Care Quality Commission

Ainsworth Nursing Home Limited

Ainsworth 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 caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 November 2014. A breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 was found, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We served a warning notice because service users were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems to regularly assess and monitor the quality of the services provided instructing the provider where improvements were needed.

As a result we undertook a focussed inspection on 12 March 2015 to follow up on whether action had been taken to address the warning notice.

Focused inspection of 12 March 2015.

The warning notice stated that the provider and manager must become compliant with this regulation by 16

Summary of findings

February 2015. We undertook a focused inspection to check that they had met these legal requirements and found that they had made improvements, however the requirements were not fully met.

During this inspection we continued to have concerns in the following areas.

We looked at care records and found that there continued to be a lack of evidence to show the service involved people in the planning and reviewing of the care they received at Ainsworth Nursing Home.

We found that the manager lacked knowledge on issues around the Mental Capacity Act 2005 and involvement of people in the consent to their care and treatment.

We found that people who required positional changes due to the risk of pressure sores were not being repositioned as frequently as identified in their care records. We had previously raised our concerns regarding this in our warning notice. Due to our findings we raised a safeguarding alert with the local authority.

We found that the registered manager was continuing to address low staffing levels and had been advertising for registered nurses. We saw that two people were interviewed for vacant post during our inspection.

We found the care records on the general nursing unit were stored securely. However we noted that the care records on the dementia unit were in an unlocked filing cabinet in a communal reception area.

The registered manager had a new system in place for ensuring nursing staff employed by the service were currently registered to practice with the Nursing and Midwifery Council.

We found that people were being weighed on a regular basis and weights were documented in care records.

During our inspection we noted that most of the bedroom doors were closed to ensure privacy and dignity for people who used the service.

The registered manager had implemented a system for the recording of complaints and concerns brought to their attention.

We looked at the quality assurance systems that were in place in the service and found that these were being completed. However we found that medicine audits were not sufficiently robust to identify when errors had occurred and infection control audits were not being completed in full.

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

We found the service was not always safe. During our inspection we found issues of concern around the prevention of pressure sores and made a safeguarding referral to the local authority.

The service had implemented a new auditing system for medication, however we found this was not sufficiently robust as medication errors had not been identified.

We found the registered manager was taking steps to improve the staffing levels within the service. During our inspection we noted two people were interviewed for vacant positions within the service.

The registered manager had a new system in place to check that all nursing staff were registered with the Nursing and Midwifery Council.

Is the service effective?

Requires improvement

We found the service was not always effective.

There continued to be a lack of evidence to show that people with capacity and without capacity were involved in the planning and reviewing of the care and treatment they received.

We found the manager lacked an understanding of the Mental Capacity Act 2005 and decisions made in people's 'best interest'. The knowledge of the staff team was not assessed during this inspection.

We found that people who used the service were being weighed on a regular basis and people who were at risk of malnutrition were weighed frequently.

Is the service caring?

Requires improvement

We found the service was not always caring.

During our inspection we found that people's bedroom doors remained closed to maintain privacy and dignity. Care records also indicated those people whose preference it was for their door to remain open.

We found that the storage of care records on the general nursing unit were stored safely and securely. However we found that the storage of care records on the dementia unit were not stored safely.

Is the service responsive?

Requires improvement

We found the service was not always responsive.

We found that people who were at risk of developing pressure sores were not being repositioned adequately or in accordance with their care plan.

Summary of findings

The registered manager had a new system in place for the recording and monitoring of complaints and concerns.

Is the service well-led?

Inadequate

We found the service was not always well-led.

The registered manager had new quality monitoring systems in place. Most of these were being completed on a regular basis, however we found the infection control audit was not being completed in full. We also noted that the audit system put in place in relation to medication was not sufficiently robust as it had failed to identify errors.

The service had failed to meet the requirements of the Warning Notice that had been issued following the previous inspection.

