HC-One Limited

Silverwood (Nottingham)

Inspection report

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Date of inspection visit: 14 and 15 April 2015
Date of publication: 06/08/2015

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 inspection took place on 14 and 15 April 2015 and was unannounced.

Accommodation for up to 80 people is provided in the home in two buildings and over two floors in each building. 57 people were living in the home at the time of the inspection. The service is for older people.

There is a registered manager and she was available throughout the 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.

Staffing levels did not always meet the needs of people who used the service and staff were not always recruited safely. The premises were not always secure enough to keep people safe. Safe infection control procedures were not always followed.

Summary of findings

There were processes in place to help make sure people were protected from the risk of abuse and medicines were managed safely.

Staff were not consistently supported to ensure they had up to date information to undertake their roles and responsibilities.

People were not always well supported to eat and drink and documentation was not fully completed to ensure that people received sufficient to eat and drink. People did not always receive support to maintain good health and limited adaptations had been made to the premises to support people living with dementia.

People's rights under the Mental Capacity Act 2005 were protected.

People's privacy and dignity were not always respected. People were not always involved in making decisions about their care and the support they received.

Some staff were compassionate and kind and had a good knowledge of people's likes and dislikes; however, some staff provided care in a task-focussed way and had limited knowledge of people's likes and dislikes.

People did not always receive assistance promptly. Care plans were in place outlining people's care and support needs but did not always contain sufficient information to make sure people's individual needs and preferences were taken into account.

People were listened to if they had complaints and appropriate responses were given.

Audits carried out by the provider had not identified all the issues found during this inspection.

People and relatives were involved in the development of the service and a registered manager was in place.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires improvement

The service was not consistently safe.

Staffing levels did not always meet the needs of people who used the service and staff were not always recruited safely. The premises were not always secure enough to keep people safe. Safe infection control procedures were not always followed.

There were processes in place to help make sure people were protected from the risk of abuse and medicines were managed safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff were not consistently supported to ensure they had up to date information to undertake their roles and responsibilities.

People were not always well supported to eat and drink and documentation was not fully completed to ensure that people received sufficient to eat and drink. People did not always receive support to maintain good health and limited adaptations had been made to the premises to support people living with dementia.

People's rights under the Mental Capacity Act 2005 were protected.

Is the service caring?

Requires improvement

The service was not consistently caring.

People's privacy and dignity were not always respected. People were not always involved in making decisions about their care and the support they received.

Some staff were compassionate and kind and had a good knowledge of people's likes and dislikes, however some staff provided care in a task-focussed way and had limited knowledge of people's likes and dislikes.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People did not always receive assistance promptly. Care plans were in place outlining people's care and support needs but did not always contain sufficient information to make sure people's individual needs and preferences were taken into account.

People were listened to if they had complaints and appropriate responses were given.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

Audits carried out by the provider and manager had not identified all the issues found during this inspection.

People and relatives were involved in the development of the service and a registered manager was in place.

Requires improvement

Silverwood (Nottingham)

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 14 and 15 April 2015 and was unannounced.

The inspection team consisted of two inspectors, a specialist nursing advisor with experience of 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 this type of care service.

Before our inspection we reviewed all the information we held about the home. This information included notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners of the service, Healthwatch Nottinghamshire and other health and social care professionals to obtain their views on the service and how it was currently being run.

During our inspection, we spoke with 11 people who used the service and five relatives. We spoke with an activities coordinator, a kitchen assistant, five care staff, a nurse, the registered manager, a relief manager and a regional manager. We looked at the relevant parts of 12 care records, three recruitment files, observed care and other records relating to the management of the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

The premises were not always managed to keep people and their belongings safe. The main entrance to one of the units was not fully secure. We observed that some fire doors were open when they should have been closed and one of these had been left open next to a back gate leading onto the street. We also saw unattended disinfectant, glue and nail varnish remover which meant that there was a risk of avoidable harm to people who used the service.

