Flintvale Limited

The Green Nursing Home

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 well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service in April 2015. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. We also checked areas where we had received some recent concerns, to include concerns about staffing arrangements. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Green Nursing Home on our website at www.cqc.org.uk

The Green Nursing Home provides care and support for up to 59 older people with physical health needs and people who live with dementia. At the time of this inspection 56 people were living in the home.

The home had a registered manager in post. 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.

Summary of findings

People and the relatives of people using this service told us they felt their relatives were safe. Care staff understood how to protect people from abuse. There were processes to minimise risks associated with people's care to keep them safe.

Staff had received induction training when they first started to working at the home and received some on-going training. Improvements were planned to the training and supervision arrangements of staff to make sure they received the training and support and develop their skills and knowledge to provide people with appropriate care and support.

Staff sought consent form people and asked their opinion of how they wanted to be supported. When people were thought to lack mental capacity the provider had taken the appropriate action to ensure their care did not restrict their movement and rights. This ensured people were supported in line with the principles of the Mental Capacity Act 2005 (MCA).

People could choose what they wanted to eat and told us they enjoyed it. There was a wide choice of food available and people could choose where they wanted to eat.

We saw evidence that some incidents had been used to learn from mistakes but that a detailed analysis of all incidents and accidents was not undertaken. This would have assisted in identifying any patterns or themes.

Some records required for the effective running of the service were not readily available or up to date. Systems used to quality assure services and manage risks were not fully effective but the services of a care consultant had recently been engaged by the provider to help the registered manager identify and action improvements.

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.

Improvements were underway to make sure there were sufficient numbers of staff available and suitable deployment of staff to meet people's individual needs.

Care staff understood their responsibility to keep people safe and to report any suspected abuse. There were procedures to protect people from risk of harm and care staff understood the risks relating to people's care.

Is the service effective?

Requires improvement

The service was not consistently effective.

Arrangements for staff induction and support needed to be improved.

The registered manager had sought and acted on advice where they thought people's freedom was being restricted. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People had support had to eat and drink and had access to healthcare services.

Is the service well-led?

Requires improvement

Some aspects of the service were not well-led.

The systems in place to check on and improve the quality and safety of the service were not always effective.

We saw evidence that some incidents had been used to learn from mistakes but that a detailed analysis of all incidents, safeguarding concerns and accidents was not undertaken.

People, relatives and staff said the registered manager was approachable and available to speak with if they had any concerns.

The Green Nursing Home

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. During this inspection the team inspected the service against three of the five questions we ask about service; is the service safe, is the service effective and is the service well led? This is because the service was previously not meeting relevant legal requirements in one of these areas and we had been made aware of concerns in other areas.

Before the inspection we looked at the information we already had about this provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

This inspection took place on 17 November 2015 and was unannounced. The inspection team comprised of two inspectors 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.

During our inspection we spoke with 10 people who lived at the home, five relatives, the registered manager, four care staff, one activity worker and one nurse. We also spoke briefly with the GP and a tissue viability nurse who were involved in people's health care during our visit. We reviewed some aspects of the care records of five people who lived at the home and other documentation relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

Prior to our inspection we had received information that indicated there were not sufficient staff available to meet people's assessed needs. During our visit we spoke with people and relatives about the staffing arrangements. We received some mixed comments about staffing levels. Some people told us there were enough staff but most who expressed a view said there had been issues with staffing. Comments we received from people included, "I think there's enough," "There could be more, I think. It's the toilet that's the problem. If you need the toilet, you might have to wait. Sometimes I wet myself and it's embarrassing." Another person told us, "They could do with another one at night. You might have to wait 10 or 15 minutes. If I have an accident, it's nothing to them but it's something to me. You have to sit and watch them strip the bed – it's not very nice." A relative told us, "I'm not sure about Saturdays and Sundays but I think there's enough at night. [Person's name] has only had to wait once or twice in about seven months."

Our observations throughout our inspection showed people were not left unattended for any length of time. In one of the lounges a nurse was giving people their morning medication and the activities co-ordinator was keeping an eye on everyone and doing teas, coffees and cold drinks. Care staff were busy assisting people with their personal care needs until after 11:45am. This meant that the activity planned had to be delayed and was shortened because of lunch.

Some people on the day of the visit displayed behaviour which had the potential to upset other people. This included one person who shouted the same short phrase over and over. This was during the time when only the activities co-ordinator was present and it was impossible for them to be responsive to all of these behaviours. We noted that the person's care plan lacked detail about how staff should try and reduce these behaviours occurring and how to respond when they did occur. This put people at increased risk of becoming upset or anxious.

