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Harker Grange Nursing Home

Inspection report

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection took place on 23 and 24 May 2016. At the last inspection on 24 February 2015, we asked the provider to take action to make improvements in the way it carried out suitable background checks on staff, this action had not been completed.

Harker Grange Nursing Home is registered with CQC to provide accommodation for up to 26 people who may require nursing or personal care. The home is also registered to provide the following regulated activities: diagnostic and screening procedures and treatment of disease, disorder or injury.

The accommodation consists of 12 single bedrooms, one of which has en-suite facilities and seven twin bedded rooms. The home has a variety of communal facilities such as lounge areas, bathrooms and toilets.

The service did not have a registered manager. 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. The previous registered manager had left in February 2016. A new manager had been appointed and was due to start work in June 2016. In the interim a temporary manager had been appointed.

People who used the service told us that they liked the people who supported them and thought they were caring and polite.

The service had a complaints policy and procedure in place.

The service regularly sent questionnaires to people who used the service and their relatives to ascertain they were satisfied with the service.

Staff had not been subject to sufficient robust checks to ensure they were of good character and the provider had not deployed sufficient staff to meet all of people's needs. Staff were not receiving appropriate training to enable them to carry out their duties.

The service was not assessing risks to the health and safety of people who used the service and were not doing all that was reasonably practicable to mitigate risks. This included the nutritional and hydration needs of people who used the service.

Topical medicines were not being managed and monitored correctly.

The premises required repair and refurbishment and infection control was not being managed efficiently.

Care and treatment of people was not being provided with the consent of the relevant person and people's

right under the Mental Capacity Act 2005 were not being upheld. The service was not treating people with dignity and respect and was not ensuring people's right to privacy.

Care being provided was not person centred and care files we looked at were not written in a person centred manner to ensure care and treatment of people was appropriate, met their needs and reflected their preference.

The service did not have effective systems in place to assess monitor and improve the safety of services provided. In addition they failed to assess, monitor and mitigate the risks relating to the health, safety, and welfare of people who used the service and others who may be at risk of harm. Furthermore they had failed to notify the CQC of incidents which is a statutory obligation.

We found breaches of the following Regulations:

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 19 (1) (a) (b) (c) (2) (a) (b) (3) (a) (b) – Fit and proper persons employed.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 (1) – Staffing.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (1) (2) (a) (b) (c) (d) (g) (h) - Safe Care and Treatment.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 (2) (a) (b) – Staffing.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 11 (1) - Need for Consent.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 14 (1) – Meeting nutritional and hydration needs.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 10 (1) (a) – Privacy and Dignity.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 (1) – Person centred care.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 (1) (2) (a) (b) (c) (d) - Good governance.

Care Quality commission (Registration) Regulations 2009 Regulation 18 (1)– Notification of other incidents.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We found that there were not sufficient staff to meet people's needs

Risk assessments were not sufficient or reviewed regularly in order to ensure that people were receiving appropriate support to minimise risk to their safety and wellbeing.

Appropriate pre-employment checks were not carried out prior to staff commencing employment.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received appropriate training.

Appropriate nutritional and hydration support was not provided.

The principals of the Mental Capacity Act 2005 were not adhered to.

Is the service caring?

Inadequate

The service was not always caring.

We observed that people's right to privacy and dignity was not upheld

People told us that the staff who supported them were kind and caring.

We observed staff speaking with people in a respectful and pleasant manner.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not written in a clear and concise way and were

not easily understood.

There was no organised activities within the home and people were not able to readily access outside spaces.

People were able to raise issues with the service in a number of ways including formally via a complaints process.

Is the service well-led?

Inadequate

The service was not well led.

The quality assurance systems were not sufficiently robust.

The registered provider had failed to identify various issues and problems within the service

The service had failed to notify us of concerning incidents within the home in a timely manner.

Harker Grange 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, 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 23 and 24 May 2016 and was unannounced.

The inspection was carried out by two adult social care inspectors.

Before the inspection 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 also reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. In addition we spoke with representatives from adult social care and the clinical commissioning group for Cumbria. We planned the inspection using this information.

We spoke with four of the people who used the service and 12 members of staff including the temporary manager, the business manager, two nurses, care staff and auxiliary staff.

We looked at eight written records of care and other policies and records that related to the service. We looked at six staff files which included supervision, appraisal and induction. We saw a record of training. We looked at quality monitoring documents.

Inadequate

Is the service safe?

Our findings

We spoke with people who used the service and asked if there were sufficient staff within the service. One person told us, "They are sometimes short." We asked staff the same question. Staff told us there were enough staff to complete necessary tasks but not enough to socially engage with people as often as they would have liked. One member of staff commented, "We need staff for activities."