We also saw that call bells were not within reach of people sitting in the upstairs lounge when no staff were in the area. We also heard another person calling out in their room; we went into the room and saw that the call bell was not plugged in. We tried to plug it in but the socket was broken and we also found another call bell not to be working. People were at risk of avoidable harm because they could not easily summon staff when they needed assistance.

Safe infection control practices were not followed at all times which put people who used the service at risk of infection. Some carpet areas were stained and some bathrooms were unclean. We also saw continence pads stored out of their packaging and some baths and bath chairs were not clean. Some commode cushions and a commode were not clean and we saw a stained crash mat, an unclean overlap table, stained bedclothes and mattress and most of the armchairs in one lounge required cleaning.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us that staff were busy and they felt that there were staff shortages which resulted in them having to wait for assistance. One person said, “I should have a bath every Friday but I don’t always get one because they tell me that there are no staff.” A relative said, “They are very short staffed.”

Staff told us that there not enough staff on duty. One staff member said “I don’t like it. It can cause meals to be late and people to have to wait for the toilet.” Another staff member said, “There is not enough staff; [people who used the service] are not getting enough attention.” Another staff member said, “Not enough [staff], we don’t have time to sit and talk with [people who used the service], sometimes it feels like a conveyer belt. We don’t get time to do baths and showers. Some people don’t get bathed or showered for three weeks.” Documentation confirmed that people were not receiving regular baths and/or showers.

Call bells not responded to promptly on the nursing unit and some people were not supported to get out of bed until 10.55am due to a lack of staff. We carried out an observation of the upstairs lounge on the nursing unit. During our 30 minutes observation we saw that interactions between staff and people who used the service were task-focussed and the lounge was unattended by staff for a total of 19 of the 30 minutes when some of the people were at risk of falls. This meant that there were insufficient staff to keep people safe and meet their needs.

We saw examples where people were put at risk due to insufficient staff on duty. On the residential unit there were no staff in the lounge area and we observed a person who used the service being verbally abusive to another person. We spoke with the person being verbally abusive and they calmed. We also noticed a person choking while eating in the dining room when there were no staff in the dining area. We drew this to the attention of a staff member who responded quickly and the person recovered following medical attention.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always recruited using safe recruitment practices. We looked at three recruitment files for staff recently employed by the service. Appropriate checks had been carried out before two of the three people started work. However, we saw that one person had made reference to serious issues regarding their professional regulation and this had not been explored during the interview process. We also saw that appropriate checks had not been completed before a volunteer, who regularly worked in the home, started work at the home.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place where appropriate and were regularly reviewed. However, two people had been admitted to the home with a history of falls but they had been assessed by the provider as at low risk of falls. The care plan for one of these people made no reference to their previous history of falls and the person had fallen

Requires improvement

Is the service safe?

while in the home and been admitted to hospital as a result. No incident form had been completed in relation to this fall. This meant that there was a greater risk of similar incidents being repeated as it had not been correctly investigated and no actions had been recorded to prevent reoccurrence. We also saw that documentation was not fully completed to show that staff had regularly monitored people's safety when in bed. This meant that risks to people were not being safely managed at all times.

People told us they felt safe in the home. We observed people who used the service were safely supported by staff when transferring from a chair to a wheelchair. Staff had received safeguarding training and they were able to tell us how they would respond to allegations or incidents of abuse. A safeguarding policy and procedure was in place and we saw safeguarding information displayed on a noticeboard so people and their relatives knew who to contact if they had concerns.

Checks of the equipment and premises were taking place, along with regular maintenance of equipment, including the lift and hoists.

We saw there were plans in place for emergency situations such as an outbreak of fire. We observed that procedures were followed when a fire alarm sounded during our inspection. A fire risk assessment was in place and a contingency plan was in place in the event of emergency. We saw that a personal evacuation plan (PEEP) was in place for people using the service. This meant that arrangements were in place to protect people from the risk of harm should an emergency situation occur.

Medicines were managed safely. We observed that people received their medicines safely.

