Dr Rais Ahmed Rajput

Spring Tree Rest Home

Inspection report

Inspection report
433 Watling Street
Two Gates
Tamworth
Staffordshire
B77 1EL
Tel: 01827251634
Website: www.example.com

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 12 May 2015 and was unannounced. At our previous inspection in October 2014 we had concerns that people were not receiving care that was safe and effective. People were at risk of abuse and were being deprived of their liberty. People had not consented to the care, treatment and support they received. We found five breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Spring Tree Rest Home provides accommodation and personal care to up to 30 people with dementia, mental health and physical disabilities. At the time of the inspection 22 people were using the service, two of which were in hospital.

The registered manager was absent on the day of 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

Summary of findings

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.

The provider did not work within the guidelines of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty safeguards (DoLS). The (MCA) is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The (DoLS) are part of the MCA. They aim to make sure that people in care homes, looked after in a way that does not inappropriately restrict their freedom. People were being unlawfully restricted of their liberty within the service and no applications for a DoLS authorisation had been made.

People were not protected from the risk of abuse. Incidents of suspected abuse were not reported or investigated.

Some people's medicines were unaccounted for and were not being stored safely. Equipment was not maintained to ensure it was safe and effective in its use.

When people required support in maintaining their health, support was not gained in a timely manner. People were not able to have a drink when they requested.

People did not receive care that was personalised and reflected their individual needs and preferences. People spent long periods of time with little or no stimulation and were restricted within areas of the service.

Relatives of people we spoke to did not feel that their complaints were managed and taken seriously. When improvements had been identified and agreed these were not met.

No improvements had been made since our previous inspection. The provider was unaware that the required improvements had not been made. There were no systems in place to monitor and improve the quality of the service.

We found several continued breaches of Regulation of The Health and Social Care Act 2008 (Regulated Activities) 2014 and issued an urgent notice of decision to suspend all new admissions into the service until the required improvements are made.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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 safe.

People were at risk of abuse, potential incidents of abuse had not been recognised or reported. Risks to people's health and safety were not managed and reviewed. People's medicines were not always managed safely.

Inadequate

Is the service effective?
The service was not effective.

People were being unlawfully restricted of their liberty. Access to health care was not provided in a timely manner when people required it. People did not have access to drinks when they requested them.

Inadequate

Is the service caring?
The service was not consistently caring.

People were restricted within their own home and their belongings were not always treated with respect. Relatives and friends were free to visit.

Requires improvement

Is the service responsive?
The service was not responsive.

People did not always receive care that reflected their individual preferences and needs. Some people told us they felt their complaints were not taken seriously.

Inadequate

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

There had been no improvements since our previous inspection. Effective systems were not in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

Inadequate

Spring Tree Rest 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. 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 the 12 May 2015 and was unannounced.

The inspection team consisted of three inspectors.

We spoke to six people who used the service and observed people's care. We spoke with four visiting relatives, five members of staff and the provider.

We looked at five people's care records to see if they were accurate and up to date.

Following our inspection we made two referrals to the local authority's safeguarding team and contacted the local commissioners. We did this because of significant concerns that we identified with people's care.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found that people were confined to locked areas within the service as each corridor was accessed through a key pad. People did not have access to the key pad code and most people would have been unable to use it due to their specific cognitive needs, such as dementia. The service was split over three floors and each floor was locked so people could not access the stairs or lift to come downstairs. During the night staff conducted hourly checks on people. This meant that people who were unable to call for assistance by using the call bell were also unable to mobilise around the service to seek support. We had asked the provider and registered manager to implement individual risk assessments to ensure that people were safe within the locked bedroom areas. At this inspection we found that the manager had not responded to ensure that people were not at risk of harm due to people being locked unsupported by staff in the bedroom areas.

At our last inspection, we saw records and staff told us, that one person was regularly found in other people's bedrooms during the night. At this inspection we saw that this was still happening. Staff told us and records confirmed that one person was regularly found in the rooms of other peoples of the opposite sex, sometimes this person was found to be naked and sitting on other people's beds. We were told by a member of staff that one person was visibly distressed at the presence of the other person being in their room, they told us: "It's a big concern to us, a new member of staff asked if we could lock him in his room". The provider and manager had not reduced the risk of these incidents happening again and had not recognised this as a potential safeguarding incident and reported it to the local authority for investigation. People continued to be at risk of abuse and harm through the lack of systems and processes in place to reduce the risks to people.

