Noblefield Limited

St Clements Nursing Home

Inspection report

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Nechells
Birmingham
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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

This was an unannounced inspection, which took place on 28 May and 3 June 2015.

St Clements is a privately owned care home situated in a residential area of Birmingham. Nursing care is provided for up to 37 older people. At the time of this inspection there were 29 people living there.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whilst people felt they were safe, we found that procedures were not always adhered to keep people safe from harm. Senior staff were not always aware of what action to take to ensure people were safe from harm. We

Summary of findings

found instances where the systems and processes were not operated effectively, to investigate allegations of abuse and as a result, the outcomes for people were unclear and therefore people were not always safe.

People did not always receive their medicines in a safe way and medicine procedures were not always followed to ensure people's safety.

Training and supervision was provided for staff, but not all staff demonstrated they were competent and confident in their role. Some nursing staff were not aware of specific medical conditions of people, so may not be able to take appropriate actions, should people require medical attention. This put people at risk of receiving ineffective care and treatment.

People's health care needs were met, but their rights were not fully protected. This included where people expressed a wish to leave the home. People enjoyed their food, but choice of food and drinks were sometimes limited and sufficient consideration was not given to people's specific dietary needs.

People felt staff were caring towards them and their privacy and dignity was respected. We found people's independence was not always promoted and they did not always get the care and support they needed to remain as independent as possible.

People could raise concerns with the manager, but the system for investigating recording and responding to complaints was not robust. Where complaints were investigated we could not tell the outcome for people.

Whilst people could speak with the manager if they needed to. We identified poor leadership within the service. We found that the provider did not have effective processes and structures in place to ensure people received a quality service and we found several breaches in the regulations. Procedures were not followed effectively and monitoring arrangements failed to identify the failings that our inspection identified

The action we told the provider to take can be seen at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Procedures were not always followed to ensure people were safe. People felt there were enough staff to meet their needs.

Medication practice did not always ensure people received their medicines safely.

People lived in a clean environment.

Requires improvement

Is the service effective?
The service was not always effective.

Not all staff demonstrated they were competent in their role; however, training was on offer to support staff to ensure their competency.

People could not be assured that their rights were fully protected.

People enjoyed their food, but choice was limited and specific diet and nutritional needs were not always given full consideration. People's health care needs were being met.

Requires improvement

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

People were treated well by staff and their privacy and dignity respected.

People's independence was not always promoted.

Requires improvement

Is the service responsive?
The service was not always responsive.

People's needs were assessed with their involvement, but their social and spiritual needs were not always met in a person centred way.

People knew how to complain and had no concerns about talking to the manager if they were unhappy.

Requires improvement

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

There was poor leadership in the service and ineffective monitoring arrangements to ensure people received a quality service.

Inadequate

St Clements 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 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 28 May and 3 June 2015 and was unannounced. The inspection team consisted of one inspector, a specialist advisor, who specialises in the care of older people and people living with dementia 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.

As part of our inspection we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We reviewed reports that local authorities sent us on a regular basis and reports sent to us by the clinical commissioning group. We contacted health care professionals that visited the home regularly, such as the GP and tissue viability nurse.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with nine people that lived at the home, four relatives, the registered manager, two trained nurses, four care staff and the cook. Records looked at included, staff training records, audits and monitoring records completed by the registered manager and we reviewed the provider's safeguarding policy. The Birmingham Cross City Commissioning Group (CCG) pharmacist was undertaking an audit of the medication process on the first day of our inspection; they gave us permission to use their findings, so we have incorporated their findings as evidence. We also advised the registered manager that this evidence will be used to inform our inspection judgment.

Requires improvement

Is the service safe?

Our findings

People spoken with said they felt they were safe. One person said, "I feel very safe." Another person said, "I feel safe as a bank." A relative told us, "I don't worry about his safety." All staff spoken with said they would report any concerns about people's safety to the registered manager. Care staff knew the different types of abuse and the signs to look for which would indicate that a person was at risk of harm. For example staff said they would observe for signs of bruising, change of behaviours or any signs of neglect, which could indicate that people were being mistreated. Care staff said they had received training on how to keep people safe from harm and knew how to report concerns within the service and to external organisations if needed. However, some senior staff did not know how to report safeguarding concerns in the absence of the registered manager.

