Central England Healthcare (Great Wyrley) Limited

Conifers Nursing Home

Inspection report

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22 November 2016

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 25 May 2016. Breaches of legal requirements were found including insufficient staffing and risks to people were not managed in a safe way. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection on 22 November 2016 to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Conifers Nursing Home on our website at www.cqc.org.

The service was registered to provide accommodation, personal care and nursing care for up to 40 people. At the time of the inspection 38 people were using the service.

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

There were insufficient staff to offer support to people and there were delays for people when they received personal care. The action the provider had told us they had taken had been ineffective in making improvements in this area.

Where previous risks with equipment had been identified the provider had completed a risk assessment, however the measures put in place had not reduced the risk. Creams were being administered by care staff and signed for by the registered nurse without observation and when needed guidance for staff was not in place when people were refusing their medicines. People did not always receive care in their preferred way and when requested.

People felt safe and staff knew how to recognise and report potential abuse. The provider ensured staffs suitability to work within the home. Risks to people had been considered and when people had behaviours that may challenge guidance for staff had been introduced. People had the opportunity to participate in activities they enjoyed and were involved with reviewing their care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 consistently safe.
There were not enough staff available and people were experiencing delays in receiving care and support when they needed it. The action the provider had taken had not been effective in addressing concerns we had raised. Risks to people from equipment had not been fully considered. We could not be sure medicines were administered as prescribed due to secondary dispensing of creams. People felt safe and staff knew how to recognise and report potential abuse. Risks to individuals had been considered. The provider had systems in place to ensure staffs suitability to work within the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People did not always receive the care and support they required and in their preferred way. People had the opportunity to participate in activities they enjoyed. People and relatives told us they were involved with reviewing their care. The provider had a complaints policy in place and people knew how to complain.

Conifers 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.

We undertook an unannounced focused inspection of The Conifer's Nursing Home on 22 November 2016. The inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 25 May 2016 had been made. We inspected the service against two of the five questions we ask about services: is the service safe and is the service responsive? This is because the service was not meeting some legal requirements. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Conifers Nursing Home on our website at www.cqc.org.uk.

On this occasion we did not ask the provider to send us 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. However we offered the provider the opportunity to share information they felt relevant with us.

We spoke with seven people who used the service, two relatives, three members of care staff, the registered nurse and the activity coordinator. We also spoke with the registered manager and the operations manager. Some people were not able to tell us about their experiences, and so we spent time observing care and support in the communal areas. We also observed how staff interacted with people who used the service. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for six people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of Conifers Nursing Home on 25 May 2016, we found people had to wait for support as there was insufficient staff available for people. This was a continued breach of Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014 following the comprehensive inspection on 10 March 2015.

At this focused inspection on 22 November 2016, we judged that there were still insufficient staff to support people in a timely manner. People told us they had to wait for support. One person said, "I don't think there are enough staff, the toilet ones are the worst. I often have to wait. I can wait 20 minutes. They say they won't be long but they are". Another person told us, "They are a little slow on the uptake if you press your button". They went on to say, "They come in the end but you don't know how long you are going to have to wait". A relative said, "There are not enough staff I don't think, especially in the mornings. I walk up and down the corridors to look for them because they take ages if you press the buzzer, but unfortunately my relation can't do that so has to wait".

We saw that people had to wait for support. For example, one person requested to be transferred to their comfortable chair from their wheelchair after breakfast. A member of staff told this person they would go and fetch the second member of staff to offer support so this could be completed safely. The person waited 15 minutes until the second member of staff came. The person was then transferred. Staff told us there were not enough of them to meet people's needs in a timely manner. One staff member said, "No there are definitely not enough staff". At 12:15pm staff confirmed that there were at least four people who they had not been able to offer all personal care to, including washing and changing their clothing. They confirmed this was because there were not enough of them available. We were unable to talk to these people about their experience. A staff member said, "The people who want to get out of bed we support first, the people who are stopping in bed all day have to wait until we can get to them". This meant that people were experiencing delays in receiving care and support when they needed it.

