Care Quality Commission

Countrywide Care Homes Limited

Clumber Court Care Centre

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

This inspection took place on 01 December 2014. Clumber Court Care Centre provides residential care for up to 64 older people, including people with dementia. On the day of our inspection 41 people were using the service. The service was split into two separate floors with different staff on each floor.

The service did not have a registered manager in place at the time of our inspection. The previous registered manager left the service on 22 October 2014. The provider had engaged a peripatetic manager to manage the service until a new manager was recruited. 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.

Not all of the staff knew how to keep people safe or how to raise any concerns if they suspected someone was at risk of harm or abuse. People could not rely on staff to keep them safe from the risks they could face through everyday living or to ensure their safety.

People may not receive the care they required because there was not always sufficient staff on duty to meet their

Summary of findings

needs. People could not be assured they would be given their medicines safely because when errors in administering medicines occurred the planned action to ensure this was not repeated was not completed.

People were supported by staff who were caring and respectful, however staff were not given the knowledge and skills needed to deliver appropriate care and support.

We found the legislation to protect people who lack capacity to make certain decisions, The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS), was not always followed correctly to protect people who were not able to make their own decisions about the care they received.

People were encouraged to eat well and supported to have their required nutritional and fluid intake. People were supported with their healthcare needs, although care plans did not provide staff with the information they needed to support people appropriately.

People were supported in a kind and caring way and had their dignity respected.

People's individual preferences to care and support were not taken into account so that care could be delivered as they preferred it to be. People knew how to raise a concern and concerns were taken seriously and were addressed.

A lack of effective systems to monitor the quality of the service resulted in people not receiving safe, effective and responsive care which met their needs.

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?
The service was not always safe.

People may not always get the care and support they require because there were insufficient staff to meet their needs and some of these staff did not have the knowledge of how to protect people from harm.

People were not protected from avoidable risks because actions that could prevent these were not identified or taken.

People were at risk of not receiving their medicines safely because when an error had occurred, the action agreed to ensure this was not repeated was not followed through.

Requires improvement

Is the service effective?
The service was not always effective.

People were supported by staff who had not received training to give them the knowledge and skills to do their work.

Staff did not always make sure people were protected under the Mental Capacity Act 2005.

People were supported to eat a healthy diet that provided them with the nutrition and hydration they needed. People were provided with the support they needed to promote their well-being and healthcare.

Requires improvement

Is the service caring?
The service was caring.

People received care and support in a kind and caring way and their dignity was respected.

People were able to express their views on how their care should be provided.

Good

Is the service responsive?
The service was not always responsive.

People's care and support was not based on their preferences and so they may not always receive this as they wished or needed.

People knew how to raise any concerns or complaints they may have and these were acted on appropriately.

Requires improvement

Is the service well-led?
The service was not well led.

Requires improvement

Summary of findings

Inconsistent leadership and a lack of effective systems to monitor the quality of the service had led to people not receiving safe, effective and responsive care.

People could not rely on auditing systems to bring about improvements to the service because actions identified were not followed through.

Clumber Court Care Centre

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.

We inspected the service on 1 December 2014. This was an unannounced inspection. The inspection team consisted of three inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. The provider completed and returned to us a Provider Information Return (PIR). This is a form which helps us to identify good practice and asks the provider to give some key information about the service, what it does well and what improvements they plan to make.

During the visit we spoke with four people who lived at the service and two relatives who were visiting. We spoke with three members of care staff, two nurses, one of whom was employed by an agency, the acting (peripatetic) manager and the human resources manager. We observed the care and support that was provided in communal areas. We looked at the care records of four people who used the service, as well as other records relating to the running of the service including audits and staff training records.

Requires improvement

Is the service safe?

Our findings

The last time we inspected the service on 27 November 2013 we had concerns that there were not enough qualified, skilled and experienced staff to meet people's needs. During this inspection we found there were less people using the service and staffing levels had not been reduced, in an attempt to ensure there was enough staff to meet the needs of people. However we found this had not been effective. People told us, and we observed times when people did not receive the care they needed due to there not being enough staff.

Some people and their relatives told us they felt there was not enough staff to meet the needs of people in a timely manner. One person said, "The staff are brilliant. It is the shortage of staff that is the problem." They also told us, "Often staff work through their breaks and they would be able to do more activities with the people if there were more staff." Another person said, "Sometimes staff are a bit rushed."