We spoke with the registered manager about the method of calculation for the staffing requirements. They told us that with the assistance of a recently employed care consultant they had conducted a review of staffing levels and we were told this was influenced by the assessed dependency of each person receiving care. They told us they were aware that there had been concerns about the staffing arrangements in the home. They told us that recently they had increased the numbers of staff at night, and were in the process of making changes to the arrangements for staff breaks during the day to ensure there were not too many staff taking their break at the same time.

We spoke with staff about their experiences of the staffing arrangements in the home. Most staff told us that there had been some issues with staffing levels but that this had improved in recent weeks. One member of staff told us, "Staffing is okay, it has got better over the last month, previously we had been struggling." Another member of staff told us, "We have been short of staff... in the last month staffing has got better."

People and their relatives described the service as a safe place to be. One person told us, "I'm not frightened of anyone or anything here." One relative said 'I've been able to sleep at night, knowing that [Person's name] is safe.'

Staff were trained in recognising possible signs of abuse and they knew how to report any possible suspicions. Staff we spoke with told us they were confident that if they reported any safeguarding concerns to the registered manager they would be dealt with appropriately. At the time of our visit the registered registered manager was co-operating with the local authority to investigate some concerns that had been raised. The registered manager shared with us the outcome of some previous investigations and told us some of these had resulted in disciplinary action with the staff involved.

Staff knew about individual risks to people's health and wellbeing and how these were to be managed. Records confirmed that risk assessments had been completed and care was planned to take into account and minimise risk. For example, detailed assessments had been completed about the support and equipment people needed if using a hoist to help people to move. Care staff said they knew how to assist people to move safely as they had regular training which included how to use a hoist. We saw several people being supported using the hoist and observed this was done safely. Once in their wheelchair, one person was finding it difficult to bend their knee in order for the foot to be on the footrest. The carers recognised this and obtained a cushion to give the leg and foot support and to ensure that there was no risk of the foot becoming trapped or dragging on the floor.

Requires improvement

Is the service safe?

During our visit the fire alarms sounded. Staff responded promptly to the alarms sounding and quickly attended the designated meeting point to receive instruction. However in one of the lounges staff only explained to one visitor and one person why the alarms were sounding and did not offer any explanation or reassurance to other people. However, this did not have a negative impact on people as we noted that people did not become distressed whilst the alarms were sounding.

Requires improvement

Is the service effective?

Our findings

At the last inspection on 27 April 2015 we found that some people received their care in a way that may have restricted their freedom. Where people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNAR) in place we could not see how the decision had been made in their best interests where they did not have capacity. This was a breach of Regulation 11 regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found measures had been put in place to help meet the regulations. People were supported in line with The Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager's assessment of probable deprivations of liberty in people lacking mental capacity had led to several applications for Deprivation of Liberty Safeguards (DoLS) being made to the supervisory body demonstrating the correct legal processes had been followed.

Our discussions with staff showed that not all of the staff demonstrated a good knowledge of the MCA and DOLS but during our visit staff regularly asked people if they were happy and how they wanted to be supported with personal care. We noted that people were supported in line with their wishes. The registered manager told us that since our last inspection staff had received training in the MCA but that the training provided to staff was now under review and an alternative training provider was being considered.

At our last inspection we identified some concerns about 'Do Not Attempt Cardiopulmonary Resuscitation' decisions. Discussions with the registered manager, a nurse and records showed that these decisions had been reviewed by the attending GP and that where people had been assessed as not having capacity discussions had been held with their relatives to take their views into account. A nurse told us, that as a minimum these decisions would be reviewed annually.

People told us they were pleased with how they were supported to maintain their health and welfare. People and relatives were also complimentary about the staff who supported them. One person told us, "I've been so pleased. The way everything has been done, right from day one." Another person told us, "You couldn't ask for more dedicated people [staff]."

We asked staff about the training they had received. The staff we spoke with did not raise any concerns about the training on offer. There was an induction process for new staff when they started to work at the service. This involved a mix of formal and practical training sessions and working alongside experienced members of staff in order to learn people's specific care needs. Our discussions with the registered manager showed that arrangements were not in place for staff who were new to the care sector to complete the 'Care Certificate' that was introduced in 2015. We were informed this would soon be introduced within The Green.

Staff told us that they had not received regular supervision but had been informed that a new system of supervision was in the process of being introduced to improve this. Supervision is an important tool which helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities.

