Cheyne Group Management Limited

Cheyne House Nursing

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 2 September 2015 and was unannounced.

Cheyne House is registered to provide accommodation and personal care for up to 26 older people or people living with a dementia. There were 24 people living at the service on the day of our inspection.

The service has had no registered manager for two months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in December 2014 we asked the registered provider to take action to make improvements to respecting and involving people. The provider sent us an action plan in July 2015 to tell us how these improvements would be made. On this inspection we found that the registered provider had made all of the required improvements.

At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation

Summary of findings

to governance and notifications. You can see what action we told the registered provider to take at the back of the full version of the report regarding governance notifications and deprivation of liberty safeguards

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act (MCA), 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves or others. Two people living at the service had their freedom lawfully restricted under a DoLS authorisation. The registered provider was unsure about the management of MCA and DoLS.

The registered provider did not demonstrate how accidents and incidents were investigated. People's safety was not always maintained, because staff did not always follow safe medicine administration guidance and people were at risk of receiving the wrong medicine. Also, the provider did not always ensure that the service was consistently clean and that safe infection control procedures were adhered to.

People were cared for by staff that were not supported to undertake training to improve their knowledge and skills. People were provided with regular meals and snacks. People had their healthcare needs identified and were able to access healthcare professionals such as their GP and dentist.

People and their relatives told us that staff were kind and caring and we saw some examples of good care practice. However, we found that people were not always treated as an equal partner in making decisions about their care.

People were not enabled to follow their hobbies and pastimes and people were not supported to maintain their independence. Some relatives felt that their loved ones were bored. Staff provided care centred on tasks rather than the person.

The registered provider did not have systems in place to monitor the effectiveness of the care and treatment people received.

We have made a recommendation that the provider finds out more about current best practice guidelines for the special care needs of people living with dementia.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff did not always follow correct procedures when administering medicines.

People were not always cared for in a clean environment.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always cared for by staff that were supported to undertake further training to carry out their roles and responsibilities.

Staff did not fully understand the key requirements of the Mental Capacity Act 2005.

People were provided with regular meals, drinks and snacks.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always involve people in decisions about their care.

Staff treated people with kindness and compassion if they were distressed and upset.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received care that was task orientated rather than person centred.

Staff did not support people to take part in meaningful activities and past times.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff had access to policies and procedures to help them undertake their roles.

The provider did not inform CQC about statutory notifications.

People, their relatives and care staff found the registered nurses approachable.

Cheyne House Nursing

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.

The inspection took place on 2 September 2015 and was unannounced.

The inspection team was made up of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection we looked at previous inspection reports and we reviewed other information that we held about the service such as information that had been sent to us by other agencies. We used this information to help plan our inspection.

We looked at a range of records related to the running of and the quality of the service. This included staff training information and relative's survey feedback.

We also looked at the quality assurance audits that the acting manager and the provider completed which monitored and assessed the quality of the service provided.

During our inspection we spoke with the provider, acting manager, two registered nurses, four care staff, a house keeper and the cook. We also spoke with six people who lived at the service, four visiting relatives and friends and a visiting health and social care professional. In addition, we observed staff interacting with people in communal areas and bedrooms, providing care and support.

We looked at the care plans or daily care records for 12 people. A care plan provides staff with detailed information and guidance on how to meet a person's assessed social and health care needs.

Before our inspection we asked the local authority and commissioners of healthcare services for information in order to get their view on the quality of care provided by the service.

Requires Improvement

Is the service safe?

Our findings

Nursing and care staff told us what they would do if they suspected that someone was at risk of abuse or harm. One staff member said, "There is no abuse, but [if there was] I would report it to the registered nurse, the manager and the social worker." Another member of staff said, "I would notify the manager or ring the local safeguarding authority. The number is in the book in the staff room." We looked at the information we held about the registered provider and found that there had been one safeguarding concern reported in the previous 12 months and the registered provider took appropriate action to investigate it.

Although the provider told us that a log of accidents and incidents was kept, there was no system analysing these falls to monitor trends and causes to prevent their reoccurrence.

When a person was admitted to the service staff undertook risk assessments relevant to different aspects of their care such as mobility and falls. Care plans were in place which enabled staff to reduce the risk and maintain a person's safety. We saw where a person's condition changed their risk of harm was reassessed and their plan of care reviewed.

We noted that some people living with dementia liked to move independently from room to room. Although, the provider's policy was to ensure that the kitchen and laundry were locked when unattended, on the day of our visit we saw that the doors were left open and products that might present a danger to people living with memory loss were within reach.