We checked the Medicine Administration Records (MAR) for six people and these were accurately completed. Medicines were stored securely; however, documentation was not always completed to evidence that prescribed creams were being applied to people.

Requires improvement

Is the service effective?

Our findings

Staff told us they had received induction and training. Most staff were happy with the induction and training although one staff member said, "The E-learning programme is not always sufficient." We saw that staff received an induction but records showed that not all staff had received all relevant training which included safeguarding and infection control.

Staff told us they had received supervision but were not happy with the content of supervisions. One staff member said, "It is punitive." Another staff member said, "Supervision is a telling off." We reviewed the supervision records. Supervision was carried out in response to poor practice or to share information, it was not focussed on the developmental needs of staff.

Staff told us they had not received appraisals. The registered manager told us that appraisals were not up to date. We saw that no appraisals had taken place in the last year. This meant that staff did not receive sufficient support to have the knowledge and skills they needed to provide people with effective care.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always appropriately supported at mealtimes. We observed mealtimes in the nursing and residential units. We observed a staff member standing over a person when supporting them to eat. We observed that another person's hot food had been left in the corner of their room while the person was in bed asleep. Another person who was struggling to eat their cereal said, "I can't lift the big spoon. My hands aren't strong enough. I usually have a small spoon." We saw another person was struggling to eat their lunch. They were eating their main meal with a large spoon but picking the food up with their fingers and putting it on the spoon. Staff did not offer any assistance to this person.

One person said, "They are always a long time bringing lunch. Everyone is brought to the tables at 12.30 but it can be at least 25 minutes before anybody gets anything to eat." While observing lunch in the residential unit we saw that five people fell asleep while they were waiting for lunch and two people left their table and started walking around because of the wait. Lunches were served at about 1.05pm.

One person had their mainly uneaten meal in front of them with a large amount of gravy on the meal. They told us they liked just a little gravy. We spoke with the kitchen assistant who told us they were not aware of the person's food preferences and we saw that there was no guidance for staff on people's preferences in the residential unit's kitchen.

We observed that people were offered mealtime choices on the nursing unit and were assisted by staff appropriately. There were a lot of staff in the dining room assisting people, however, staff told us that this was not usually the case as not all the staff present usually supported people at mealtimes.

People's nutrition and hydration risks were not always effectively managed. Staff had an understanding of which people were at risk of choking but we saw that one person's care records were inconsistent on whether they needed assistance when eating because of their risk of choking. Documentation was not always fully completed to ensure that people's nutrition and hydration needs were met. We saw that food and fluids charts were not always fully completed with quantities of food and fluid taken and times of meals. There were no entries made after 5pm on a number of people's food and fluid charts so it was not clear whether people received food and drink in the evening. This meant that there was a greater risk that problems with people's nutrition and hydration intake would not be promptly identified.

These were breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health needs were not always managed effectively. Care records showed that other health and social care professionals were involved in people's care as appropriate. However, we saw that repositioning charts were not fully completed to show that people at risk of skin damage was receiving care in line with their care plans. We also saw that the urinary output for a person with a

Requires improvement

Is the service effective?

catheter had not been consistently recorded for four days. This meant that there was a greater risk that problems with the person's catheter would not be promptly identified by staff.

We observed staff explaining to people what they were going to do, before they provided care. However we saw that a consent form had not been completed for one person who had bed rails in place. This meant that there was a risk that their rights had not been protected.

Staff understanding of the requirements of the Mental Capacity Act (MCA) 2005 was mixed. The MCA was an Act introduced to protect people who lack capacity to make certain decisions because of illness or disability. Staff had received MCA training and two staff had an understanding, one staff member had no understanding and another staff member said, "I can't remember much about it." The registered manager told us that there had been no MCA documentation in place when they started in the home. However, we saw that assessments of capacity and best interests' documentation were in place for people who lacked capacity.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The registered manager told us that no DoLS documentation was in place when they first started at the home. The registered manager told us that they had completed DoLS applications for people living in the residential unit but had not had time to completed applications for people living in the nursing unit yet.