We saw some occasions on the ground floor where all the staff were involved in other duties resulting in a lack of supervision in the communal areas. On one occasion we had to summon staff to attend to a person who had fallen. Staff were unaware this person had fallen as there were not any staff in this communal area. Had we not witnessed the fall, the person would have been left on the floor until staff came back into the communal area.

Staff we talked with said the overall care staffing levels had recently improved slightly. However they felt this was still not sufficient and told us they had tried to develop a way of working when they were short staffed to minimise any effect on the people who used the service. This was done by working together as a team and prioritising what needed to be done, by focusing on the basics to ensure people received the care they needed.

This was a continued breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff also told us the shortage of registered nurses was a problem. Staff told us there were not enough registered nurses employed for there to be one on duty each shift, and they had to rely on agency nurses a lot of the time. There was only one registered nurse in addition to the acting manager employed at the time of the inspection. However the acting manager was actively trying to recruit registered nurses and following our inspection the nurses were successfully recruited.

People told us they felt safe living at the service. One person told us, "I feel safe and well cared for, I have got nothing to worry about."

Some staff were able to describe the signs and symptoms of abuse and were aware of the action they should take if they identified a cause for concern. However there were other staff who demonstrated a limited awareness of how to safeguard people from the risk of harm or abuse or if they had been harmed in any way. This posed a risk that incidents may not be acted on as staff did not have the knowledge of how to recognise or respond to incidents which may constitute abuse.

People had care plans in place to give staff guidance on how to manage the risks they faced in everyday living. However these had not been updated when any changes occurred. For example one person had been identified as being at high risk of falls, and had fallen on a number of occasions. Their care plan had not been updated with this information and guidance was not recorded to tell staff how to monitor and manage this risk. Another person was identified as being at risk of falls, but there was no falls prevention care plan in place for them. A lack of preventative measures placed these people at risk of further falls.

We saw there were appropriate systems being used for the safe storage of medicines and guidance was provided to staff on the procedures they were expected to follow when administering medicines. The provider told us in the PIR that any person who wished to administer their own medicines was risk assessed to ensure they could do so safely. However when errors in the administration had occurred, steps were not always put in place to minimise the risk of these errors occurring again in the future. Staff who had made the errors were not given training and assessed as being competent to administer medicines following the errors.

Requires improvement

Is the service effective?

Our findings

People felt staff had the skills needed to care for them. One person who used the service said, "If we aren't very well, they (the staff) notice and get the doctor in." Another person said, "Staff soon notice if you are not well."

However we found that people were not always supported by staff who had the skills and knowledge to care for them. Staff told us about training they had received and they felt this was suitable and appropriate. A staff member told us, "The training is good." However we found some staff unable to answer questions we asked on how to safeguard people from the risk of abuse. The acting manager told us staff had not been given training or guidance in relation to equality or diversity. A lack of knowledge and training presented a risk that staff would not recognise if care being delivered was safe and appropriate for the people they were supporting.

Staff did not always have the knowledge or skills to give people the support they needed. For example, we saw one person who had periods of being anxious was settled when staff spent time with them. However staff did not always respond to the person when they were anxious. We looked at the person's care plan and there was no guidance informing staff how to support the person when they became anxious and some staff told us they were unsure of the appropriate way to support the person.

Where an error had occurred over the administration of someone's medicine the planned action to prevent this reoccurring was not followed through. The acting manager told us about two occasions where mistakes had been made with administering people's medicines. As a result the staff concerned were expected to have additional training and supervision to ensure they knew how to manage people's medicines safely. We found the additional training and supervision had not been provided as planned. This posed a risk of further medicines errors occurring.

This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's rights in relation to the MCA were not always protected. Staff had received training on the Mental Capacity Act 2005 (MCA) The MCA is in place to protect people who lack capacity to make certain decisions because of illness or disability. Most staff had a good understanding of the MCA, but some staff were unable to demonstrate an understanding of the act and so may not be aware of their role in relation to ensuring people had decisions made in their best interests. We found that where assessments had been completed for people who lacked the capacity to make certain decisions, these were not always fully completed to ensure the decision being made was appropriate.