Prior to our inspection we had received a concern that people's needs were not always met in regard to any special diets they needed. We spoke with people and relatives about the meals on offer. Most people were happy with the meals provided. Comments from people included, "Ooh, the food is lovely. Only thing is, I'd like more seconds." "The food is good. I have plenty to eat and drink." One person told us how the chef had noticed they did not eat the bread that was usually provided and so the chef had discussed with them the type of bread they preferred and ensured this was provided. Another person told us they sometimes did not like what was on the menu and so the chef provided them with an alternative meal. We saw this was the case during our visit.

Comments from people's relatives included, Relatives told me: "The food is exceptional, I think. There is plenty to eat

Requires improvement

Is the service effective?

and drink." "There's enough for [Person's name] to eat and drink." One person's relative told us they were on a soft diet because of their swallowing difficulty and that this was always provided.

During the visit, we saw that plenty of drinks and snacks were offered. Some people had jugs of juice on their over chair tables. Those that didn't were offered top-ups. One person who was unable to communicate was being supported to drink tea from a beaker. When the member of staff realised that the person was not drinking much, they went to get a carton of juice with a straw which the person drank readily. Some people were in bed when we visited and we saw that they had been provided with drinks that were within their reach.

We saw that during lunch people got the support they needed from staff to eat their meal, however we did note that not all staff communicated to people what the meal was. Staff who supported people did not rush them and people ate at their own pace.

People and relatives were complimentary about the attention that was given to their health needs.

People told us that they saw the GP whenever they needed to. One person told us, "They've [staff] sorted out my hearing aids for me." A relative told us, When I need to take [person's name] to hospital, an escort always comes with us." We spoke with two health care professionals during our visit and both confirmed that the staff followed their advice.

Requires improvement

Is the service well-led?

Our findings

Following the previous inspection, the new manager had completed the registration process and was now the registered manager for the service. People and relatives spoke positively about the registered manager. One person told us, "If you've got any problems, you can speak to any of the staff or the Manager. They will help you out". Whilst the manager's name was on display in the home some people told us that they knew the registered manager but they didn't know her name, but another person told us, "Helen is the manager, she always comes and says good morning and is about if needed." We saw that the registered manager had put her contact details on display in the home and she told us she encouraged relatives to contact her if they had any concerns or queries. The relatives we spoke with had not had cause to make a formal complaint but all seemed comfortable with being able to express concerns if they had them. One relative told us they had raised an informal concern and that they had been listened to and action taken.

Staff told us there had been a recent staff meeting so that the registered manager could feedback any issues to staff to help improve the service people received. It was also an opportunity for staff to share their views and opinions. Staff told us the registered manager was approachable. One staff told us, "The manager does listen but I am not sure if things have always been acted on, but there are now a lot more changes taking place." A health professional told us that whilst they had not had a lot of contact with the registered manager they seemed to be more pro-active than the previous manager. Our discussions showed that the registered manager had a good understanding of the issues in the home and the work that still needed to be done.

People we spoke with did not recall attending residents' meetings or being asked to give feedback via questionnaires. Relatives said that they could not remember being invited to attend meetings but had all received a questionnaire the week before the visit. This showed that some action was starting to take place to seek views about how the service could improve.

The registered manager kept a log of accidents, incidents and safeguarding concerns that had occurred at the home but was unable to evidence that a detailed analysis of all incidents and accidents was undertaken. This would have assisted in helping identify and patterns or themes over time. There was a risk the provider might not learn from people's experiences and concerns in order to take action to prevent similar concerns from happening again.

Where people were at risk of poor nutrition, or required pressure relief, daily charts to record food and fluid intake and positional changes were in place. We noted there were some gaps in the records we looked at. Our discussions with the registered manager showed that there were currently no formal, regular audits completed to make sure these were completed in line with the provider's expectations. Some records we requested during our visit could not be located when we asked for them. Where reviews had taken place of people's care this had not always led to the changes being recorded in the person's care plan. One health care professional raised that a person at the home who needed assistance with their skin care did not have appropriate information in their care plan in regard to how their nutritional needs were being met. We looked at the person's care records and saw this issue still needed to be addressed.

Systems used to quality assure services and manage risks were not as effective as they could have been but the services of a care consultant had recently been engaged to help the registered manager identify and action improvements. A service development plan had been put in place with the help of the care consultant and we saw that some of their recommended actions were already being put into place. This included for example, changing the location of the administration office so that staff were more accessible to people and visitors to the home. A weekly report was also being introduced for the registered manager to report back to the provider important events in the home to include accidents, occurrence of pressure ulcers, notifications sent to the commission, complaints and safeguarding incidents.