When forms of restraint were used we found that appropriate decisions had been made in the person's best interest and these decisions were recorded. For example, we saw where one person was at risk of falling from a chair that they had a care plan to support the decision trail for the use of a lap belt. We saw that the person used this on their dining chair and armchair.

We looked at two staff files and saw that there were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post.

People told us that there were enough staff to meet their needs and one person added, "They are very good on the whole. They spend the time they can afford to spend with us."

We observed the end of the morning medicines round and found that safe management of medicines guidelines were not followed. For example, the registered nurse took medicines from the medicine trolley for two people who were in their bedroom and did not take the medicine administration records (MAR) with them to check the person's identity. There was a risk that these medicines could be mixed up and people could receive the wrong medicine that could cause them harm. In addition, when the morning medicine round was finished the registered nurse signed all the MAR charts rather than sign the charts as soon as a person received their medicine. We found that the registered nurse had not followed safe management of medicines guidelines although they had received safe administration of medicine training in April 2015.

We looked at 17 MAR charts and found that some people did not have a photograph for identification purposes. Most people at the service were living with a dementia and this increased the risk that people could receive the wrong medicine due to lack of identification. One person had their medicine through a slow release skin patch however records were not kept to identify the rotation of skin sites to be used. This left the person at risk of skin rashes and irritation. MAR charts did identify if a person had any allergies and recorded any special instructions for taking medicines, such as "given with a spoon".

Medicines were stored securely in two locked trolleys in the nurse's office and in locked cupboards in the hairdresser/ clinical room. We observed the registered nurse order medicines in a timely manner and arrange for prescription to be collected by the pharmacist from the GP. In addition, out of date and unwanted medicines were disposed of safely. However, we did see prescribed nutritional supplements stored in the dining room, rather in a secure cupboard and these were accessible to people who had not been prescribed them.

We found weaknesses in infection control procedures. For example, staff did not dispose of clinical waste safely; we found two clinical waste bags on top of the clinical waste bin in the car park. Furthermore, discarded beds, commodes, and several other items of furniture were rotting in this area. This area was accessible to visitors and

Requires Improvement

Is the service safe?

passers-by and could be a public health risk. We saw that staff had access to single use protective personal equipment such as gloves and aprons. This area was visible to visitors making their way across the car park to the front door

We looked at all areas of the service and found evidence that standards of cleanliness were not maintained and people were not protected from the risk of cross infection from contaminated equipment. For example, we saw soiled toilet cleaning brushes, limescale on hand washing sinks that increased the risk of bacteria growing, damaged shelving and work surfaces in the medicine and wound dressing preparation area and shared hoist slings.

Requires Improvement

Is the service effective?

Our findings

We spoke with the registered provider, acting manager and nursing staff about their understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The MCA is used to protect people who might not be able to make informed decisions on their own about the care or treatment they received. Where it is judged that a person lacks capacity then it requires that a person making a decision on their behalf does so in their best interests. We found that the registered provider, acting manager and nursing staff had a poor understanding of MCA and DoLS. They were unable to tell us how many people were being cared for under a DoLS authorisation and when a request for a DoLS authorisation should be made. We were shown a DoLS authorisation for one person that was not valid as it applied to another care setting. DoLS authorisations are not transferrable between care settings. Although staff had requested a new DoLS authorisation they did not understand that the previous authorisation was not valid. Following our inspection we contacted the local authority DoLS team who confirmed that two people were currently being cared for under a DoLS authorisation.

Staff were not always trained to meet people's needs. For example, we observed two members of care staff assisting a person to walk in an unsafe way that put the person at risk of harm.

Most people were living with a form of dementia. However the training matrix identified that by August 2015 65% of staff had received dementia training and there were no appointed dementia champions. A dementia champion helps other staff to change the way they think, act and talk with people living with dementia. Following our inspection the provider told us that further dementia training sessions had been planned.

The acting manager had been in post for six weeks and had not yet undertaken or planned appraisals or supervision sessions with staff. However, they told us that they had spoken with some staff on a one to one basis but had not kept a record or minutes of these meetings. Staff were not always provided with feedback on their performance or supported to identify their professional development training needs. We found that this had been an issue for some length of time. For example, we spoke with one registered nurse who had been employed by the service for four years who had received one appraisal and no supervision in that time and a head of department told us that they had not received feedback on their performance since February 2015.