Ainsworth 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. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced focused inspection of Ainsworth Nursing Home on 12 March 2015. This inspection was carried out to check the provider and manager had met the legal warning notice we had served following our comprehensive inspection which took place on 12 November 2014.

The service was inspected against all five of the questions we ask about services; is the service safe, is the service effective, is the service caring, is the service responsive and is the service well led. This is because the service was not meeting relevant legal requirements.

The inspection was undertaken by two Adult Social Care inspectors. During our inspection we spoke with two people who used the service, a relative of one of the people who used the service, three care staff, one registered nurse and the registered manager. We carried out observations in all public areas of the home. We also looked at the care records for five people who used the service, staff rotas and assessments that looked at how much support people required from staff. We also looked at a range of records relating to how the service was managed; these included quality assurance systems and policies and procedures.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Ainsworth Nursing Home on 12 November 2014 we had concerns about the staffing levels in the home. Staff we spoke with on the dementia unit told us there was a lack of staff on this unit and as a result they were under pressure in trying to meet people's needs. The manager informed us there was no dependency level assessment tool in place and the provider expected them to meet the needs of people within current resources.

We also found that there were no systems in place to ensure that nursing staff employed in the service were registered with the Nursing and Midwifery Council. This meant there was a risk that people might receive care and treatment from unregistered nursing staff within the service.

We found there were no systems in place to monitor the effectiveness of the arrangements for the administration of medicines in the service. The registered manager told us no medication audits had taken place for some time.

This meant effective management systems were not in place to ensure potential risks to people were identified and addressed. We issued the provider with a warning notice on the 31 December 2014 instructing the provider that improvements were needed to ensure compliance with the relevant regulation.

We received an action plan on the 15 January 2015 informing us of the steps that the provider and registered manager would take to ensure compliance with the warning notice.

At our focussed inspection on 12 March 2015 we checked to see if the notice had been met. We found that some improvements had been made and some were continuing to be addressed by the registered manager.

On the day of our inspection one staff member had rung in sick resulting in the registered manager being included in the staffing numbers for the day.

Staff we spoke with told us that the numbers of staff employed by the service had increased since our last inspection. However they felt that more bank staff were required for times when a staff member was sick. One staff member told us there were currently enough staff for the number of people using the service, although they felt they would need more staff if occupancy levels increased. Another staff member told us "There is not enough staff at times. It is difficult if people's behaviour is challenging."

We also spoke with a visitor who told us "There is enough staff for the number of people at the minute, although staff sometimes seem busy."

We found that the registered manager had put a dependency assessment tool in place in order to assess how many staff members were required to meet the needs of people who used the service. This tool looked at the level of care people needed and how many hours they required support from staff. We found the outcome of this tool reflected the number of staff on the rota. We also noted that this had been reviewed regularly, the last review being the day previous to our inspection. This should help to ensure that there was always adequate staff on duty to meet the needs of people using the service.

The registered manager informed us that they had found difficulties in recruiting registered nurses for the service despite advertising, contacting agencies and other services. During our inspection we noted that the registered manager interviewed two people for nursing vacancies within the home, both of which we were informed were offered positions in the service. This meant the manager was actively seeking to source suitable staff to fill the vacancies within the home.

We found that the registered manager had a new system in place to check that all nursing staff employed by the service were registered with the Nursing and Midwifery Council. We found evidence that registration details for nurses were documented and dates when these had been renewed or were due for renewal. This system should ensure that yearly checks are undertaken to ensure nursing staff continue to renew their registration.

The registered manager informed us that they had recently had a pharmacy audit. We looked at the records relating to this and found that this had been mainly completed by the registered manager. We noted that the pharmacist had documented their findings from the audit, i.e. missing signatures on medication administration record sheets (MARS). We discussed with the registered manager how

Requires improvement

Is the service safe?

they were addressing these findings and if an action plan had been put in place. The registered manager informed us that they had not put an action plan in place but they were auditing medication on a daily basis.