In addition we asked people if they felt safe within the service, one person said, "No one is ever unkind, if I had a problem I would tell my daughter."

At the last inspection on 24 February 2015 we asked the registered provider to take action to make improvements to the way they carried out pre-employment checks. During this inspection we asked for evidence to demonstrate that the registered provider had carried out appropriate pre employment checks, including criminal record checks (DBS). The registered provider was unable to show us evidence to confirm that all staff had DBS checks. The business manager told us he thought '95%' had been checked.

We looked at personnel files. We found evidence that some staff had a criminal history and inadequate references. There was no evidence that the registered provider had pursued any further references for staff or evidence that they had carried out any form of risk assessment to underpin their decision to employ staff with a poor pre employment history.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 19 (1) (a) (b) (c) (2) (a) (b) (3) (a) (b) – Fit and proper persons employed. We judged the staff the provider employed had not been subject to sufficient robust checks to ensure they were of good character.

The staff we spoke with all agreed that there were sufficient staff to carry out care tasks on a day to day basis but there was not sufficient staff to provide people with activities to help give them a structured and meaningful day. For example, we observed no organised activities taking place throughout our inspection.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 (1) – Staffing. We judged that the provider had not deployed sufficient staff to meet all of people's needs.

We looked at how the service managed risks to individuals. We found assessments did not include up to date information and had not been reviewed or updated As people's needs changed. For example staff told us that one person who used the service had exhibited behaviour associated with self harm. There was nothing in this persons' written record of care about any incidents of self harming behaviour nor had their risk assessment been reviewed. The poor management of this persons behaviour's had resulted in them causing a significant injury to themselves. In addition another persons' record falls risk assessments had been completed on admission but had not being subsequently reviewed or updated following a series of falls. This meant that the registered provider had not done everything reasonably practicable in order to mitigate risks for people who used this service.

We looked at how people's medicines were managed. We found that the service had appropriate arrangements in place for the ordering, storage and safe disposal of medicines. We carried out spot checks on the medication administration records (MAR charts) for oral medicines and noted they were in order. When we looked at the MAR charts for topical creams we found these had not been signed for correctly. Furthermore we found that topical creams were not stored safely, in fact they were left out in service users rooms which were not secure. It was impossible to confirm whether people using this service received this type of medicine as their doctor had intended.

Areas of the premises were unsafe. For example two roof windows had been installed in two ceilings on the ground floor. Neither ceiling had been made safe following these alterations. We saw that there were exposed cavities between the ceiling and the roof which contained dirty insulation material. There were loose wooden panels in one of the ceilings that had to be made safe on the first day of our inspection.

The laundry was in a poor state of repair with missing tiles and worn surfaces that were not possible to clean. Inspectors found a cracked toilet that was still in service. These areas could not be cleaned properly and potentially harboured bacteria which could in turn have caused infection.

Infection control and prevention were poorly managed. Handover notes recorded that two people who used the service had presented with episodes of vomiting and diarrhoea on the two days prior to the inspection. We spoke with staff responsible for cleaning and providing laundry services within Harker Grange Nursing Home. The staff told us that they had not been made aware that there had been diarrhoea and vomiting in the home. Therefore they had failed to take the necessary precautions to prevent the spread of any infections present.

The above were breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (1) (2) (a) (b) (c) (d) (g) (h) - Safe Care and Treatment. We judged the service was not assessing risks to the health and safety of people who used the service and were not doing all that was reasonably practicable to mitigate risks. Medicines were not managed correctly. The premises required repair and refurbishment and infection control was not being managed efficiently.

Inadequate

Is the service effective?

Our findings

We spoke with people who used the service and their relatives. We asked them if they felt staff were able to provide appropriate support. A relative told us that the staff were, "Helpful and willing."

We spoke with staff and asked them if they felt well supported and correctly trained. Staff told us they had been "shown" what to do. One commented, "I've had moving and handling [training] and was shown how to put a [continence] pad on."

We spoke with staff and asked how people were protected from bullying, harassment and avoidable harm. Staff were able to tell us about different kinds of abuse and how they would report it to their manager. Three staff on duty told us that they had not received formal safeguarding training. We looked at training records which confirmed this. In addition the training records provided showed that all staff had not completed training the provider deemed mandatory. In fact one member of staff had completed no mandatory training at all.

We looked at supervision records for staff. We found that staff had not received supervision for over eight months. This meant that staff had not received the support and training they needed in order to undertake their roles and responsibilities safely and competently.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 (2) (a) (b) – Staffing. We judged staff employed by the service were not receiving appropriate training to enable them to carry out their duties.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met

We looked at written records of care for eight people who used the service. We were told that all of these people lacked capacity. We found no evidence of capacity assessments, as outlined in the Mental Capacity Act 2005, taking place.