A relative we spoke to told us: "I do not think my relative is safe, I visit every day to make sure and check he is alright. The staff are lovely but do not know how to support people properly". They also told us that their relative had received some unexplained bruising and a skin tear two days previously which they had reported to a member of staff. We asked the deputy manager who told us that this had not been investigated or reported as a potential safeguarding incident.

Another relative told us that their relative had been upset as another person had accused them of serious sexual assault. This had not been investigated or reported as a possible safeguarding incident. The deputy manager told us that the alleged victim often made false accusations, however there was no risk assessment in place for this and no action had been taken to investigate whether the alleged abuse had taken place or not.

At lunchtime we observed an altercation between two service users. One person was holding a knife and threatening the other. A member of staff, who had only been employed by the service for a day, intervened and supported one person to move to another table. They said to the other person: "Are you going to behave yourself now"? When we fed this back to the deputy manager at the end of the inspection, they were unaware that this incident had taken place as it had not been reported. This meant that staff did not recognise and act upon incidents of abuse.

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

Two staff members told us that they had recorded and reported potential safeguarding issues but the management had not acted upon the information. One member of staff said: "I feel like I am nagging but I just get ignored".

We were told that one person had recently recovered from skin damage. We looked at this person's care records and could see no plan to reduce the risk of further skin damage occurring. We checked to see if they had a pressure mattress on their bed and saw that they did, but it was almost deflated and would have been ineffective. Staff could not tell us when the mattress had last been inflated. This person was therefore at risk of obtaining a further pressure ulcer due to the use of ineffective equipment.

There was a deputy manager and three care staff on duty throughout the day. There was also a cook and a domestic. Consideration to the deployment of staff had not been considered during the night shifts. Three staff worked during the night and the service was split over three floors, each floor was locked. Staff told us they did hourly night checks on people, however care records showed that one person was regularly found in other people's bedrooms during the night who resided on the third floor. One staff member told us: "We prop the fire doors open at night so

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Is the service safe?

we can hear [person who enters others rooms] when they are waking about". Propping fire doors open would constitute a fire risk. The provider and manager had not considered the fire risks, deployment of staff or use of assistive technology to ensure constant monitoring of the locked areas.

We checked that the provider had safe systems to manage and store people's medicines. Some people's medicines required refrigeration. We found that the fridge was not in working order and the ice compartment had frozen, then defrosted and medication had become soaking wet. The medication in the fridge had not been kept at the correct temperature so its efficiency could not be guaranteed.

One person who we were told did not have the capacity to self-medicate had an inhaler in their bedroom. When the deputy manager saw this they immediately took it and told us: "No, that shouldn't be there, they can't take their own medication". This meant this person was at risk of taking the medication inappropriately. We saw a box of sleeping tablets belonging to one person in the medication cupboard. The prescribing label on the box said 'to be given as required'. We found there was some sleeping tablets unaccounted for. We asked to see the medication administration record (MAR) for this person and found that the sleeping tablets were not recorded on it. The deputy manager could not show us why these tablets were missing or whether they had been administered. We saw tubs and tubes of external preparations in people's bedrooms, the prescribing labels had been removed so we were unable to determine if these had been prescribed for the person or not. This meant that people were at risk of receiving the incorrect external preparation.

These issues were a breach or Regulation 12 of The Health and Social Care Act 2010 (Regulated Activities) 2014.

Inadequate

Is the service effective?

Our findings

At our previous inspection, we found that people were being deprived of their liberty through the use of locked doors throughout the service and were not free to leave. The provider was not following the guidance of the Mental Capacity Act 2005 (MCA) and The Deprivation of Liberty Safeguards (DoLS) to ensure that decisions to restrict people's freedom were done so in their best interest. The MCA is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The DoLS are part of the MCA. They aim to make sure that people in care homes are looked after in a way that meets their needs in the least restrictive way possible. At this inspection we saw two people ask to go out of the lounge area and both people were refused. One person was observed to ask to leave and was told: "I can't open the door for you, come and sit down". We spoke to the local authority who confirmed that no application for a DoLS authorisation had been made for anyone using the service. This meant that people were continuing to be deprived of their liberty unlawfully.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

Several people who used the service became anxious and required support to manage their behaviour that challenged to ensure theirs and other people's safety. One person had a mental health diagnosis and we were told they were being supported by a community psychiatric nurse (CPN). Their medication had recently been reduced and they had become more anxious and difficult to reassure. We observed this person became anxious throughout the day. We looked at this person's care records, to see how staff were supported to care for this person at these times. The care plan stated that this person did not have behaviours that challenged, however daily records showed that this person was becoming increasingly more anxious. We saw that on the previous day that this person had refused their medication. We asked the deputy manager whether they had been regularly refusing their medication and they were unable to tell us or find the documentation to show us. We asked what they planned to do now that they were aware that this person had refused their medication. They told us they would tell the person's CPN when they visited later in the week. This would have meant a delay of at least four days before advice and support was gained for this person.

