Symphony Care Limited

Symphony House 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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place over two days on 16 and 20 June 2017.

Symphony House Nursing Home is registered to provide support for up to 25 people who require accommodation and personal care or nursing care. At the time of this inspection there were 23 people living in the home.

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.

At the time of the inspection it appeared that we had not received statutory notifications of deaths or safeguarding referrals that had occurred in the home. These are notifications that are required to be submitted by the provider to CQC by law and we are currently looking into this matter.

Appropriate systems and processes were not in place to assess, monitor and improve the quality and safety of the service. The provider did not have sufficient oversight of the service and the registered manager's workload had impacted on their ability to carry out their role effectively. Records related to training were incomplete and there was no plan in place for future training.

People's capacity to consent to their care and support was not always considered. Applications under the Deprivation of Liberty Safeguards (DoLS) had not been made as required for some people. Some staff had not received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS); there was a risk that staff would not have sufficient understanding of the requirements of the MCA (2005).

Recruitment procedures protected people from receiving unsafe care from care staff that were unsuitable to work at the service; however there was no process in place to review criminal records checks. Although there were enough staff on duty, the way in which they were deployed meant that people sometimes felt rushed.

Arrangements in place for formal staff supervision required strengthening. Records showed that staff did not have regular opportunities to formally meet with their line manager to discuss their role.

People continued to receive safe care. People were consistently protected from the risk of harm and received their prescribed medicines safely. People were supported to maintain good health and had access to healthcare services when needed; relevant health care professionals were appropriately involved in people's care. Staff supported people to have sufficient amounts to eat and drink to help maintain their health and well-being.

People developed positive relationships with the staff, who were caring and treated people with respect,

kindness and courtesy. People had detailed personalised plans of care in place to enable staff to provide consistent care and support in line with people's personal preferences. People knew how to raise a concern or make a complaint and the provider had implemented effective systems to manage complaints.

The service had a positive ethos and an open culture. People, their relatives and staff told us that the registered manager was a visible role model in the home. There were opportunities for people and staff to contribute to the running of the home.

At this inspection we found the service to be in breach of one regulation of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

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

The service was not always safe.

Staff deployment needed to be adjusted to ensure that staff were deployed to meet people's needs consistently.

Recruitment procedures needed to be strengthened to ensure the suitability of staff to work in the home.

Systems were in place to manage medicines in a safe way and people were supported to take their prescribed medicines.

People felt safe and comfortable in the home and staff were clear on their roles and responsibilities to safeguard them.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity to consent to their care and support was not always considered. Applications under the Deprivation of Liberty Safeguards (DoLS) had not been made for some people as required.

Some staff had not received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS); there was a risk that staff would not have sufficient understanding of the requirements of the MCA (2005).

Staff had received training in other areas to ensure that they had the knowledge and skills to support people appropriately.

People's nutritional needs were met.

People were supported to access appropriate health and social care professionals to ensure they received the care, support and treatment that they needed.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of provider oversight of the quality and safety of the service.

Systems and processes were not effective at ensuring all aspects of the service were delivered appropriately.

Records relating to training were incomplete.

The registered manager's workload had impacted on their ability to fulfil all aspects of their role effectively. They were active and visible in the home.

People, their families and staff were encouraged to share their experience of the home to help drive improvements.

Symphony House 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 16 and 20 June 2017. The inspection was unannounced and was undertaken by one inspector and one 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.

Before the inspection we reviewed whether we had received the required statutory notifications from the provider. A statutory notification is information about important events which the provider is required to send us by law. We also contacted the local health and social care commissioners who place and monitor the care of people living at Symphony House Nursing Home.

The registered manager had 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. The provider returned the PIR and we took this into account when we made judgements in this report.

