HC-One Limited

Chandlers Ford Christian 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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 7 January 2015 and 2 February 2015. At which breaches of legal requirements were found. This was because risk assessments had not been regularly reviewed and updated, people were not supported to eat food which was suitable to their needs and there were not sufficient numbers of staff to keep people safe and meet their needs. People were at risk of dehydration, staff had not received sufficient training to meet people's needs and advice from health professionals had not been transferred to care plans and care was not being delivered in the recommended way. The provider was not acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and there was a risk that people were being illegally detained against their wishes because Deprivation of Liberty Safeguards (DoLS) were not followed. Privacy and dignity was not always respected, staff didn't have a detailed

Summary of findings

knowledge of people's individual needs and staff were unable to respond appropriately to people's needs due to a lack of detailed and accurate care plans, risk assessments, daily records and handovers. The home was not responding appropriately to people's concerns and complaints and audits were carried out but were not effective in detecting and responding to concerns.

After the comprehensive inspection, we issued three warning notices requiring the provider to meet legal requirements in relation to three regulations by 13 March 2015. We also asked the provider to tell us what they would do to meet legal requirements in relation to seven other breaches.

We carried out an unannounced focussed inspection on 24 March 2015 to check whether action had been taken in relation to the three warning notices. We found that the provider had complied with the requirements of the warning notices relating to meeting nutritional needs, however the warning notices in relation to care and welfare and consent to care remained in breach. We met with the provider and asked them to produce an additional action plan with a clear timescale on when the remaining warning notices would be met. The provider told us this would be met four weeks from the date we met.

We carried out a further unannounced focussed inspection on 18 May 2015 to follow up whether action had been taken to meet all outstanding breaches. We found significant improvements had been made and the two outstanding warning notices in relation to consent and care and welfare had been met. Legal requirements had been met in relation to all but one breach which was in relation to record keeping. Two new breaches of regulations were identified.

This report only covers our findings at the inspection on 18 May 2015. You can read the reports from our last comprehensive and focussed inspection, by selecting the 'all reports' link for 'Chandlers Ford Christian Nursing Home' on our website at www.cqc.org.uk.

Chandlers Ford Christian Nursing Home provides accommodation and nursing care for up to 45 older people. The home is located in the centre of Chandlers Ford behind the Methodist church and close to local shops and amenities. The home is located on the ground and basement floors of a large purpose built building. The first and second floors are flats with separate access. There were 28 people living in the home on the day of the inspection.

Chandlers Ford Christian Nursing Home did not have a registered manager in post on the day of the inspection. A relief manager was 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.

At our focussed inspection on 18 May 2015 we found that the provider had not complied with all legal requirements.

Medicines were not always safely administered. Care plans in relation to medicines to be taken 'as required', known as PRN were not consistently in place. The risks in relation to a person's medication regime had not been fully assessed.

Since our last inspection staff had received training in respect of the Mental Capacity Act 2005 (MCA) and showed an understanding of its principles. The provider was aware of the need to consider the mental capacity of those people with a cognitive impairment; this process was partially complete.

There was some improvement in record keeping since the last inspection, for example topical medicine administration records were now being completed, however there were still some significant gaps in other records, such as records relating to wound care.

Risk assessments were in place to manage risk appropriately. Care plans included a number of risk assessments in relation to people's individual risks such as dependency, falls, moving and handling and continence.

There were sufficient numbers of staff on duty to meet people's needs. Dependency assessments had been completed to ensure that staffing remained at appropriate levels. The atmosphere in the home was calm and staff did not appear to be rushed.

Summary of findings

Where the care and support arrangements in place, whilst in people's best interests, meant there was a risk of the person's liberty or freedoms being restricted, relevant applications for a deprivation of liberty safeguards (DoLS) had been submitted.

Staff had received sufficient training to meet people's needs which included clinical training on aspects of clinical care for the registered nurses. Staff confirmed that they had had recent supervision meetings and records showed this.

People's privacy and dignity was respected and promoted. People were assisted, without being rushed, in a caring way.

The new relief manager was more visible 'on the floor' which meant there were opportunities for people and staff to discuss any concerns, and people were encouraged to do so. Staff and people's concerns about low staffing levels had been addressed and meetings had been held with relatives, people and staff to encourage feedback.

The atmosphere in the home had improved. Staff said that morale had increased, and they knew the importance of teamwork. Improved quality monitoring processes were in place, such as a care plan audit and a falls audit. Monthly trends were recorded and analysed.

As a result of this inspection, we revised the ratings in respect of each of the five domains and this meant the overall rating changed from inadequate to requires improvement.

We found three of breaches. You can see what action we asked the provider to take at the back of the full version of the 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?

We found that action had been taken to improve the safety of the service, and the rating was revised from inadequate to requires improvement.

The service was not always safe. Further improvements were needed in the management of medicines.

Risk assessments were in place and had been updated.

There were enough staff on duty to meet people's needs.

Requires improvement

Is the service effective?

We found that action had been taken to improve the effectiveness of the service, and the rating was revised from inadequate to requires improvement.