We found that there were some processes in place to support people who were unable to give their consent to care and treatment. For example, we looked at MAR charts and supporting care plans for three people who took their medicines covertly. We saw that their capacity to make decisions had been assessed, their GP and family had been involved and decisions were made in their best interest. However, we found that staff did not always follow the correct process to take to gain consent from a person who was unable to communicate verbally or with reduced cognitive function. For example, we observed some staff tell people what they were going to do rather than ask the person what they wanted to do.

Almost all of the people who lived at the service had a do not attempt cardio pulmonary resuscitation (DNACPR) order at the front of their care file. A DNACPR is a decision made when it is not in a person's best interest to resuscitate them if their heart should stop beating suddenly. It was unclear if these orders reflected a person's current health status as some had not been reviewed since 2011.

People and their relatives told us that the food was good. One person said, "The food is good. I have the alternative menu sometimes." Another person said, "It's wholesome, not a luxury dish. If I want some more I just ask." People had access to pictorial menus to help them make choices at meal times. However, we saw that the pictorial menu board was not changed throughout the day and only displayed the breakfast choices at lunch and tea time.

Hot and cold drinks and snacks were provided at regular intervals throughout the day. However, we found that people who were cared for in bed had their meals served earlier than people who took their meals in the dining room. For example, breakfast was served at 6.30am to people who were awake, followed by lunch at 11.30am and tea at 3.30pm. Whereas meals served in the dining room were at more conventional times. We questioned why mealtimes were so early and were told that this was because people who remained in their bedrooms throughout the day required assistance with their meals or had a soft diet and staff attended to their needs before they served people who were more able.

Requires Improvement

Is the service effective?

Some people were not always supported to eat enough to maintain a balanced diet. For example, we observed lunchtime and saw one person was brought to the dining table by wheelchair at 12.45pm. At 2.30pm they were sat alone in the dining room with a plate of cold mashed potato in front of them, we noted that they took an occasional small spoonful. A care worker approached them and asked if they wanted some more. When we asked why they were sat so long on their own with cold food, the care worker said, "He is a slow eater, this is his norm." At 3.30pm the person was sat in the same place asleep in their wheelchair. We did not see care staff attend to them to offer a dessert or hot drink after lunch. This person's care plan acknowledged that they were a slow eater; however staff did not have processes in place to ensure the person received hot food.

The cook explained how they provided people with a balanced diet and that they fortified some dishes to support people who may be at risk of weight loss or malnutrition. For example, we found that cream was added to desserts and butter to mashed potatoes. We noted that most dishes were homemade and made with fresh ingredients. We observed that some people had requested and received alternatives to the daily menu choice such as soup or an omelette. However, there were no seasonal variations to the menu.

Staff sought the support of health and social care services for people such as their GP, dentist and optician, but not always in a timely manner. For example, we saw that two people who had difficulty swallowing were referred on the day of our inspection to the speech and language therapist (SALT) for a swallowing assessment and advice on their diet. However, we did notice that one person had been provided for some time with a soft diet by staff although they had not been referred to or assessed by SALT. We observed this person being assisted to eat their meal at lunchtime and they were not supported to sit upright to take their food and drink. This put them at greater risk of choking. The person's eating and drinking care plan did not identify ways to reduce the risk of choking

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in December 2014 we identified that the registered provider did not make suitable arrangement s to ensure the dignity, privacy and independence of service users and did not always treat them with consideration and respect. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

On this inspection we found that some improvements had been made and the registered provider was no longer in breach. However, we did see some examples of undignified care. Staff were able to tell us how they would maintain a person's privacy and dignity. For example, the housekeeper said, "I offer them the same respect and attitude as if I was attending to my mother and father. If they are in bed I don't go into their room, I ask if I can go in." Another member of staff told us that people were respected as individuals and said, "They wear their own clothes and can have their hair done if they want. Since your [CQC] last visit dignity has had a high profile." However, we observed that staff did not always respect a person's privacy and dignity when providing care in communal areas. For example, we observed a registered nurse and carer approach a person sat in the lounge and replace a medicine skin patch to their back in full view of other people using the lounge.

People who were cared for in shared bedrooms were not given the same level of privacy and dignity as a person who had a single bedroom. We noted that the dignity screens between the beds did not adequately serve their purpose and maintain a person's privacy and dignity. For example, they were either too short, see through or when drawn they would lie on the person's bed.