According to one persons' written record of care they had capacity in July 2015. Despite this a best interest meeting had taken place. This is contrary to the Mental Capacity Act 2005. In addition we found several

examples of relatives who had signed documentation on behalf of people who used the service. The relatives in question only had lasting powers of attorney over service user's finances, not over their care and welfare. Therefore these relatives had no legal right to sign documents involving decisions related to service user's care and welfare.

We found evidence to show that one person who lacked capacity had tried to leave the home and had been prevented from doing so by staff. This person had tried to leave the home regularly and were prevented from doing so as all the doors leading outside were locked with electronic key pads. None of the people who used the service had the code to unlock the doors. This constituted a potential deprivation of people's liberty as they were not able to leave the home if they chose to do so. We asked the registered provider to review whether people needed applications made to deprive them of their liberty under the Mental capacity Act 2005.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 11 (1) - Need for Consent. We judged that care and treatment of people was not being provided with the consent of the relevant person and people's right under the Mental Capacity Act 2005 were not being upheld.

We spoke with people and asked them about the quality of the food at Harker Grange. One person told us, "The food is very good…I am catered for very well. In a recent customer satisfaction survey carried out by the home a relative had written, "Some days meals are dry and small portions especially at teatime…Drinks are not always available for [my relative] and I often wonder if [my relative] is offered sips of juice regularly when there is no sign of a cup."

People who used the service had a food and fluid intake diary. These had been poorly completed and it was not possible to establish how much someone had eaten or drank. There was no indication of portion sizes, no indication of fortified diets/drinks being used or any evidence to confirm that when people had refused meals or had been sleeping, that they had been offered an alternative or a meal when they were awake.

There were no records to confirm that people were offered drinks outside of set meal and snack times. For example one persons' record of daily diet and fluid intake for the 10 May 2016 stated they-- had no breakfast, no mid morning snack or fluid, a sandwich and 'half a bowl of quavers' for lunch, then 'tea and cake' for supper. Therefore according to the daily diet and fluid intake records, this person had drank one cup of tea in a 24 hour period.

Another persons' nutritional care plan described them as having a "normal diet and normal fluids". They were described as being independent with eating and drinking and that their weight was recorded as "below average on admission". Records indicated that they weighed 68.80kg at the time of their admission. This had fallen to 59.65kg by February 2016. The persons' care plan should have described them as requiring a fortified diet to help gain weight. Accurate records should have been kept as to their food and fluid intake. We looked at 16 days of this persons' records of daily diet and fluid intake. Each morning they had breakfast cereal, toast, tea and juice listed. There was no record as to the size of portion or how much had been consumed. Furthermore information about the persons' nutrition had not been crossed referenced with their skin care plan and risk assessment for pressure ulcers. A healthy diet and good fluid intake are an integral part of good pressure area care.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 14 (1) – Meeting nutritional and hydration needs. We judged that the nutritional and hydration needs of people were not being met.

We saw from the written records the service regularly involved other health and social care professionals in people's care. We found evidence that staff discussed people's health problems with GPs and the local district nursing teams.

Inadequate

Is the service caring?

Our findings

We spoke with people who used the service and they told us that staff were caring and treated them kindly. One person commented, "These ladies are lovely." Another said, "The staff are very kind, speak nicely and are not rude."

We spoke with staff who told us they had built relationships with people who used this service. One member of staff said, "I know my residents really well because I sit and talk to them."

There were three shared bedrooms at the time of our inspection. There were no arrangements in place to ensure that those who shared rooms had their privacy and dignity upheld. For example one person in a shared room exhibited behaviour that challenged. According to incident reports this included lashing out at staff, being verbally abusive to staff and throwing items including food and drink. There were no documented arrangements in place to ensure that the person who shared their room was in any way prevented from being exposed to the behaviour. Neither were any measures taken to ensure their privacy and dignity was upheld when exhibiting behaviour that challenged. The service had failed to recognise the need to review the two people's living arrangements in light of the ongoing incidents.

We found that each of the people who shared a room had a 'room risk plan of care'. All were similar in nature stating that it was important, 'to keep the room tidy and clean and free from any safety hazards, to prevent any accident to resident while occupying room." There was no mention of privacy or dignity in any of the 'room risk plan of care' documents. These documents did not reflect the individual needs and preferences of the people sharing rooms.