The service was not always effective.

The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005, because although work was underway, capacity assessments had not been completed for everyone who needed them.

Training had improved and staff were being provided with training which helped them to meet people's treatment, care and support needs.

Requires improvement

Is the service caring?

We found that action had been taken to improve care, and the rating was revised from requires improvement to good.

The service was caring.

Staff respected people's privacy and dignity and encouraged their independence.

Good

Is the service responsive?

We found that action had been taken to improve the responsiveness of the service, and the rating was revised from inadequate to requires improvement.

The service was not always responsive.

People's care plans were more personalised and responsive to their needs.

Record keeping had improved but in some cases was not adequate to ensure people's needs were met.

Requires improvement

Is the service well-led?

We found that action had been taken to improve the leadership of the service, and the rating was revised from inadequate to requires improvement.

A registered manager was not in post.

Requires improvement

Summary of findings

Morale in the home had improved and the new relief manager was more visible in the home. Staff had worked hard to improve teamwork.

Chandlers Ford Christian 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 was planned to check whether the provider was meeting legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to decide whether it was appropriate to revise the rating under the Care Act 2014.

We undertook a focussed inspection of Chandlers Ford Christian Nursing Home on 18 May 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 7 January and 2 February 2015 and our focussed inspection on 24 March 2015 had been made. We inspected the service against all of the five questions we ask about services. This is because the service was not meeting legal requirements in relation to all five questions.

You can find full information about our findings in the detailed key questions of this report.

Before the inspection, we reviewed all the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

The team comprised of two inspectors and a specialist advisor in the care of frail older people living with dementia. During the inspection we spoke with five people using the service. We also spoke with the relief manager, the deputy manager, one nurse, seven care workers and a visiting GP. We reviewed records relating to nine people's care and support such as their care plans and risk assessments.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Chandlers Ford Christian Nursing Home on 7 January and 2 February 2015 we found that risk assessments had not been regularly reviewed and updated, people were not supported to eat food which was suitable to their needs and may represent a choking risk and there were not sufficient numbers of staff to keep people safe and meet their needs.

These were breaches of Regulations 9 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focussed inspection on 8 May 2015 we found that the provider had taken action to meet shortfalls in relation to the requirements of Regulations 9 and 22 above.

As a result of this, we revised the rating from inadequate to requires improvement.

Medicines were not always safely administered. One person's care plan stated that they liked to have their medicines dispensed into a pot, which was placed in front of them, so they could take them in their own time. The service had not assessed the risk associated with individual medicines in relation to this practice, for example one of the medicines had a requirement to be taken half an hour before food. One of the medicines was a controlled drug. Controlled drugs have specific protocols around their management which are designed to keep people safe, and these were not being followed in this case.

One person had been prescribed a medicine to be taken 'as required', known as PRN. There was no PRN care plan in place to advise staff when this medicine should be administered. This increased the risk of this person not being given this medicine when they needed it.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe Care and treatment.

Risk assessments were in place to manage risk appropriately. Care plans included a number of risk assessments in relation to people's individual risks such as dependency, falls, moving and handling and continence. These had been updated and staff were aware of the risks and how to mitigate them. The home had taken action to identify emerging risks, by discussing potential risks to people's health and wellbeing at weekly clinical meetings. One person who had a risk of repeated urinary tract infections had a care plan in place to address the known risk.

There were sufficient numbers of staff on duty on the day of the inspection to meet people's needs. We discussed staffing with the relief manager. Dependency assessments had been completed to ensure that staffing remained at appropriate levels. We were told there were always at least three care staff and a nurse on a night shift and seven care staff and two nurses on a day shift. Records since our last inspection showed these consistent levels of staff on duty. The atmosphere in the home was calm and staff did not appear to be rushed. Call bells and requests for assistance were responded to.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of Chandlers Ford Christian Nursing Home on 7 January and 2 February 2015 we found that people were at risk of dehydration, staff had not received sufficient training to meet people's needs, advice from health professionals had not been transferred to care plans and care was not being delivered in the recommended way, the provider was not acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and there was a risk that people were being illegally detained against their wishes because Deprivation of Liberty Safeguards (DoLS) were not followed.

These were breaches of Regulations 9, 11, 14, 18 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focussed inspection on 24 March we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 14.

At our focussed inspection on 18 May we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulations 9, 11, 18 and 23. However we identified a new breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to need for consent.

As a result of this, we revised the rating from inadequate to requires improvement.

Since our last inspection staff had received training in respect of the Mental Capacity Act 2005 (MCA) and showed an understanding of its principles. Following our inspection on 7 January 2015 and 2 February 2015 we issued a warning notice citing two people whose records showed that they had not given valid consent for care and treatment. During this inspection we found that the home had followed the principles of the MCA in order to protect the rights of the people concerned. Appropriate Deprivation of Liberty Safeguards (DoLS) applications had been made.