During our inspection we visited the home and spoke with six people who used the service and four relatives. We spent some time observing care to help us understand the experience of people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight members of staff including nursing staff, care staff, kitchen staff and the registered manager. We reviewed the care records of three people who lived in the home and four records in relation to

staff recruitment and training; as well as records related to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

The arrangements in place for the deployment of staff were in need of strengthening. There was no formal calculation of staffing requirements or deployment and all of the people we spoke with told us that although care staff worked hard to meet their needs, their care sometimes felt rushed. One person said "they could do with more staff." Another person told us that staff were busy answering call bells and this sometimes meant that staff were rushed. The provider had carried out a survey in September 2016 and this showed that people thought staff responded to their requests in a timely manner, met their needs and were caring and kind. However, during the inspection six people who lived in the home told us that they felt there were not enough staff and that their care sometimes felt rushed. In the main staff felt that they did have time to meet people's care and support needs, but that this depended on the way in which they were deployed and worked as a team.We discussed these concerns with the registered manager who was aware that the mix of people living in the home currently required staff to work more flexibly to answer call bells and had been trialling different ways of deploying staff. They recognised that they needed to monitor the deployment of care staff to ensure that staff worked flexibly to provide people's care in the way they preferred and answer call bells when necessary.

People were protected against the risks associated with the appointment of new staff. There were appropriate recruitment practices in place, taking into account staff's previous experience and employment histories. Nursing staff were registered through their professional body and there were systems in place to ensure that their registrations had been maintained. Records showed that staff had the appropriate checks and references in place and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out criminal record and barring checks on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions. However, the provider had not assured themselves of the on-going suitability of staff, as they had not carried out a risk assessment to determine whether criminal records checks should be updated at regular intervals for staff who had worked in the home for a number of years. We discussed these concerns with the registered manager, who recognised the need to review the current recruitment policy.

Safeguarding policies and procedures were in place and were accessible to staff. Discussions with staff demonstrated that they knew how to put safeguarding procedures in to practice and staff described how they would report concerns if they suspected or witnessed abuse. One member of staff said "If I thought anything was wrong I would report it to the manager or CQC [Care Quality Commission]." The manager had worked with the local safeguarding team to investigate safeguarding referrals when necessary; which demonstrated their knowledge of the safeguarding process.

People's medicines were safely managed. Registered nurses managed and administered medicines within the home. We observed staff administering medicines to people and we saw that they were patient, offered each person the support they needed and explained what the medicines were for. Staff followed guidelines for medicines that were only given at times when they were needed for example Paracetamol for when people were in pain. The medicines policy covered receipt, storage, administration and disposal of medicines.

Robust risk assessments were in place and these were focussed on enabling people to live life as they chose whilst maintaining their safety. Where people's mobility had deteriorated their risk assessment reflected their changing needs. People's care plans provided instruction to staff on how to mitigate people's risks to ensure people's continued safety. For example, the type of hoist and slings to use to support people to move.

People were closely monitored for 36 hours following a fall or an accident. Staff were prompt in referring people for medical attention and kept their families informed. The registered manager monitored data from people's falls to detect areas where future accidents could be prevented.

People lived in an environment that was safe. There were environmental risk assessments in place and a list of emergency contact numbers was available to staff. Contingency plans were in place in case the home needed to be evacuated and each person had a Personal Emergency Evacuation Plan (PEEP) in place to provide information to emergency services in the event of an evacuation. People were protected from the risk of fire as regular fire safety checks were in place.

Requires Improvement

Is the service effective?

Our findings

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 to 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).

Staff had not consistently received training in Mental Capacity; there was a risk that staff would not have an appropriate understanding of the requirements of the Mental Capacity Act 2005 (MCA 2005), resulting in support being provided that was not in people's best interest. Although the registered manager had recently facilitated training in MCA for nursing staff this had not yet been provided for care staff.

We checked whether the service was working within the principles of the MCA. People's care plans contained assessments of their capacity to make decisions for themselves and consent to their care. Written records reflected that some of these assessments did not consider all aspects of people's care and support needs and the registered manager was currently reviewing these. The registered manager had applied for DoLS appropriately for some people, but was aware that there were other people living in the home who required applications to be made and was in the process of making these referrals.

In the main people received care from staff who had the knowledge and skills needed to carry out their roles and responsibilities effectively. People and their relatives told us that they had confidence in the knowledge and skills of the staff providing their care and support. Staff received an in house induction that involved shadowing and learning from experienced staff and mandatory training such as manual handling. Staff were also encouraged to obtain a recognised care qualification through the Qualifications and Credit Framework (QCF).