In addition, complaint records looked at showed that on two occasions care staff had reported allegations of abuse to the registered manager and the appropriate actions were not taken to ensure these people were safe from harm. In one incident, a care staff had alleged they overheard a trained member of staff shouting at a person, who had become very upset. In the other incident a person living in the home alleged that a member of staff slapped them on the wrist and legs and they were upset and crying. Neither of these incidents had been reported, under the local safeguarding procedures. The registered manager said she had discussed one of the incidents with her line manager and was told to go ahead and investigate. The registered manager also said that she had been told, by someone who came into the home to talk about safeguarding, that these incidents could be investigated in house, without reporting them under the local safeguarding procedures. Our records showed that when similar incidents had occurred previously, the registered manager had followed the correct procedures to ensure people were safeguarded from harm. We reviewed the provider's safeguarding policy, to see what instructions were given to staff. We saw that the policy identified both of these incidents as abuse and gave staff instructions to report these matters to the relevant authorities and not to investigate internally. This meant that the provider's procedures were not followed effectively. Following the inspection the registered manager said she had made retrospective safeguarding alerts to the local authority for both of these incidents.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw two members of staff using an underarm transfer of a person from one chair to the other, which meant the person was not being supported in the safest way. A nurse that was present told us this was not usual practice and that all staff had received moving and handling training and were aware that this practice was not allowed. We saw that the control of substances hazardous to health cupboard was left open during the day. Although we did not see that anyone had had an accident, this was poor practice and posed a risk for people who were able to access the basement level via the lift. This was because the entrance of the home is at basement level and although the doors on the upper floors had safety measures that would be out of reach for most people, people could access the basement via the lift. We saw that the flooring in a number of the bedrooms were torn and ill fitting, which posed a trip hazard for people. The registered manager had an action plan in place, which indicated that the damaged floorings would be replaced in time.

The provider information return (PIR) stated that risk assessments were undertaken for each person, this was confirmed by staff that we spoke with. Staff told us that where risks to people's care was identified, such as falls, choking and pressure areas these were all included in people's risk assessments. Staff said they did not know if the risk assessments were always reviewed, but they were informed of any new risks during shift handovers.

We spoke with staff about incidents that had occurred that had changed their practice. One member of staff said that a person was having a number of falls. They told us the registered manager held an emergency meeting, so that ways of reducing these falls could be discussed. This had resulted in increased monitoring of the person by staff and as a result the number of falls had reduced.

Staff spoken with knew the procedures for handling emergencies, such as fire and medical emergencies. Staff said that someone was employed to maintain the building and that an external contractor came in to check the safety of equipment, such as the lift, hoists, fire equipment, water,

Requires improvement

Is the service safe?

gas and electricity. Records looked at confirmed this. A staff member said all staff had responsibility to ensure they checked the safety of equipment before use to ensure people's safety.

People felt there were enough staff to meet their needs. Care staff spoken with said there were enough staff and we saw that there were sufficient staff on duty. A member of staff said, "We have no problem with staff, if we are short they get agency in." However, nursing staff said they felt under pressure due to staffing limitations. Two nurses told us, they had, "Very little time to carry out specific nursing duties."

The provider information return stated that there were no medication errors in the service within the last 12 months. Two members of staff said the trained nurses were responsible for administering medicines, but some nurses left medicines on people's bedside tables and often asked the care staff to give them. The member of staff said that medicines were often found under people's pillows and on the floor, so people did not always receive their medicines safely. The registered manager said staff had raised these issues with her and she had addressed them in a meeting, and was of the view that these incidents had stopped. Records looked at confirmed this discussion had happened, however, a member of staff told us that these incidents were still happening.

The CCG had alerted us to concerns about medication management at the home and on the day of our inspection the pharmacist team was undertaking their third audit to see if improvements had been made. Their assessment showed that improvements had been made although there were outstanding issues of concerns. These included, no protocols for medication prescribed when required to modify or control people's behaviours and gaps in records which indicated that people may not always receive their medicines as prescribed. The practice of giving medicines disguised in food and drink was not in line with good practice guidance.