A member of staff told us that they had reported that one person who used the service had been showing signs of being unwell and they had been reporting it to the manager and recording it in their daily records for several weeks. We checked this person's records and saw the entries. We saw that there was a delay from when the records began and when GP advice was sought. When the person finally saw the GP they were diagnosed and prescribed medication for their condition. Another person had been reported as being unwell and requiring a GP visit. Staff told us that the GP was not contacted and the person had become seriously unwell and required the support of the paramedics. This meant that these people's health care needs were not met in a timely manner potentially causing them further harm and suffering.

These issues were a breach or Regulation 12 of The Health and Social Care Act 2010 (Regulated Activities) 2014.

Staff had received some basic training, one staff member told us: "I am doing my NVQ in care here". However three relatives we spoke with expressed concerns over the inexperience of some of the staff. One relative told us: "I am unsure about staff training but they don't seem able to help the people with dementia properly. I overheard one staff member telling a person their husband would be visiting and they could go home. This is not right as the person's partner is dead and there is no way she can go home. It's such a shame to see this".

People we spoke with told us that the food was 'fine' and that they had enough to eat. One person told us: "The food is okay, I get enough", and a relative told us: "They [relative] seem well fed". However one person told us that their relative did not have enough to eat and they had to bring in snacks for them to eat to keep them going".

We observed two people during the day ask for a drink and were told they had to wait. We heard a member of staff ask another staff member if they could get a person a drink and they were told no as that staff member was too busy. Some people were at risk of dehydration and malnutrition and required careful monitoring of their food and fluid intake. Records we looked at were incomplete and did not

Inadequate

Is the service effective?

demonstrate the amount of food and fluid that people had consumed in a day. This meant that people were at risk of not receiving the correct amount of nutrition to remain healthy.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

People who used the service and their relatives gave mixed opinions on the care being delivered. One person told us: "It's ok here we have our ups and downs but it is always clean", another person said: "It's alright, nothing special". Relatives we spoke with told us that they thought the staff were kind and did their best. When people became distressed or disorientated staff redirected them in a gentle manner. However we saw that people were restricted within their home and not free to leave the areas they were in, this meant that people's right to freedom and independence was not being respected.

We found that people were not offered a choice of where to go and what to do and were not receiving care that was responsive to their individual needs. We were told that everyone was brought down into the lounge area after they had been supported to get up in the morning. Only people whose bedrooms were on the ground floor were able to go back to or remain in their rooms during the day. The provider told us that this was their idea as they did not want people to be isolated in their bedrooms.

This constitutes a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that some people who did not supply their own bed linen, shared bed linen that had been provided by the service. We saw that the bed linen on one person's bed was soiled; however the bed was made up ready for the person to get into. We were told that this person's bed linen would be washed and then could be put on somebody else's bed as there was no way of knowing who's bed linen was whose. This meant that people's dignity was not being respected and consideration was not given to people having to share bed lined that had been soiled.

Some people looked unkempt. They had long dirty fingernails, were unshaven and their hair had not been brushed. We looked at the care records for two of these people and saw that it was recorded that personal care should be offered and that they were happy to undertake the tasks required including the cutting of nails and having a shave. Staff were not able to tell us why these people had not had their personal care needs met. The deputy manager told us: "Some people need more encouragement than others".

Within the bathroom areas we saw toiletries. Some were named and others were not. The deputy was not able to tell whose they were and why the named ones had not been returned to people's bedrooms. This meant that people's belongings were not being respected.

One person had a visit from their GP, we saw that a member of staff supported them to the privacy of their own bedroom for the consultation. Everyone had their own ensuite toilet and washbasin facility and people were able to personalise their room to their own individual taste.

Relatives were free to visit at any time and we saw several relatives on the day of our inspection. One person told us: "I can come anytime I want".

Inadequate

Is the service responsive?