The acting manager told us Deprivation of Liberty (DoLS) applications had been made to the supervising body due to people's movements being restricted by a keypad on the door. DoLS protects the rights of people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed.

We found that staff had the opportunity to discuss their work and any training or support needs they had. Staff told us they had supervision from the acting manager where they could discuss their role and responsibilities. Staff also had an annual appraisal where they received feedback on their work performance.

People told us they enjoyed the food and that they had sufficient to eat and drink. A person told us, "The food is very good. They try their best to please you." A relative said, "The food is fine, there are often three choices at lunchtime and it is nutritious."

A staff member sat with people who needed help and provided them with support and encouragement when they were eating. Where people had a risk of weight loss or choking we saw they were referred to a dietician or the Speech and Language therapy team (SALT). We saw recommendations made by these external professionals were followed, such as staff completing nutrition charts to monitor how much people were eating.

People felt they received appropriate support to ensure their healthcare needs were met. For example one person told us staff had supported them to be referred to the hospital for a health issue recently.

The acting manager told us nurses would ensure people were referred to any external healthcare services they needed, so they received the healthcare support they required. We saw this in practice with a staff member

Requires improvement

Is the service effective?

following up on some medical tests one person recently had to obtain the results. People's care records showed they had contact with various healthcare professionals to support them with their ongoing healthcare.

Good

Is the service caring?

Our findings

People told us they found staff to be kind and caring. One person said, “Everyone is friendly.” Another person told us staff were, “Always kind, I don’t have any hassle whatsoever.” Relatives told us staff would always phone them if there was an issue with their relation.

People told us staff listened to them and asked them for their views. They said they were happy with the quality of care provided. One person said, “I am happy with my care.” They said they had been allocated a member of the care staff and they could go to them at any time if they had an issue or problem.

We observed lunch in one of the dining rooms and saw people were offered choices of what they would like to eat. People who required support with eating their meal were provided with this and everyone appeared to enjoy their meal. Food was provided on adapted crockery where necessary to enable people to eat independently, and adapted utensils were available if needed.

There was information available about advocacy services, but the acting manager said there was no one who currently used one of these. Advocates are trained professionals who support, enable and empower people to speak up.

People told us they were treated with respect and their privacy and dignity was promoted. One person said, “We have no complaints that way.” Staff described the steps they took to preserve the people’s privacy and dignity such as knocking on people’s bedroom door before entering and locking the door when attending to people’s personal hygiene. There was one member of staff who had completed the training to become a dignity champion. There was a noticeboard in the entrance foyer about promoting people’s privacy and dignity.

The acting manager told us they had observed that staff spoke in a respectful way to people who used the service and that people enjoyed the time that staff spent with them. The agency nurse we talked with said they liked working at the service because the care was good and the staff “Genuinely care” for the people living there and that, “Nothing is too much trouble.” They described the staff team as, “Good and caring.” The acting manager told us staff had good relationships with people and were very caring and protective of them.

Requires improvement

Is the service responsive?

Our findings

People did not have sufficient opportunity to follow their interests and take part in activities. One relative said their relation, "Gets fed up." They went on to say that there were occasionally entertainers who came to the service, but there was little other activity provided. They said, "If they could just get out in the afternoon it would be lovely."

During our observations we saw the majority of involvement staff had with people who used the service was limited to providing them with support around their care. We did see two people involved in putting up Christmas decorations with a staff member, but there was a lack of stimulation at other times and there was no evidence that people were supported to maintain hobbies or interests they had. The acting manager told us they would like to see more individual based activities in line with people's hobbies and interests, but this was not yet something they had addressed. The acting manager told us the activities coordinator took people on trips to local shops and garden centres.

People's life history was not known and care was not planned around their interests. Each person was meant to have a life story which would detail any important events and significant interests' people had to help staff know about people and promote involvement with them. We looked at four care plans which had recently been reviewed and updated and we saw the life history documents had not been completed or had been completed with very basic information.

Each person had a range of care plans to ensure their needs were met. This included details of the best way to communicate with each person. We saw a staff member was updating people's care plans. Staff told us they involved people and/or their relatives when they reviewed these.

A relative told us staff had talked to them when their relative's care plan had been reviewed.

People were informed of their right to complain. A person who used the service told us they had attended a residents' meeting the previous week and had been asked if they had any complaints. Another person said they, "Couldn't complain because there is nothing to complain about. Nothing to grumble about as everything is alright."