At the last inspection we raised concerns about the records the staff kept that were being completed to ensure people remained safe in the communal areas. At this inspection we found no improvements to these records had been made. We saw there was a protocol in place for the communal lounge which stated that staff should complete 20 minutes checks when people were present. We observed for two periods during the day that these checks were not completed, but the records we looked at stated these had been completed. Records we saw stated that one person had been checked while in the lounge, however during this period the person had not been in this area. This meant we could not be sure the records were completed accurately and people were observed during these times as required.

We spoke with the registered manager and the operations manager about the changes they had made in relation to staffing since the last inspection. They told us that shift patterns for staff had changed. The morning shift now started earlier for some staff, however they confirmed they had not increased the amount of staff on each shift since the last inspection. Staff told us the change of times to shift patterns had had no effect on how quickly they could get people up. One staff member said, "It's made no difference, we have

people who have higher needs now, so we have more people who need more support". This meant the action the provider has taken in relation to staffing levels had not been effective.

We looked at the dependency tool that the provider used. We saw that when people's dependency was assessed it was not always accurate. For example on one person dependency tool we saw the total had been added up incorrectly and therefore did not reflect the correct score for this person. Furthermore, we could not be sure this tool was effective as on the day of inspection there was no system in place to show how the agreed staffing levels were calculated. We were told that the staffing levels were based on the numbers of people with very high or high support needs. Other people's needs were not taken into account. The registered manager and operations manager were unable to tell us how the actual staff numbers had been calculated. It had also been agreed by the provider that if 50% of people using the service were assessed as high or very high needs then staffing would be reviewed. We saw the registered manager had documented that they had emailed the provider to inform them that this was the case, however we did not see this had been responded to or any action taken. Since our last inspection the dependency tool showed us that eight more people had high or very high needs that used the service and there had been no increase in staffing levels.

This is a continuing breach of Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

At our comprehensive inspection of Conifers Nursing Home on 25 May 2016, we found risks to people were not always managed in a safe way. This was a continued breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found some improvements had been made, however further action was needed.

At the last inspection we observed that in the laundry there was an electronic iron. The door to the laundry was left open and this piece of equipment was not supervised when switched on. This equipment was hot to touch. At this inspection we saw that the door to the laundry remained open and the piece of equipment remained hot to touch. We spoke with a member of staff about this. They said, "We can't shut the door as the room gets hot, we make sure we turn off the equipment before we leave". The staff member confirmed that the equipment was still hot when the room was left unattended. We spoke to the operations manager about this. They confirmed a risk assessment had been put in place for this. The risk assessment stated that 'staff to ensure the iron is not left unattended when in use'. This demonstrated that the provider had not considered all the risks associated to this equipment as it remained hot to touch and people continued to have unsupervised access to this.

We spoke with the registered nurse about how creams were administered. They told us that care staff would administer creams that had been prescribed by the GP. They confirmed that the nurse would sign the medicine administration record to confirm this had been administered, even though they had not seen these creams being applied. This practice is known as secondary dispensing and considered to be unsafe as it increases the risks of medicines being administered to the wrong person.

We observed that one person was offered their medicines however we did not see this person's medicines were administered. We spoke with the registered nurse about this. They told us that the person would often refuse their medicines. They confirmed there was no guidance in place stating what action to take when this occurred. This meant we could not be sure appropriate action had been taken for this person when needed.

At the last inspection we found when people had behaviours that may challenge there were no management plans in place and staff had an inconsistent approach. At this inspection we found the

provider had made the necessary improvements. We looked at care records for two people and we saw care plans had been introduced. There was clearer guidance for staff to follow. This included information on what may trigger people's behaviours and action to take if they occurred. Staff confirmed and we did not see any records that any incidents for these people had occurred since the last inspection. A staff member told us, "We have looked at people and their behaviours since the last inspection, we feel more equipped now".

We saw that individual risks to people had been considered. When people were at risk of developing sore skin we saw risks assessments were in place. People were supported in line with these. For example, when people needed specialist equipment it was provided for them. We observed staff transferring pressure relieving cushion between seating for people. One person commented, "They never forget about me sitting on this". Checks on this equipment had been completed to ensure it was maintained and safe to use.