On two occasions we witnessed one person using a commode in their bedroom and another person using their commode as a seat, in full view of anyone passing their rooms. The registered provider told us that this had been the personal choice of the people concerned. However, there were no strategies in place to help support and protect the privacy and dignity of these people, for example by the use of screens or replacing the commode with a chair. We observed that the staff who were present continued with their normal daily duties and gave no thought or consideration to the privacy and dignity of these people in their care.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 10 (1) (a) – Privacy and Dignity. We judged the service not treating people with dignity and respect and were not ensuring the privacy of service users.

We spent time in communal areas of the home. We observed staff speaking with people in a friendly and caring manner. It was clear that staff got along well with the people who used the service.

Inadequate

Is the service responsive?

Our findings

We spoke with people who used the service and asked them how the home responded to their needs. People raised the issue of a lack of meaningful activities with us. One person said, "There's no activities like games or bingo, the telly is always on."

We spoke with staff who told us, "We normally don't do activities."

We looked at people's care plans. There was no evidence that people's likes and preferences had been used to inform any activity plans relating to social stimulation. We did not witness any form of organised activity over the course of the inspection. For example it was noted that despite it being warm and sunny no-one accessed the outside garden areas though staff told us, "Two people were outside last week."

We noted that peoples' care plans were task orientated. There were no records about service users' communication abilities or personal preferences in relation to their care. Staff told us they did not read care plans or use them as they had been shown what, "Needed to be done." They added that it was "Difficult to find information in them." And, "It's hard to get time to read them, they are not very good, they could be simpler."

We found evidence of a 'pad round', a process where staff changed people's continence pads according to the time of day. For example there was a 'toileting chart' in place for one person that indicated they had their pad changed four times on 23 May 2016. There were no specific times documented other than, 'am, pm, evening and night'. We looked at this persons' continence care plan. It did not contain sufficient detail to indicate when continence issues could arise and the actions staff should take in order to meet this persons' individual needs. This meant that people who used this service did not receive care and support that was dignified or centred around their needs and they may have been left in soiled incontinence products until checks were carried out.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 (1) – Person centred care. We judged the care being provided was not person centred and care files we looked at were not written in a person centred manner to ensure care and treatment of people was appropriate, met their needs and reflected their preference.

We spoke with a relative and asked if issues or concerns they raised were responded to quickly and appropriately. They told us, "I have raised small things with staff and it's been dealt with."

The service had a formal complaints policy and procedure. The procedure outlined what a person should expect if they made a complaint. There were clear guidelines as to how long it should take the service to respond to and resolve a complaint. The policy mentioned the use of advocates to help support people who found the process of making a complaint difficult. There was also a procedure to follow if the complainant was not satisfied with the outcome.

Inadequate

Is the service well-led?

Our findings

We spoke with one person in the home and told them we were here to do an inspection. They responded by saying, "Good, it needs checking." We asked them for clarification of this statement but they declined to expand further.

Staff told us that the registered providers were, "Caring people."

We observed that all staff were working hard in the service and the temporary manager was making every effort to ensure the service was managed effectively.

However we identified a number of serious concerns in relation to the safety and quality of the service during the inspection, which had not been identified or acted upon by the registered provider or the temporary manager.. These included failure to monitor the administration of medicines, failure to carry out adequate pre-employment checks, failure to set staffing levels in accordance to service users' needs, failure to identify risks relating to the spread of infection, failure to ensure staff were adequately trained, failure to identify individuals who required an application to be deprived of their liberty, failure to ensure that service users consented to their care and treatment, failure to protect people from poor nutrition and hydration, failure to protect people's right to privacy and dignity and failure to provide person centred care.

We also looked at health and safety audits That had been carried out by the registered provider. The environmental audit failed to note the issues with the poorly finished roof light type windows, unsafe window restrictors and had not included the laundry which was in a poor state of repair.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 (1) (2) (a) (b) (c) (d) - Good governance. We judged the service was failing to assess monitor and improve the safety of services provided. In addition they failed to assess, monitor and mitigate the risks relating to the health, safety, and welfare of people who used the service and others who may be at risk of harm.

We compared the record of statutory notifications received from Harker Grange Nursing Home that the Commission held with the incident and accident book maintained at the home. We found that statutory notifications had not been made in a timely manner. This included a serious allegation of abuse.

The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

This was a breach of the Care Quality commission (Registration) Regulations 2009 Regulation 18 (1)– Notification of other incidents. We judged that the service had failed to notify of incidents that they had a statutory obligation to do so.

We saw evidence that questionnaires were sent to people who used the service. They were designed to ascertain whether people were satisfied with the service they received.

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 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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We found that you were depriving service users of their liberty without lawful authority.