People were able to raise any concerns and knew these would be acted upon. A relative told us they had made a complaint some time ago. They said they felt this had been properly dealt with and appropriate action was taken. The acting manager told us they had received one complaint since they took up their position about a picture that had been displayed at a social event. The acting manager had removed the picture and we saw this had been recorded as a complaint in the complaints file.

Requires improvement

Is the service well-led?

Our findings

People had not experienced a consistent and stable service due to frequent changes in management. There was no registered manager in the service and management was due to change again as the current acting manager was employed on a temporary basis whilst a new manager was recruited. The acting manager had been working at the service for the last three weeks following the departure of the previous registered manager. The HR manager told us they were in the process of recruiting a new manager and some interviews had already taken place. A staff member commented this was the fourth different manager during three years at the service.

The acting manager told us their work was made more difficult by a number of circumstances, which impacted on how effective they were able to be in their role. These included that part of their role required them to act as the nurse on duty for two days a week. This meant they had less time to spend on the management duties for the service.

Areas needing improvement which had been identified by audits carried out in the service were not always being addressed. A "Home presentation audit" carried out on 10 November 2014 identified a number of actions needed to improve the environment. Some of these had passed the timescales for the actions to be completed by, but none of these actions not been addressed. For example, one action had been to provide a person who used a pressure relieving overlay with a mattress underneath. We checked the person's room and found this had not been provided.

Audits of the environment had taken place but these had not been effective in identifying the risk in relation to people who may not be able to call for assistance from staff when in their room, because they did not always have a call bell within their reach. For example, one person who was sat in a chair in their room told us they could not reach the call bell cord and would not be able to call for staff for assistance if they needed to. We also saw there were a number of other bedrooms which did not have leads for the call bells so these could be placed within people's reach and the acting manager told us they did not have enough of these to provide one in each room. This posed a risk that people would not have their needs responded to if they should need assistance from staff and this had not been recognised or addressed by the provider as part of their monitoring of the quality of the service.

We also found the audits of the environment had not been effective in improving bedding which was in poor condition in some people's bedrooms. During the inspection we went into one person's room and saw the person had inadequate bedding. This included a very thin quilt and pillow, both of which were in a poor condition. We checked a number of other rooms and saw more bedding in poor condition and some people had a quilt cover but no quilt on their bed, including some people who were in bed. The acting manager told us they had told staff on a number of occasions people needed to have proper bedding. This posed a risk that people would be cold whilst in bed and despite the acting manager being aware of this, effective systems had not been put in place to address this on an ongoing basis.

Other actions identified included reviewing and updating a number of people's care files each week and completing life story documents. The acting manager said they did not have the time to complete these. There was also an action about what to do with the information contained in people's food and fluid intake charts. We looked at three people's charts and saw the required action had not been followed.

The acting manager told us there had been an infection control audit carried out prior to them coming to the service. The action plan from this was due to be completed shortly but they were unable to find the original audit and so this could not be used to ensure the improvements had been made and were effective.

The acting manager had a number of accident and incident forms on their desk. They told us these should be passed to them on a daily basis but they had not been. This posed a risk that accidents and incidents may not be responded to in a timely way.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person who used the service said, "I find the (acting) manager very approachable and easy to talk to." The person told us the acting manager had told said that that if the person had any problems they should speak with them.

Requires improvement

Is the service well-led?

Staff told us the acting manager was supportive and spent time out of the office speaking with people on a daily basis. They said the acting manager knew all of the people who used the service and worked with the staff to deliver care on occasion.

A staff member told us staff were a good staff team and communicated with each other well. Staff said there were staff meetings every two months and the acting manager took on board people's views and tried to address any issues. A staff member described how they had felt supported when they had raised some concerns and had felt these were acted upon. The human resources (HR) manger told us they felt some development could be undertaken with support staff over how they prioritised their work.

The acting manager was entering the details of these incidents and accidents onto the provider's quality monitoring system. They told us the quality assurance manager would analyse these and identify if any additional action needed to be taken, such as making a referral to the falls prevention team.

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	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes had not been established and operated effectively to ensure the service was assessed, monitored and improved. Regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of suitably qualified and skilled staff deployed, who were supported and trained as necessary. Regulation 18 (1)(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.