The CCG told us about recent concerns they had about infection control, namely torn floorings, lack of domestic staff and cleaning schedules not being maintained. People said they thought the home was clean and tidy and our observations confirmed this. There were domestic staff on duty during our inspection and staff confirmed that domestic staff were available to ensure the home was cleaned. Staff spoken with said they had infection control training. The home was being decorated at the time of our inspection, which should ensure that paintwork and the decor was fresh and clean. The manager who was the lead person for infection control, had an action plan to replace the floorings and had employed more domestic staff; we also saw that cleaning schedules were in place.

Requires improvement

Is the service effective?

Our findings

The PIR stated that no applications had been made to a Supervisory Body, under the DoLS for people living at the home. The registered manager told us, that she had made DoLS applications for some people and will be making applications for others also. At the time of our inspection DoLS applications had not been made for these two people, as the registered manager had not recognised or prioritised the applications for these two people.

People did not always receive the support they needed with their specific dietary needs. There were several people living with diabetes, which was controlled by diet. Two members of staff told us that no specific diabetic diets would be served at lunchtime. We saw that desserts were not tailored to the needs of people living with diabetes and the cook told us that people living with diabetes were served smaller portions. We did not see evidence of fresh fruit or snacks available outside of designated meal times.

People's nutritional needs were not always met in a way that ensured their well-being. Care staff said they were aware of how to support people who may be at risk of poor nutrition. Staff said some people may require their weight to be monitored to ensure they were not gaining or losing weight. Staff talked about the use of fortified foods and drinks to support people's nutritional needs and the need to involve the GP and dietician, if necessary. However, one person's records showed they had lost three kilograms of weight within a month. There was no evidence to show what actions had been taken to manage the person's weight loss. The cook told us they had been told they could use cream and milk powder to enrich the foods for people who needed additional dietary support, but said they did not use these supplements. The registered manager said she was unaware that this was not happening.

People told us they enjoyed the food and had a choice of meals. One person told us, "I really enjoy my meals." Another person said, "The food is good, I have a choice." There were no condiments on the dining table, so no choice of salt, pepper or sauces was available. There was also only a blackcurrant drink which was served with lunch with no other choice. One person's record showed that their relative had been concerned about them being served the same meals three evening in a row.

Staff told us they always sought people's consent before providing care and support. A member of staff told us, "We always ask people what they want, and check the care plans for people's likes and dislikes."

Whilst most staff were able to describe in detail the needs of people we asked them about, one staff member did not demonstrate that they were competent in their role. For example a nurse was unable to explain the specific medical needs of a person that we asked them about. This was important, because should the person become unwell, the nurse would need to be able to recognise the symptoms relating to the person's condition and give staff guidance. We fed back our concerns to the registered manager, whose response was that the nurse in question had notified them of their responses to our questions. The registered manager said they were not sure why the nurse had responded in this way.

Care staff told us that plenty of training was on offer and that they had the training needed to do their job. A member of staff told us, "There is a training plan and we have updated training every year." Staff told us that they received regular supervision sessions and an annual appraisal. We saw that the registered manager walked around the home regularly so that she was able to observe staff practices.

We saw that staff appeared to understand the needs of individuals who had specific communication needs. For example one person used a picture book to aid their communication. We asked a member of staff to show us how the book was used to support the person when making choices. We saw the member of staff used their knowledge of the person's needs to help the person to decide on what food choices they wanted.

People were supported to see health care professionals when needed. People told us they saw the doctor when needed. Staff told us the GP visited weekly to see people and where necessary other health care professionals such as dentists and chiropodists visited when needed. We contacted the GP who visited people on a regular basis; they had no concerns about how people's health care needs were managed.

Requires improvement

Is the service caring?