However, whilst, the provider was aware of the need to consider the mental capacity of those people with a cognitive impairment, this process was only partially complete. The deputy manager demonstrated a clear understanding of the requirements and was in the process of completing capacity assessments. Therefore there was no assurance that people were giving valid consent to aspects of their care and treatment. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to need for consent.

Aspects of some people's care and support, whilst in their best interests, meant there was a risk of their liberty or freedoms being restricted. Where this was the case relevant applications for a deprivation of liberty safeguards (DoLS) had been submitted. This meant that the risk that people were being illegally detained against their wishes, had been mitigated.

Staff had received sufficient training to meet people's needs. Staff told us that they had completed further training since our last inspection in subjects such as mental capacity. Nurses said that they had also received clinical training for example in phlebotomy. Specialists had been contacted, such as stoma care nurses in order to arrange further training. Weekly clinical supervision meetings were held with nurses in order to discuss people with particular needs, such as people at risk of losing weight or requiring wound care. Nurses said this helped them to o keep up to date with people's needs, the actions that needed to be taken and deliver effective care. Staff confirmed that they had had recent supervision meetings and records showed this.

Good

Is the service caring?

Our findings

At our comprehensive inspection of Chandlers Ford Christian Nursing Home on 7 January and 2 February 2015 we found that privacy and dignity was not always respected and staff didn't have a detailed knowledge of people's individual needs.

These were breaches of Regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focussed inspection on 8 May 2015 we found that the provider had taken action to meet shortfalls in relation to the requirements of Regulations 9 and 17 above.

As a result of this, we revised the rating from requires improvement to good.

People's privacy and dignity was respected and promoted. People were assisted, without being rushed, in a caring way. For example, staff ensured that people were comfortable when they sat down to eat their lunch. Staff took time to chat to people and were aware of what was important to people, for example referring to family members by name. One person said "This is a wonderful place with wonderful staff, I could hardly walk when I came here and now I walk with this stick. The staff have encouraged me to be independent and it has worked."

People were treated in a dignified way, one person described how they only liked female staff to assist them with their personal care, and this was respected. Another person said "It's got a lot better really – staff respect you." People told us there was a current newsletter which provided information about the service and they were pleased that they had been asked to contribute towards future issues. This showed that people's input was valued.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Chandlers Ford Christian Nursing Home on 7 January and 2 February 2015 we found that staff were unable to respond appropriately to people's needs due to a lack of detailed and accurate care plans, risk assessments, daily records and handovers and the home was not responding appropriately to people's concerns and complaints .

These were breaches of Regulations 9 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focussed inspection on 24 March 2015 we found that the provider continued to breach the legal requirements in relation to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focussed inspection on 8 May 2015 we found that the provider had taken action to meet shortfalls in relation to the requirements of Regulations 9 and 10 above. However we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to good governance.

As a result of this, we revised the rating from inadequate to requires improvement.

There was some improvement in record keeping since the last inspection, for example topical medicine administration records were now being completed, however there were still some significant gaps in other records. We found that actions to reduce the risk of pressure ulcers and skin breakdown had been taken. People were being regularly repositioned and pressure relieving equipment was in place. Care plans had been written to address the risk; however these were not always consistently followed. For example, one person had a care plan which stated that their dressing should be changed every three to five days. The last recorded dressing change was 7 May 2015, which meant that on the day of the inspection, the dressing had not been changed for 11 days. Nurses admitted that the dressing change was overdue. Other records in relation to the wound were unclear, in that they reported the wound to be 'skin intact but sore' which would imply the wound was being monitored. The records did not provide a clear picture of the care and support the person received to treat their wounds. There was no evidence that people's wounds were deteriorating.

The new relief manager was more visible 'on the floor' which meant there were opportunities for people and staff to discuss any concerns, and people were encouraged to do so. Staff and people's concerns about low staffing levels had been addressed and meetings had been held with relatives, people and staff to encourage feedback.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Chandlers Ford Christian Nursing Home on 7 January and 2 February 2015 we found that audits were carried out but were not effective in detecting and responding to concerns.

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

At our focussed inspection on 8 May 2015 we found that the provider had taken action to meet shortfalls in relation to the requirements of Regulation 10 above.

As a result of this, we revised the rating from inadequate to requires improvement.

There was no registered manager in post at the time of this inspection, however a relief managers have been managing the home since the previous registered manager left on 9 January 2015.

The atmosphere in the home had improved. Staff said that morale had increased, and that they knew the importance of teamwork. One member of staff said "Everyone needs to work together." People were appreciative of the recent changes and liked the fact that the relief manager came round to ask how they were. One person said "It makes you feel like you're part of something." Staff told us that the last Care Quality Commission report had been discussed with them and proposed actions for improvement. For example staff were given a care plan and asked to comment on how it could be improved.

Improved quality monitoring processes were in place, such as a care plan audit and a falls audit. Monthly trends were recorded and analysed. There was evidence that action plans were developed as a result and appropriate actions taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met: The registered person did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met: The registered person did not provide safe care and treatment in relation to the proper and safe management of medicines Regulation 12 (1) (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met: The registered person did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment. Regulation 17 (1) (2) (c)**