We looked at the care records for two people who had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form in place. Neither forms were fully completed, one had no review date, another did not note whether the person had capacity to make their own decision about this. A list of people with a DNACPR form in place was clearly displayed on the residential unit, but it was not in place on the nursing unit. This meant that there was a greater risk of people's resuscitation status not being promptly identified and appropriate action taken on the nursing unit.

We saw that limited adaptations had been made to the design of the home to support people living with dementia. Not all toilets and communal rooms were identified by signs and symbols and there was little directional signage to aid people to orientate themselves or move around the home independently. Not all bedrooms had people's names on them which may have made it difficult for people to find their own rooms.

Requires improvement

Is the service caring?

Our findings

We observed that people's care records were not always stored securely. We also observed staff speaking about people who used the service in front of other people who used the service. This meant that people's privacy was not always respected by staff.

We observed staff knocking and waiting before entering people's bedrooms and maintaining people's privacy when assisting them to the toilet. Staff explained how they respected people's dignity and privacy. However; we saw that people's dignity was not always respected. After lunch on the nursing unit we saw that people were taken in wheelchairs to a lounge. We saw that three people were left unattended in their wheelchairs queued up outside the lounge area for a number of minutes. This did not respect their dignity. There were also no dignity champions in the home. A dignity champion is a person who promotes the importance of people being treated with dignity at all times.

We observed that people received visitors throughout the inspection and the guide for people using the service provided details on arrangements for people visiting the home.

People told us that staff were caring. One person said, "Most staff are good. One or two are really kind." Another person said, "[The home] has its ups and downs but staff are really nice." A health and social care professional told us that they had been told by a person who used the service and their family that, "Staff are very attentive." We observed that some staff chatted with people as they supported them but most interactions were task-focussed and carried out with little to no conversation with the person being supported. We discussed the preferences of people who used the service with care staff. Some staff had a good knowledge of people's likes and dislikes; some staff's knowledge was limited.

On admission to the home the provider took into account and explored people's individual needs and preferences such as their cultural and religious requirements. We saw that a person's care records included information regarding cultural and religious needs. However, one person's care records stated, ''No culture' in the cultural section and another person said, "I miss going to church. I watch Songs of Praise on Sundays because I can't get to church. I used to go to church regularly but there isn't any support for me to go. I'm hoping they can organise for me to get to the local Methodist church." This meant that people's religious needs were not always met.

Staff explained how they involved people in decisions about their care. A staff member explained how they effectively communicated with people who were living with dementia. We saw that care reviews were taking place on the residential unit and people and their relatives were involved in these reviews. However, no reviews had taken place on the nursing unit.

A guide provided for people using the service contained details of an advocacy scheme available for people if they required support, however, advocacy information was not available in the main reception area on the nursing unit.

Requires improvement

Is the service responsive?

Our findings

We observed that people's requests for assistance were not always responded to quickly. We observed a staff member responded promptly and effectively when we told them that a person was choking. However, we observed that call bells were not responded to promptly on the nursing unit. We saw that one person waited for 25 minutes for their call bell to be answered and another two people had to wait over 10 minutes to be assisted to the toilet after we had requested staff support. One staff member said, "The needs of [people who used the service] are not met in a timely fashion at times."

One person told us that they were very cold. We asked a staff member to find the person a blanket which they did. The staff member said, "[The person]'s always complaining of being cold." The person had been seated in a shaded area of the room and might have been warmer if they'd been seated in the area of the room where the sun was coming through the windows. This showed that staff had not considered the person's preferences when seating them.

We asked people whether they were supported to follow their preferred hobbies or interests. One person said, "I love flowers and gardening and they help me to look after my greenhouse here. Staff fetch me the gardening equipment that I need." This showed that the person was supported to pursue their preferred interests. We saw activities taking place on the nursing unit and the activities coordinator was interacting positively with people.