People did not always receive a consistent caring approach from staff. Some staff did not always treat people as equals and did not speak to them in the same way as they would speak with each other. For example, we heard a staff member speak to a person in a raised and childlike voice. This person did not have any communication or hearing difficulties. Another person told us that staff were mediocre and added, "Carer [name of care worker] shouts at me in a nasty way." However, other people told us that they were well cared for. One person said, "We're well looked after here." Another person said, "They're very obliging staff." A relative told us that their loved one was unable to verbally express her opinion of the staff but added, "She always smiles when they come in her room, so I take that as a good sign about her care." Furthermore, some staff had the skills to reduce the risk of distressing situations. For example, we observed a member of care staff take a caring approach to a person living with dementia who was unsure where their bedroom was. The care worker asked, "Do you fancy coffee and cake in your room?" The person then put their trust in the care worker and walked back to their room with them.

We found that people had care plans developed to meet their individual needs. The people we spoke with could not recall being involved in their care plans. However, relatives told us that when their loved one was unable to discuss their care needs with staff that they had been involved. One relative said, "Yes, I've seen her care plan. They keep me informed when she had changes to her tablets. I'll just pop into the office if there is anything to sign."

Information leaflets on the role of the advocate were available at the front door. However, people who used the service did not use this area and therefore would be unable to access the information leaflets on their own. An advocate can be appointed to support a person through complex decision making, such as permanently moving into the care home. We saw that two people had an advocate appointed to support them.

Requires Improvement

Is the service responsive?

Our findings

People had their care needs assessed, relatives were involved in planning their care, and personalised care plans were in place to outline the care they received. One person said, "They decide my care, not me. I'd like to be asked more." We observed that care was task orientated, rather than person centred and there was a risk that people could become institutionalised.

Most people expressed their feelings about the lack of social and recreational activities. One said, "No one suggests anything. It would be nice if staff would come and sit with me for a chat. It's just me in a chair." Another person said, "There's no activities. I like singing and dancing. We used to have a dog that came in. I feel sad for the older people." Comments from relatives supported what people told us. For example, one relative said, "He used to do lots at his previous home; they had things four times a day. Now, nothing. They just sit him in the lounge all day. He really needs a group activity so as he can interact. I ring him on his mobile several times a day and he'll say, "I'm bored. I'm fed up." The staff are too busy to spend any time with them." Finally, another relative said, "I come in the afternoons and haven't seen anything going on. She'd look at the television if it had subtitles as she can't hear well."

We found that there was little stimulation or social interaction and some people were at risk of social isolation. For example, several people were cared for in bed, but we did not see staff spend time with them other than when they provided personal care. Two people spent all day in the conservatory and we did not observe any social interaction from staff other than when the drinks trolley went round. Furthermore, one person was sat at a table on their own in the dining room at lunchtime. Staff told us that the person could become agitated and spill their food and drink on the table. However, there were no support mechanisms in place to give this person a sense of belonging or include them in social interactions with other people. We noted that people who sat in the lounges were not offered a choice of what to watch on television or listen to on the radio and no one was supported to be engaged in meaningful activities to pass their time. For example, after lunch we observed a member of care staff select a film to be played on the DVD player, rather than show people the available DVDs and support them to make a choice. There was a selection of books and soft toys in one lounge but people were unable to access them as chairs were placed in front of them.

Staff confirmed that there was very little for people to do as there was not an activity coordinator. They said that people never went on outings and occasionally they would take someone for a walk round the village in their wheelchair. The service had not engaged in any external links with volunteer visitor schemes. However, when we spoke with the acting manager they confirmed that a new activity coordinator had been appointed and in the process of planning and preparing activities.

We looked at the garden and saw that it was not accessible to most people as there was a high lip to step over at the door frame leading onto a ramp that only had a security handrail on one side. A member of care staff said, "I've never taken a wheelchair outside and I don't think it would be easy." However, we found that some people would have liked to use the garden. One person told us, "I don't get much chance to go out there. I'd like to go out more." And another person commented about the garden, "I'd like to sit outside if someone would come with me. I used to have a lovely garden." The provider was looking at options to extend the conservatory and enable people to make better use of the garden.

People and their relatives told us how they would share their concerns if they were unhappy. One person told us that if they had a concern they would speak with the nurse or care worker. A relative told us, "I just accept it. If things don't go right, I'd just ask any carer. They'd help." There was a suggestion box situated by the front door, however, there had been no suggestions received recently from people or their visitors. A staff member told us how they would respond if a person had concerns. They said, "I would speak to them and try to resolve it at the time and ask if they wanted to speak to the manager and owner. We have forms if they want to put it in writing." One family we spoke with told us that they had recently made a formal complaint and that they were not happy with the response they had received so far from the acting manager. However, this complaint had not been recorded and so the provider was unaware of it.