Training was delivered by a mixture of in house sessions facilitated by the registered manager and externally accredited courses. Staff told us that they attended regular training; one member of care staff told us "[Registered Manager] likes things done properly; I've had training in things like manual handling to make sure I do things the right way." Staff had also received training that was particularly relevant to their role; such as syringe driver training for nursing staff. A syringe driver helps control symptoms by delivering a steady flow of liquid medication through a continuous injection under the skin. Staff told us that the registered manager arranged for them to undertake the training they requested. A member of kitchen staff said "I asked to do NVQ 3 in cooking and the manager arranged it for me." We observed that staff in the home worked effectively with the people they were supporting and were knowledgeable about how they should provide support to people. Records showed that all staff had recently attended refresher training in infection control and fire safety.

There were some arrangements in place for formal supervision and appraisal, although these required

strengthening to ensure that staff had access to regular supervision and appraisal meetings. Staff were able to gain support and advice from nursing staff and the registered manager when necessary and told us that they felt supported. One member of staff said "I know if I have any problem I can sit down and talk to [Registered Manager]."

Nursing staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST) and referred people to their GP and dietician when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely; for example where people required their food to be pureed we saw that this was provided.

People had mixed views on the variety of the food provided at main mealtimes. Some people were happy with the food on the menu, however others said that it lacked variety and was sometimes bland. We observed breakfast and lunch being served in the home and people were provided with a choice of meal and an alternative to this if they did not like what was on the menu. Drinks and snacks were readily available to people living in the home and staff supported people with eating and drinking as needed. Where people received their nutrition by a percutaneous endoscopic gastroscopy (PEG) tube, staff followed the advice of appropriate health professionals. Staff received training in the care of PEG tubes and the procedures and protocols to be followed to ensure safe administration of food and fluid. Records confirmed that people were supported to have a sufficient amount to eat and drink, based upon their specific dietary requirements.

People had access to health care support when they needed it. Records showed that staff had promptly contacted health professionals in response to any deterioration or sudden changes in people's health and acted on the instructions of the health professionals. We saw evidence of regular health checks taking place and people were supported to access a range of healthcare professionals such as specialist professionals in areas such as epilepsy, speech and language therapists and physiotherapists.

Good

Is the service caring?

Our findings

People developed positive relationships with staff and were treated with compassion and respect. One person told us "It's a home from home, a family atmosphere." Another person's relative told us "I'm very happy with the care, all the staff are very nice and [Registered Manager] is lovely."

People were relaxed in the company of staff and clearly felt comfortable in their presence. We observed that staff knew people well and engaged people in light hearted conversation. People's choices in relation to their daily routines and activities were listened to and respected by staff and their independence supported and encouraged. One person told us that staff had organised the clothes in their wardrobe in a particular order so that they could reach items more easily. Staff were observed speaking to people in a kind manner and offering people choices in their daily lives, for example what activities they wanted to take part in and where they wanted to spend their time.

People were treated with dignity and respect. We saw that where people required support to move this was provided sensitively. Staff explained to people what they were doing and encouraged them to do as much as they could for themselves. We observed staff supporting one person to move in the hoist; they explained what was happening and spoke calmly to the person throughout the transfer.

Good

Is the service responsive?

Our findings

People received care that met their individual needs. A range of assessments had been completed for each person and detailed care plans had been developed in conjunction with people living in the home and where appropriate their relatives. Staff knew people very well; they understood each person's background and knew what care and support they needed. One person's relative told us "The manager supported me to think about [Names] end of life care and to do what needed to be done to ensure they will supported in the way that they would want when the time comes." One staff member said "This isn't just a job; it's about caring about people and doing what they want."

People were supported to follow their interests and take part in social activities and told us that there was plenty to do. For example on the day of the inspection many people in the home went to the local pub with their relatives and staff for lunch. We saw one person teaching a member of staff to knit; they were enjoying chatting, whilst they unravelled the wool together. People were kept informed of planned events, including restaurant nights where food from different countries was served, live musical entertainment, quizzes and visits from a pet as therapy dog.

