate improvements had been made, or that people consistently received a more timely response to calls for assistance.

We called for assistance for one person who shouted for help as we passed by their room. There were no staff present at the time in this area of the home. The staff were in the other area on the same floor. The person was not able to use the call bell. We stayed with the person for 10 minutes. We then used the call bell and staff responded within two minutes.

Most of the staff we spoke with told us they did not always have enough staff to provide the care and support people needed. Staff told us they had raised concerns about staffing levels and deployment of staff

in the home on a number of occasions. We read the minutes of a registered nurse and team leader meeting held in June 2017. It was recorded that the home manager was aware of the staff shortages and that they were working with senior management to review and increase the staffing budget. During our visit we were told that an increase in staffing had taken place and an additional member of care staff had been agreed. We read the minutes from a meeting held with night staff in June 2017. The home manager had recorded at this meeting they were trying to increase the staffing levels. The staffing levels for night shifts had not been increased since this meeting. We were shown the results from the 'Bristol Care Homes Annual Staff Survey' This had been completed by 19 staff. In response to the question, 'Do you feel staffing levels are adequate?' 21% of staff answered 'Yes', 68% of staff answered 'No' and 5% of staff answered ''Sometimes'.

The Commission had received whistleblowing concerns from staff that had led to us raising safeguarding alerts with the local authority. This was because staff had given specific examples of how they believed insufficient staffing levels had impacted on the care and treatment people received.

Some staff told us they were often allocated to work in different areas of the home. They told us this meant they were able to compare the staffing throughout the home. Staff told us there were two floors on the home where they believed staffing was consistently not sufficient. One member of staff told us, "I go home crying some days it's so draining upstairs" and, "It's not so bad on the ground floor because they're [people using the service] more independent but we need more staff it's as simple as that."

In one area of the home staff told us they had the time to provide the personal care people needed. A member of staff told us, "I think we meet people's care needs, like washing, dressing, food, but other things like going into the garden is hard. We can't just leave one member of staff on the floor." Another member of staff told us, "It's better than where I last worked. I think it's a lovely place and most of the time we have enough staff. It's just if staff are sick and we have agency staff then it's more difficult."

Staff in the other areas of the home told us they did not always meet people's care needs. Staff told us, "[Name of person] was left on the toilet for 10 minutes this morning as there was no one to assist as she was giving personal care to someone else and the agency staff had gone to fetch milk from another floor", "In the last two days [name of person] has not been getting up at 8.30am as she likes to. We have not been able to get her up until 11.30am as it can take up to 45 minutes" and, "[Name of person] loves a bath, but it takes about an hour and we don't always have time".

We observed care and support provided to people in the communal areas, and we observed staff interactions with people throughout the day of our visit. We saw that staff usually stopped and briefly spoke with people as they passed by. For example, we heard a member of staff ask one person, "Would you like another cup of tea?" then, "Of course, I'll get you one right now. Would you like a biscuit too?"

We also saw that staff sometimes walked past people without acknowledging them or addressing their needs. For example, in one area of the home at approximately 11.25 am, six people were sitting in a communal lounge, where music was playing on the television. Three people were asleep. One person had their head in their hands and called out, "Turn it off." One member of agency staff was present in this area. They responded to the person by saying, "Yes sir". However, they did not respond to the person's request. The person slowly bent forward in their chair until their head was almost on their knees. When other staff passed through this communal area, they did not acknowledge the person, check they were comfortable in this position, or offer to assist them into a more comfortable position.

We saw that people were not always provided with the care and support that staff had planned or agreed with them. For example, one person in a lounge area was told by a member of staff they would be assisted

to the area of the home where activities were taking place. The member of staff told the person, "I'll take you to activities when [name of staff] is back on the floor." This did not happen. When the member of staff returned, they both provided personal care to another person. The person was not taken to the area of the home where activities was taking place.

We checked care and monitoring charts and found they were not all up to date and did not always reflect the care people were assessed as needing. We saw repositioning charts, food and fluid charts and topical cream administration charts that had not been fully completed. One member of staff told us, "We try our best to give the care, but it's the records that sometimes don't get done." One of the home managers' told us they were aware that records were not always up to date.

We looked at the falls records for the home. The last analysis of falls had been completed for December 2016, trends had been identified and actions were recommended. No further analysis had been completed since this date. Following our visit we requested and received an updated summary of falls in the home. This showed the overall number of falls, on average each month, had reduced since December 2016. The home manager told us that following our visit they had re-introduced a monitoring and analysis system. This was to make sure that themes and trends could be identified and actions taken in response.

People's dependency levels had been recorded, in that people were assessed and recorded as being low, medium or high dependency. Recommended staffing levels for each dependency score did not form part of the assessment tool. The provider had compared the staffing at Quarry House with other care homes in the local area. This had shown that Quarry House had significantly higher staffing levels than the other homes. The comparison had acknowledged geographical differences within Quarry House. However, the comparison had not taken into account that Quarry House had four floors and eight completely separate areas within the home. People were living in each of the eight areas. Each of the eight areas were accessed separately by a keypad door entry system. These environmental factors had not been fully taken into account when calculating safe staffing levels.

We were told by the home manager and the representative for the provider that staffing levels had been increased approximately three weeks prior to our visit. We were given copies of the rotas which we checked in detail for a period of 19 days leading up to the day of our visit. These did not provide up to date and accurate information. When we received the updated information we found 5 days where shifts had not been covered with the numbers of staff we were told were needed to provide sufficient staffing in the home.

Although the provider had taken action since our last inspection, changes made had not been embedded into the home. This was due to the changes in the management of the home, staff vacancies and weekly reliance on agency staff. People had not experienced a consistently improved quality of care.

Our findings overall were that, despite efforts having been made to increase and enhance the staffing levels to enable people's care and treatment needs to be met, further improvements were needed.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not always deployed to meet peoples' care needs.