However, we didn't see any activities taking place on the residential unit. Most people were just sitting in chairs in the lounge. A television was on in the corner but nobody was watching it. On the activities board it was shown that there would be a 'sing along' in the lounge of the residential unit at 10.30am that morning but that did not happen and there was no explanation as to why not. One staff member thought there were sufficient activities offered but most staff did not. One staff member said, "There's not enough for people to do. People need more activities to stimulate the brain." Another staff member said, "There is an effort made but more is needed, there are only 22 hours [per week] allocated for the nursing unit and there are no activities staff here at weekends."

Care records did not always contain detailed information regarding people's individual needs and how to meet them. One person's care record contained very limited information regarding their life history and their preferences. Another person's individual room profile did not have a photograph of them or information noted for 'what people like and admire about me' or 'important things about my life'. It was noted that, 'During the day I enjoy activities, watch TV, to sit in lounge with other residents.' We observed that the person was sitting in the lounge but not near other people who used the service or the television. Another person's important things in my life lacked detail and were simply noted as, "Holidays and family." People's preferences around medicines were not always recorded. One person's care plan for physical health was not individualised. This meant that insufficient guidance was in place for staff to meet people's individual needs.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two relatives told us that that they had raised concerns regarding their relative with a staff member who became very defensive and abrupt. However they spoke to another staff member who listened to their concerns and provided an explanation.

The complaints procedure was displayed in the reception and was also included in the guide provided for people who used the service. We looked at the complaints records and saw there was a clear procedure for staff to follow should a concern be raised. Staff knew how to respond to a complaint. We looked at recent complaints and saw that they had been investigated and responded to appropriately.

Requires improvement

Is the service well-led?

Our findings

Audits were completed by the registered manager and also representatives of the provider not directly working at the home. Audits had taken place and action plans with timescales were in place to address identified concerns. Actions were signed off when completed.

However, we identified concerns in the areas of person centred-care, nutrition and hydration, the safety of the premises, staffing and recruitment processes during this inspection which had not been identified by the provider or had been identified but actions had not been taken to address the concerns by the time of the inspection. These constituted breaches of a number of regulations.

We saw that meetings for people who used the service and their relatives had taken place recently; however, we also saw that a relative had raised concerns about staffing levels and we found the same concerns at this inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that details on how to feedback on the service were in the guide provided for people who used the service and the registered manager told us that completed questionnaires by people who used the service and their relatives were currently being analysed. We saw that a response to comments made in previous questionnaires was displayed in the main reception areas.

A whistleblowing policy was in place and contained appropriate details. Staff told us they would be happy raising concerns. We saw that the provider's set of values were displayed in the main reception areas and were also in the guide provided for people who used the service, however, during our inspection we observed that staff did not always act in line with the values of the service.

Staff told us that they enjoyed working at the home. A staff member said, "I've been here for a number of years and I just love it. I find supporting people living with dementia incredibly rewarding." Staff told us they were listened to and said, "The [registered] manager is very approachable and fair."

Another staff member said, "[The registered manager] is a positive influence since coming here. Lots of things have come to light that needed addressing and [the registered manager] will get it sorted." Another staff member said, "Can't fault [the registered manager] at all, she helps us out a lot, firm but nice, works on the floor sometimes, she's here all day nearly every day."

A registered manager was in post and she clearly explained to us her responsibilities. We saw that all conditions of registration with the CQC were being met and the registered manager had sent notifications to us where required. The registered manager had been at the home for three months. There was no deputy manager in post. The registered manager told us they felt well supported by the provider and were receiving additional support from the provider in order to address a number of issues identified at the home. We saw that a staff meeting had taken place in February 2015 and the registered manager had clearly set out their expectations.

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
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of service users must be appropriate, meet their needs and reflect their preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The nutritional and hydration needs of service users must be met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **All premises and equipment used by the service provider must be clean, secure, and suitable for the purpose for which they are being used and properly maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures must be operated effectively to ensure that persons employed meet the conditions in paragraph (1) of this regulation.