We recommend that the provider finds out more about current best practice guidelines on the special care needs of a person living with dementia.

Requires Improvement

Is the service well-led?

Our findings

We found weaknesses in systems to support safe practice with cleanliness and infection control, governance and medicines. However, there was little evidence of internal and external audit in the last four years to monitor the safety and quality of the care people received in these areas. For example, the last infection control audit was in 2011, quality assurance in 2012 and external medicines audit in March 2014. We found that there were no supporting action plans or evidence of feedback to staff to enable them to drive forward improvements to the service. In contrast, staff had access to policies and procedures on topics relevant to their roles, for example, we saw policies on medicines and housekeeping.

Overall, we found that the provider did not share potential risks that could compromise the quality of care people received from the care team. A recent audit of all care files undertaken in August 2015 identified errors and omissions to each person's care plans. For example, some did not record a person's GP contact details, others did not record whether a person had an allergy and some did not have care plans appropriate to people's individual care needs. The findings of this audit had not been shared with staff. In addition, we saw a recent Medicines Administration Record (MAR) chart audit undertaken by night staff, that identified when errors had occurred, such as a medicine not signed as given. However, we did not see an action plan of how this was followed up to reduce the risk of a reoccurrence. Therefore, people continued to be at risk of receiving inappropriate care and treatment as the errors and omissions had not been corrected

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered provider did not meet all of their CQC registration requirements. We have not received any statutory notifications from the provider in the last two years. For example, we found that two people were living at the service with a valid deprivation of liberty safeguards authorisation. However, the registered provider did not follow their legal responsibility and notify us of these events. We discussed this with the registered provider who told us that they were unaware of the incidents and events that should be notified and did not know where to find this information.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was not a registered manager in post. The previous manager had left their role in July 2015 and the acting manager had submitted their resignation. The registered provider told us that they intended for the area manager to register as manager with CQC.

Although there was a line management structure in place, people and their relatives did not always know who the acting manager was. However we observed that the registered nurses were approachable and people who lived at the home, their visitors and care staff called at the nurse's office to care for them. One relative said, "The old manager was more approachable. I haven't seen the new one." However, we found that in the absence of visible leadership from the acting manager that the registered nurses were approachable. We observed that people, their visitors and care staff called at the nurse's office to speak with them. In addition, care and ancillary staff told us that they could go to the registered nurses at any time for support.

We found a culture in the service that did not support nursing and care staff to undertake their designated roles; to provide personal care and treatment to people. The acting manager told us and staff confirmed that nursing and care staff were expected to undertake non-care duties such as prepare breakfast and evening meals and undertake domestic duties such as laundry on a daily basis as domestic and catering staff were not on duty after 2pm. A registered nurse told us that it was not clear what was expected of them. They said, "An RN should not be doing laundry. I should be looking after residents, spend time with them."

In addition, staff told us that they were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered provider and CQC. However, we have not received any whistleblowing concerns about the areas of weakness that we have identified.

The registered provider sought the opinion of relatives about standards in the service and had undertaken a quality assurance questionnaire in May 2015. We looked at 10 completed responses and noted that relatives found most aspects of the service, including communication and standards of care good or very good. Where people

Requires Improvement

Is the service well-led?

responded that the service was less than good or had made suggestions for improvement the registered provider had developed an action plan. We saw that most actions related to the internal environment and that they had been achieved. With the exception of a recent relatives and residents meeting attended by two families, we found no evidence that people had a say in the running of the service. For example, people were not involved in planning the menus.

However the registered provider had met with all staff in August 2015 to inform them about changes they planned to make in the service. We saw from the minutes of this meeting that future training, staff rotas and care plans had been discussed. The acting manager had held a meeting with the registered nurses, but they did not receive a copy of these minutes.

Staff did not have access to current best practice guidance on key topics such as caring for a person living with dementia and safe infection control practices. We found that information boards and resource folders had not been updated for at least two years. In addition, staff were not supported to network and learn from colleagues from other residential care settings through local quality improvement networks. We found that any previous links with the local community were no longer in place. People and staff told us that there were no volunteers or visitors to the service from the local community.

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 and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How they regulation was not met: The provider did not operate effective systems and processes to make sure that they assess and monitor their service.**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **How they regulation was not met: The provider did not notify CQC when a request to lawfully deprive a person of their liberty was granted.**