Our findings

People's independence was not always supported. We saw that the walking aid of a person shouting for help had been placed behind a chair out of their reach. Their call bell had been disconnected and was wound up at the top of the bed out of reach also. This meant the person could not get up or use the buzzer to call for help. The person told us they needed to use the toilet urgently. We saw another person lying in bed trying to eat their lunch, with the plate balanced on their chest trying to eat with a knife and fork. Staff said the person could eat their meal independently and preferred to eat in this position. However, the person had one pillow under their head, did not look comfortable and was struggling to eat their meal. Staff came into the room and we heard the person say they needed more pillows and staff adjusted the bed and gave the person an additional pillow. We saw someone else lying on the side of their bed trying to eat their lunch that had been placed on a bedside table. Staff had given the person their meal and a drink, but had not checked that they were in a comfortable position to eat their meal independently. We saw someone trying to retrieve their glasses case which they had dropped under a chair. A staff member who was in the room did not try to help the person until we pointed out that the person needed help.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People reported a caring attitude and willingness from staff to meet their needs. One person said, "I have nothing to grumble about." Another person said, "Staff are cheerful and happy." One relative told us, "Yes they do care for her."

People felt staff met their needs and felt they were well cared for. We saw compliment cards that had been sent by relatives. One read, "Thank you for all you did for mom, forever grateful." Another read, "Thank you all for looking after mom."

A GP reported that on the whole staff had a caring attitude towards people. Interactions between staff and people that we saw were positive. For example during the inspection we saw a member of staff kneeling beside people to talk to them at their level. We overheard another staff speaking to someone in their own language. Another member of staff explained that the staff member had done research to ensure they knew key words of the person's language, so they could communicate with them. We heard the person responded to the staff member.

People's privacy and dignity was maintained. We saw that staff closed bedroom doors when attending to personal hygiene needs. We saw that people were dressed in individual styles of clothing appropriate to their age, gender and the weather, so their dignity and preferences were maintained. Staff told us that they always ensured people chose the clothes they wore. A member of staff said, "I get their clothes out and ask if they want to wear this today." The staff member then went on to say, "Even if people can't communicate verbally I always ask. If people show distress I wouldn't proceed with what I am doing." We saw that staff addressed people by their preferred name.

Requires improvement

Is the service responsive?

Our findings

We saw that the complaints process was not consistently applied. All of the people we spoke with said they would speak to a member of staff if they had any worries or concerns. We saw people coming in to discuss things with the registered manager during the inspection. We saw that the complaints procedure was on display in the hallway and accessible for people to see. We looked at a sample of complaints and we saw that they were investigated, but people didn't always get a written response and it was difficult to track the outcome of complaints that had been investigated, so it was difficult to determine if people were responded to in a timely manner. This indicated that the complaints system did not give assurances that people's complaints were always responded to appropriately. When we raised this with the manager she showed us a written response that had been sent to the CCG about a complaint they had raised, so in this instance the CCG did get a written response.

People felt that social activities were limited and some people said they didn't know they could pursue certain activities that they liked. For example one person told us, "I liked the horse racing and putting a bet on but I wouldn't be allowed here." We spoke with the registered manager about this and she said the person had never mentioned this to them and that staff supported other people to put a bet on the horses. Another person said, "Nothing to keep you occupied." Someone else said, "Sitting in the lounge is boring." A relative commented, "I notice that the television is always on the same channel, a bit of variety may suite more people." We saw that some people were asleep; others were awake and talking to their visitors. On the second day of our inspection we saw staff doing chair exercises with people in the lounge.

There were two part time staff employed with designated responsibility for supporting people with their social activities and interactions. On both days of the inspection we saw staff doing some group activities in the afternoon with a small group of people. However, we did not see any engagement with people that were in their bedrooms or whose abilities were more limited. Staff responsible for activities were also care workers, who had insufficient time to undertake therapeutic activities with everyone. We saw that activities mostly took place in the afternoons, when people in their bedrooms were asleep.

One person told us they no longer practiced their faith. This person said, "I used to go to communion and enjoyed going to church." They said although they had attended a church service whilst living at the home, it was not their church. The manager said that someone comes in to do holy communion and the priest gets a list of people who are catholic and at assessment people are asked about their faith or religion. Staff spoken with confirmed that church services did take place.

People's bedrooms were personalised with personal items of furnishing. However, the lounge areas were starkly furnished, with no evidence of stimulation for people and there was no clock or calendar in the home to help in people knowing the time of day and day of the week. The registered manager said she would address this.

People that lived at the home and relatives spoken with told us that the staff discussed their care with them and they were involved in how they wanted their care provided.