People and their relatives knew how to make a complaint if they needed and were confident that their concerns would be carefully considered. One person's relative told us that they had raised a concern with the registered manager in the past and they had been happy with how the manager responded. A regular meeting was held with people and their relatives to provide a forum for people to raise any suggestions and concerns. Records were maintained of all issues raised with the manager, detailing the action they had taken.

Requires Improvement

Is the service well-led?

Our findings

There was insufficient monitoring of the quality and safety of the service. The manager told us that the provider visited the service informally but did not complete any quality monitoring or audits of the service. As a result there was a lack of provider oversight of the registered manager and of the quality of the service experienced by people living in the home. The provider had not ensured that sufficient staffing resources were allocated to enable the manager to carry out all aspects of their role sufficiently. The registered manager was working excessive hours covering nursing, administrative and other ancillary duties and this had impacted on their ability to carry out their role and have sufficient oversight of the service.

The registered manager was aware that some MCA assessments were generic and DoLS referrals for people were outstanding but had not yet completed the necessary applications. There was a risk that care would be provided to people that was not in their best interest and people would be unlawfully deprived of their liberty.

Staff told us that staffing rotas were not issued until Sunday for the following week. Staff did not have sufficient notice of all the shifts they would be working week to week. We discussed this with the registered manager, they acknowledged that this was not ideal but said that they did not have the opportunity to plan the rotas further in advance.

Records relating to staff training were incomplete and the registered manager was not able to say how staff training was planned. There was no complete record of staff who had received training or plan in place for staff training. We found there was no process in place to record the training that was required or when this was planned

Systems in place to ensure staff had access to regular formal supervision and appraisal were in need of strengthening. Although staff had access to informal support; supervision and appraisal meetings did not happen regularly and there was no overview or plan of supervisions and appraisals for staff.

The provider did not have sufficient policies and procedures in place to protect people from the risk of staff that were unsuitable to provide care. The provider's employment policy did not detail the need to carry out risk assessments to determine whether criminal record checks were required to be updated regularly for staff.

This constitutes a breach of Regulation 17 (1) (2) (a) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

At the time of the inspection it appeared that we had not received statutory notifications of deaths or safeguarding referrals that had occurred in the home. These are notifications that are required to be submitted by the provider to CQC by law and we are currently looking into this matter.

The registered manager did carry out audits in some areas and action had been taken to rectify any

shortfalls found. Medicines were regularly audited and we saw action plans that had been completed in response to the findings of infection control and kitchen audits.

People said that the manager was approachable and they had confidence in their ability to manage the home. People, their relatives and staff consistently told us said that the manager worked hard to ensure that people were provided with appropriate care and support. One person said "the manager is the most dedicated person you could hope for." Another person said "[Registered Manager] does their very best to all the things we want."

Staff understood their roles and responsibilities and there was a shared commitment to ensuring that support was provided to people in the best way possible. Staff were confident in the manager's leadership and found them to be approachable and friendly. They told us that they felt able to ask for support, advice and guidance about all aspects of their work. One member of nursing staff said "[Registered Manager] is a very good mentor; they will work alongside and support you until you feel more confident." We observed that the registered manager was visible and accessible to people living in the home and their relatives.

Policies and procedures to guide staff were in place. We spoke with staff that were able to demonstrate a good understanding of policies which underpinned their job role, such as whistleblowing; staff were able to explain the process that they would follow if they needed to raise concerns outside of the company.

Staff meetings took place to inform staff of any changes and for staff to contribute their views on how the service was being run. The content of staff meeting minutes demonstrated a positive, open culture, with discussions about the culture and philosophy of the service, feedback on quality surveys and correct completion of care documentation.

The provider carried out regular surveys of the views of people living in the home, their relatives and staff. We saw that questionnaires completed by residents and relatives had been analysed by the registered manager and action taken in response to comments made.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficient arrangements in place to monitor the quality and safety of the care and support provided in the home. 17 (1) (2) (a) (d)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The registered provider failed to notify the Commission without delay of all the deaths of people receiving care at the service.

The enforcement action we took:

We have issued a fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to notify the Commission without delay of any abuse or allegation of abuse in relation to a service user.

The enforcement action we took:

We have issued a fixed penalty notice.