We looked at the medication audit and found this was being completed on a daily basis. The registered manager informed us it was the role of the nurse administering medication to undertake the daily audit. We found the audit was not detailed or sufficiently robust as it had failed to identify the errors which the pharmacy audit had documented.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of Ainsworth Nursing Home on 12 November 2014 we had concerns that people who had been identified as at risk of malnutrition were not being weighed regularly. This meant we could not be certain if people's nutritional needs were being adequately met.

We also found people were not involved in making decisions about their own care. The registered manager told us that nursing staff were responsible for completing regular reviews with people who used the service and their family members. However, we saw no evidence in care records that people were involved in this process.

At our focussed inspection on 12 March 2015 we found that improvements had been made to the frequency and recording of the weights of people who used the service.

We spoke with one staff member who could not tell us how often people who used the service were weighed and that the nurses would tell them. Another staff member told us they weighed people at the end of every month and if they had any concerns about weight loss/gain they would pass this on to the nurse in charge. We also spoke with a relative during our inspection who told us "They weigh [relative] often. He has put weight on."

Care records we looked at showed that one person who was assessed as 'at risk' in relation to nutrition and hydration had their weight reviewed on a weekly basis. These records showed that this person had gained weight since their admission to the service. We noted there was a care plan in place in relation to eating and drinking and this contained information for staff about action to take, i.e. fortified meals, regular snacks, milky drinks etc. This meant the service was actively ensuring people at risk of malnutrition were monitored on a regular basis.

We looked at four care records and found that no changes had been made to the way that care plans were written and reviewed. Whilst care plans were reviewed and updated on a regular basis, there continued to be a lack of evidence to show that people who used the service were involved in this process.

We spoke to the registered manager to ask if and how people were involved in the decision making and reviewing of their care plans. The manager informed us that she had been informed by the local authority that people who lacked capacity did not have to consent to their care plans as the service would be acting in their best interests..

We found that one person who used the service was deemed to have capacity and had signed their care plan; however there was no evidence to show that this person was involved in the reviewing of their care plans since signing them. Consideration had not been given to the Mental Capacity Act 2005 or people's ability to consent to care and treatment.

We discussed with the registered manager alternatives ways of involving people in decision making processes regarding their care and treatment and the importance of involving everyone in this process. The registered manager agreed that they would work with the nursing staff to look at ways of improving this to ensure that people who use the service were involved in some way. We found the registered manager lacked knowledge around the principles of the Mental Capacity Act 2005 and decisions made in a person's 'best interest'. This meant there continued to be a risk people might receive inappropriate care.

Requires improvement

Is the service caring?

Our findings

At our comprehensive inspection of Ainsworth Nursing Home on 12 November 2014 we had concerns that people's privacy and dignity was not always maintained. This was because people were in bed asleep with their door open. We found no evidence that people had consented for their doors to be left open. None of the care records we looked at identified the need for doors to be left open whilst people were in bed.

We also noted care records for people who used the service were kept in an unlocked cupboard under the workstation which was located at the entrance to the service. This meant that inadequate arrangements were in place to ensure that people's personal information was kept safely and confidentially.

At our focussed inspection on 12 March 2015 we found that some improvements had been made.

During our inspection of the service we found that most bedroom doors were closed. Some bedroom doors were open but people were not in their room at the time. Staff told us they left some of the doors open so that people who can become disorientated were able to locate their own room independently.

We looked at care records that indicated the need for some bedroom doors to be left open when people where in bed. These records indicated if this was a personal preference or if there was a need to ensure peoples safety when they were in their room. This meant the service was ensuring people's privacy and dignity was maintained at all times.

We found that the care records for people residing on the general nursing unit were placed in a locked cupboard. We noted throughout our inspection that the cupboard remained locked when not in use and this could only be accessed by staff members who had access to the key.

However, we found that the care records for people residing on the dementia unit were placed in an unlocked filing cabinet in the communal reception area. We spoke with the registered manager regarding this to ask why these had not been placed in a locked cupboard. The manager informed us that she had not been asked to ensure these were locked away and believed that she only needed to address those on the general unit.