People's needs were assessed, with their involvement, when they moved into the home so that the provider knew whether or not they could meet people's needs. People's needs assessments looked at contained limited information about people's life history. Staff spoken with told us that the assessment process included information about people's background and lifestyle before they moved into the home and personal preferences and knew where to find it. A member of staff told us, "There is a section in the care plan. It asks the likes and dislikes, example food, activities and what they like to wear. If people give the information it is recorded." This same staff said, "I like to talk with people, so they tell me about their past. I like to have that talk with them." When asked care staff were able to tell us in detail about the life history of people we asked them about. The registered manager told us that the CCG had provided support with care planning documents that were being implemented, which should enable a more personalised assessment process.

People were supported to maintain contact with friends and families; relatives confirmed that they could visit at any time as there were no restrictions on visiting. We saw relatives spending time with their family members at the home. Relatives told us the staff were welcoming. One relative told us, "Staff are very attentive."

Inadequate

Is the service well-led?

Our findings

We found that the service had a culture of poor leadership and oversight, which has resulted in people not benefitting from a well led service. The provider had some systems in place for monitoring the service. This included, auditing of care plans, medication, infection control and health and safety. However, we found that these systems were not effective. For example the CCG told us about a number of errors and shortfalls in medication practice, which indicated that people's medicines, were not managed in a safe way. The CCG report showed that the medication monitoring arrangements were not sufficiently robust to establish, which member of staff were responsible for the poor practice in medication.

We found that monitoring arrangements were not in place to ensure that people's specific dietary needs were being met. For example the registered manager didn't know that the cook was not providing fortified foods for people that were losing weight or at risk of losing weight.

We found two incidents where the registered manager had used the complaints procedure to investigate allegations of abuse instead of instigating the safeguarding procedures. In both incidents allegations had been made against staff members and the outcome for people was unclear. There was no evidence that the provider was monitoring to ensure that the appropriate procedures were adhered to.

Staff told us that resources were not always available to replace items of furnishings and floor coverings to a satisfactory standard. We saw that the floorings were torn and there were very few chairs in the dining room for people to sit on. Where the provider had previously replaced floorings, these were not completed to a standard that ensured people were not at risk of slips, trips and cross infections.

The provider sent us their provider information return (PIR), within the timescale requested, but this was not adequately completed and did not give us all the information we needed. This information would have enabled us to make a decision that the provider was aware of the shortfalls we identified in the service and were taking action to address the concerns We raised this with the registered manager and she made no response.

Not all staff felt they could raise concerns about the quality and safety of the service, although they felt they said they could speak to the registered manager they did not always feel their concerns were listened to. A member of staff told us, "I don't think we as care workers get listened to. We know a lot about the residents, but the nurses can't be bothered a lot of the time. I don't bring things up anymore." The member of staff went onto say they did not blame the registered manager, as they had seen her try to get things right. The manager said that the management structure was not sufficient to meet the needs of the service. For example, there was no one available to deputise for the manager or to take a lead role in supporting the manager to maintain and sustain quality within the service. Many of the trained nurses were part time, so did not have the time commitment to offer the necessary management support to help in raising the quality of the service.

We saw that care records were not fully up to date with relevant information. For example people's care was not always reviewed. The manager said they were introducing new care planning procedures and was in the process of reviewing all the care plans. In addition complaint records did not give details about who was making the complaint, the date the complaint was made, and the outcome of the complaint. Where allegations of abuse had been made the investigation records did not state who the alleged perpetrator was or the person that had made the allegations, so it was difficult to follow the process of the investigation and action taken to ensure the safety of people.

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

People using the service and relatives told us they could speak with the manager and that staff were friendly. Everyone knew who the manager was and called her by her first name.

The provider had processes in place to consult with people and relatives about their care. We saw that questionnaires were available for people in the reception area, so they could complete them whenever they wished. We saw that the provider analysed these monthly and we saw that some actions were taken from the analysis. For example we saw that relatives had commented that they did not know how to complain and the provider took action to display the procedures in the hallway for people to see.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's independence was not always supported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to keep people safe from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not followed effectively to ensure proper assessment and monitoring of the quality and safety of the service people received.