Our findings

At our previous inspection we had concerns that the provider did not always respond in a timely manner when people's needs changed and people were not offered stimulating activities based on their individual needs and preferences. At this inspection, a relative of a person who used the service told us: "There is very little for people to do, they get bored". We saw that people sat in the lounge area with little or no stimulation. A film was on TV, but most people were disengaged or asleep. When one person became anxious they were asked to 'sit down' rather than being offered something of interest to do. When two people were asking to leave the lounge area, they too were asked to return to their seats in the lounge. A member of staff told us: "I feel the residents should be given more space to enjoy and more activities. I think they are bored. It only takes one to become upset and it affects everyone."

A large proportion of people who used the service were living with dementia. Some people required support to move freely around the home however others were able to be more independent. There were no visual prompts or sensory materials around the service to help people to orientate to time and day. Good practice regarding the design of environments for people with dementia includes incorporating features that support spatial orientation and minimise confusion, frustration and anxiety, such as better-quality environments, reality orientation cues and high light levels.

At lunchtime we saw that everyone was presented with the same meal and pudding, we did not hear anyone being offered a choice and no drinks were offered during meal times. We asked staff if there was a choice of meals and staff told us that people could have something different if they asked. Most people who used the service were living with dementia and may not have been able to ask for something different, they were not supported to make decisions about what to have to eat in a format that met their individual needs. One person asked for some salt to accompany their meal. There were no condiments on the table and a staff member brought the person some salt in a bowl with a tea spoon, which meant that the salt was applied to their dinner in a large measure and not spread evenly across the meal. When we asked if there were any condiments for the table, the deputy manager informed us that the one salt pot they had was broken and a replacement had not been brought.

Two relatives we spoke with told us that they felt that when they raised concerns about their relative's care they were seen as a nuisance by the management. One relative told us: "There is no willingness for staff to listen". The provider and deputy manager told us that they had some relatives who persistently complained about their relatives care and that some staff found it difficult to handle the complaints. Staff had not received support in how to respond to complaints effectively and because of this some people were left feeling their complaints had not been taken seriously.

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We found that no improvements had been made following any of the concerns raised at our last inspection in October 2014. Although we had received an action plan from the registered manager, it was late and only received after we rang and spoke to them to prompt them to send us one. Nothing on the action plan had been completed, such as DoLS referrals and people who used the service continued to be at risk of receiving poor care that did not meet their needs. The provider told us that they thought the improvements had been made, they had not checked to see that they had and no systems had been implemented to monitor the quality of the service.

The manager had not raised safeguarding referrals with the local authority when there had been incidents of suspected al abuse. Investigations were not carried out to reduce the risks to people and lessons were not being learned to ensure people were protected from further harm.

The provider held relative meetings which were planned quarterly. At a meeting held in November 2014 we saw that the relatives had been concerned about the restriction of their relatives being prevented from going outdoors, that there was a lack of activities for people and one person had requested condiments for their relative. We found that nothing had been done to rectify these concerns and there had been no improvements in the care their relative received.

Checks on equipment were not made to ensure they were safe for use. We found the medication fridge was not working properly and one person's pressure mattress was deflated although in use. This meant there were no systems in place to ensure that equipment for use with people was safe and effective.

Following the inspection we fed back our concerns to the provider and they informed us that a new manager would be coming to the service who they felt had the right skills to make the required improvements. We asked the provider for reassurance that people would be made safe on the day of the inspection until the new manager was in post. The day after the inspection we rang to speak to the senior staff at the service. We were told that there were three care staff on duty, but no manager, we were also told that no risk assessments had been implemented to make people immediately safe. This meant that the provider had not acted to keep people safe and people continued to be at risk of receiving poor care.

The above evidence shows that effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke to told us that they were concerned that issues they had reported had not been acted upon. They told us they looking forward to the new manager starting and hoped for improvements. A relative told us: "There is a lack of leadership, and some of the nicer staff have left which is a shame".

Since registration in December 2013 the provider had not notified us of any significant event as it is required for them to do, such as safeguarding incidents. This meant that they were not complying with the terms of their registration.

This was a breach of Regulation 20 of The Health and Social Care Act (Regulated Activities) Regulation 2014.

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.

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 to service users was not appropriate, met their needs or reflected their preferences.**

The enforcement action we took:
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided in a safe way.**

The enforcement action we took:
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Service users were not safeguarded from abuse and improper treatment.**

The enforcement action we took:
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems were not established and operated effectively to ensure compliance with the requirements.**

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
The service was placed into special measures and an urgent notice of decision was served on the provider to suspend all new admissions into the service.