People were safe. One person said, "They would never hurt me, I don't worry about anything when I am with the staff". A relative told us, "They are safe here, things happen and the staff always let me know but nothing that ever worries me". Staff knew what constituted abuse and what to do if someone was being abused. A member of staff said, "It's keeping people safe and recognising if something is wrong, if they are coming to harm by someone else". Another staff member told us, "I would report my concerns to the manager". We saw there were procedures in place to raise and report any concerns to the local authority. When needed we saw these procedures were followed to ensure potential abuse was investigated appropriately.

Staff we spoke with were aware of people's emergency plans and the level of support they would need to evacuate the home .We saw plans were in place to respond to emergency situations. These plans provided guidance and the levels of support people would need to be evacuated from the home in an emergency situation. The information recorded was individual and specific to people's needs.

We saw staff administer medicines to people individually. Time was taken to explain what the medicine was for and ensure they had taken them. Medicines were stored in a safe way to ensure people were protected from the risks associated to them.

We spoke with staff about the recruitment process. One member of staff told us, "Staff have to have a DBS before they can start. It takes a bit longer to get them in the service but they have to be checked". The DBS is the national agency that keeps records of criminal convictions. This demonstrated there were procedures in place to ensure staffs suitability to work within the home.

Requires Improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Conifers Nursing Home on 25 May 2016, we found people were not always provided with the care they required. At this inspection further improvements were needed. For example, we observed one person had been sitting in their wheelchair since breakfast time. At 12:30 we heard this person ask to transfer again as they said they were getting increasingly uncomfortable. However, the person remained in their wheelchair until they went out after lunch. This demonstrated that people still did not receive care in their preferred way.

At the last inspection we found people were not always provided with the care they required. For example we saw one person had a percutaneous endoscopic gastrostomy (PEG). A PEG is a flexible feeding tube which is placed through the abdominal wall and into the stomach. The care plan for this person stated the PEG should be cleaned and rotated on a weekly basis. We looked at records for this and found this was not completed in line with the care plan. At this inspection a chart had been introduced and was completed weekly to demonstrate that the PEG had been cleaned and rotated, however the care plan stated this should be completed every morning. Staff told us this person had been reviewed and it had been agreed by other professionals, however the care plan had not been updated. Therefore we could not be sure this person received the care they needed.

At the last inspection we observed people were not transferred from their wheelchairs to the dining room chairs at mealtimes. At this inspection we found further improvements were needed. At mealtimes we saw some people remained in their wheelchairs. We saw people had a preference sheet in their files stating where they would like to sit at mealtimes; it was however unclear how the person had been involved with making this decision. We spoke with the member of staff who had supported people to complete these. They said they had asked people and their relatives their preference. We did not see and the registered manager confirmed these conversations had not been documented. When people could not make the decisions themselves the staff member told us they had made the decision for that person based on their knowledge of them. This meant we could not be sure people were fully involved with this decision.

People told us they had the opportunity to participate in activities they enjoyed. One person said, "I did exercises yesterday they keep me fit, I enjoy that". We observed that there was an activity coordinator in post and activities were taking place throughout the inspection.

People and relatives told us they were involved with reviewing their care. One person said, "Yes I am involved, they ask me things". A relative told us, "They let me know about anything that's happened. I know my other relation has been to meeting". We saw there was a review record in people's care files stating who had been involved with the review of the persons care. The care files we looked at confirmed where possible people were involved with reviewing their care.

People and relatives told us they were happy to complain. One person told us, "I would talk to staff or the manager". A relative said, "I would have a quiet word and then look at it more formally if needed". The provider had a complaint policy in place and systems in place to manage these complaints. We saw when

complaints had been made the provider had investigated and responded to these in line with their policy.

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	Regulation 18 HSCA RA Regulations 2014 Staffing People had to wait for support as there was insufficient staff available for people.

The enforcement action we took:

We issued a Warning notice.