During our inspection we observed the registered manager make a request to the maintenance man to ensure that the key for the filing cabinet was located and that this was locked immediately. Prior to leaving the service the filing cabinet was locked and all care records were adequately stored to ensure confidentiality.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Ainsworth Nursing Home on 12 November 2014 we had concerns that people who had been identified as at risk of developing pressure sores did not receive regular positional changes. There was also a lack of clarity about the frequency at which people should be repositioned.

We also found the service did not record concerns or complaints raised by people. This meant the manager was unable to demonstrate the action they had taken when someone complained and any learning from this.

At our focussed inspection on 12 March 2015 improvements were still required.

We looked at the care records for two people who had been as assessed at 'high risk' of developing pressure sores. We found both people had positional charts in place and it was noted that two hourly positional changes were required.

We looked at one person's positional chart for the previous two week period. We found that there were 18 occasions where this person's position had not been changed for three hours, two occasions where they had not been repositioned for three and a half hours and three occasions where they had not been repositioned for four hours. We spoke with the registered manager regarding these concerns. The registered manager said they were not aware that positional changes were not being undertaken as directed. They also could not provide a reason why positional changes were not occurring at the times they should be.

Whilst looking at care records we found that one person had been identified as high risk of developing pressure sores but found no evidence of any actions taken to prevent this. On the 10 December 2014 it was documented that this person had developed blisters however no further action was identified. We found that a positional chart had been put in place on the 10 March 2015, however there was no documented reason for this. We spoke with the registered manager regarding these concerns. They informed us that this person only required positional changes when they were in bed during the day and that they had only recently started to do this. We asked the registered manager why positional changes were not carried out during the night since the risk had been identified or when the blisters appeared. The registered manager could not tell us why this had not been undertaken. This meant staff were not responding appropriately to ensure people received safe and appropriate care.

All the staff we spoke to were able to tell us the procedure they would follow if they wanted to make a complaint. One staff member told us "I would go straight to the manager or the nurse in charge" and one relative told us they felt the registered manager was approachable and would listen to them if they had any concerns.

During our inspection of the service we noted there was a complaints procedure displayed in the entrance part of the building for people who used the service, relatives and visitors to see.

We found the service had a new complaints system in place. We looked at two complaints that had been raised by people who used the service. There was a detailed account of the complaint, the initial action taken and by whom, acknowledgement of the complaint by the registered manager, the outcome and lessons learned. This meant the service was actively learning from the feedback they received.

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection of Ainsworth Nursing Home on 12 November 2014 we found the service had a lack of quality assurance systems in place to identify where improvements were needed and how and when these were to be addressed. We issued a warning notice due to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The warning notice stated that the provider and manager must become compliant with this regulation by 16 February 2015.

At our focussed inspection on 12 March 2015 we found the provider had not met the requirements of the warning notice. in the time specified.

The service had an infection control audit in place which identified areas such as staff sickness, if people who used the service had an infection, hand washing, notifiable diseases and hospital admissions. We found these had been completed for January 2015 and February 2015 but noted that both of these had not been completed in full.

Audits to the medication system were not sufficiently robust as errors found by the supplying pharmacist had not been identified and addressed by the registered manager ensuring people were not place at risk of harm.

Whilst audits/checks had been regularly completed in areas such as communal areas and complaints others were incomplete or not sufficiently robust to ensure the risks to people were minimised, such as the infection control, medication and care records.

We looked at the weekly audit file and found that this was being completed on a regular basis. Weekly checks included safeguarding, accidents/incidents, complaints, staff recruitment and hospital admissions. We also looked at the audits relating to care plans and found that these were being completed on a regular basis and had last been completed in March 2015.

We found the service had a system in place for the auditing of all the rooms in the service, both communal areas and bedrooms. The last dated audit for this was the 16 February 2015. The manager informed us these would be completed at least monthly.