Galleon Care Homes Limited

Lindsay Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Lindsay Hall Nursing Home on 01 and 02 November 2016. This was an unannounced focussed inspection.

Lindsay Hall Nursing Home provides accommodation and nursing care for up to 38 people living with differing stages of dementia who have nursing needs, such as diabetes and strokes. There were 20 people living at the home on the days of our inspections.

Lindsay Hall Nursing Home is owned by Galleon Care Homes Limited, who have two other homes in the South East. Accommodation was provided over three floors with a passenger lift that provided level access to all parts of the home. The lower ground floor was closed for refurbishment.

There was no registered manager in post. An appointed manager was in post and had submitted their application to register with the CQC. We have confirmed that this is in process. 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 and associated regulations about how the service is run.

At a comprehensive inspection in March 2015 the overall rating for this service was Inadequate. At this time we took enforcement action. Seven breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified.

During our inspection in August 2015, we looked to see if improvements had been made. We found that improvements had been made and breaches in regulation had been met. However as the improvements needed further time to be fully established into everyday care delivery the overall rating was Requires Improvement. Due to a high number of concerns raised with us about the safety of people, the meal service and staffing levels, we undertook a comprehensive inspection on the 5, 6 and 7July 2016, so we could ensure that people were safe. We found that people's safety was being compromised in a number of areas. As part of our enforcement process, the service was placed into special measures and we served warning notices for Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 with a specific date for compliance so we could be assured that the provider had taken urgent action to mitigate the risk to people. We received an action plan from the provider that told us that they had taken immediate action to ensure the safety of people who lived at Lindsay Hall Nursing Home.

This focussed inspection on the 01 and 03 November was specifically to look at "Is the service safe". This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lindsay Hall Nursing Home on our website at www.cqc.org.uk. We found that whilst there had been significant improvements made, the breaches of Regulation 12 and 18 were not fully met. It was clear that the organisation was committed to improve the service and more time was needed to fully embed the improvements to care delivery and build up the staff

team. This will be reviewed at our next comprehensive inspection which will be in the New Year.

Care plans and risk assessments had been updated to reflect people's assessed level of care needs. There was some confusion found on specific care plans as there had been amendments made to care delivery but the changes were not always clear and could potentially lead staff to deliver inappropriate care. We found that people with specific health problems such as diabetes did not have sufficient guidance in place for staff to deliver safe treatment. Inaccurate recording of fluids placed people potentially at risk from dehydration. Medicine practices had improved and people received their prescribed medicines on time. However organisational policies in respect of covert medicines were not always being followed and there was a lack of monitoring of those who receive mood altering medicines. Incidents and accidents were recorded and there was evidence of auditing but there were some irregularities in October 2016 that had no recorded investigation and outcome. The overall cleanliness of the home had improved considerably, but there were areas that we identified as a concern, such as strong odours in specific bedrooms.

The lack of suitably qualified and experienced staff impacted on the care delivery on the 01 November 2016 and staff were under pressure to deliver the care in a timely fashion. Shortcuts in care delivery were identified. However on the second day of the inspection we saw that care was delivered by suitably experienced staff which meant that the care delivery was safe and more person centred.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Lindsay Hall Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC), which was up to date.

Safeguarding policies and procedures were in place and were up to date and appropriate. Staff had received training in safeguarding adults at risk, and they felt confident that they would recognise and report unsafe care.

Risks to the environment were managed and there was an appropriate maintenance schedule in place to make sure the environment remained safe for people, such as gas and electricity checks and fire equipment.

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

Lindsay Hall was not consistently safe and whilst improvements had been made, was not fully meeting the legal requirements that were previously in breach.

Risk assessments were devised and reviewed monthly. However, day to day management of people's individual risk assessments to maintain their health, safety and well-being were not always followed and therefore placed people at risk.

There was not always enough suitably qualified and experienced staff to meet people's needs.

Whilst the management and administration of medicines had improved and people received their medicines as prescribed, clarity of the use of covert medicines needs to be improved.

Staff had received training in how to safeguard people from abuse and were confident about how to respond to allegations of abuse. Staff recruitment practices were safe.

Lindsay Hall 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.

The focussed inspection took place on the 01 and 03 November 2016. This visit was unannounced, which meant the provider and staff did not know we were coming.

Two inspectors undertook this inspection.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and Clinical Commissioning Group (CCG) to ask them about their experiences of the service provided to people.

We observed care in the communal areas and over the two floors of the home. We spoke with people and staff, and observed how people were supported during their lunch. We spent time looking at records, four staff files and training programmes and other records relating to the risk management of the home, such as complaints and accident / incident recording and medication audit documentation. We looked at five care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' four people. This is when we looked at people's care documentation in depth and obtained their views on how they found living at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the morning of the 01 and 03 November 2016. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 10 people living at the service, three visiting relatives, seven care staff, (which included agency staff), a housekeeper, one registered nurse, the area manager and the manager.

Requires Improvement

Is the service safe?

Our findings

At our inspection in July 2016 we found that people's health safety and welfare were not always safeguarded. The provider had not taken appropriate steps to ensure that there were measures in place to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had also found there were not sufficient, experienced staff deployed to keep people safe or assist them to receive appropriate care and support. The service had not assessed the skills of agency staff working in the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider submitted and action plan detailing how they would meet the legal requirements by 30 October 2016. Whilst we found that significant improvements had been made and risk to peoples' health and well-being had been mitigated, the provider was still not fully meeting all of the requirements of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at Lindsay Hall Nursing Home. One person told us, "I have no worries about my safety." A relative told us, "I have had concerns about some aspects of care but overall there has been a definite improvement in the amount of agency staff used." Another relative said, "I can see a difference, the carers are happier and we see familiar faces now which really helps." Staff said, "It is a better place to work, we are working as a team."

At the last inspection, peoples' risk assessments were not all up to date and some lacked sufficient information and guidance to keep people safe. At this inspection peoples risk assessments had been reviewed and updated. There was some confusion found on specific care plans as there had been amendments made to care delivery but the changes were not always clear. For example, one person's call bell risk assessment (dated 24 February 16 and reviewed 25 August 2016) documented it was in their best interests not to use the call bell because although they could use it, they was not able to remember to use it, However on the 01 September 2016 the care plan stated 'cannot use a call bell, makes noise so much that you go to ask.' There were no monitoring records in relation to calling out behaviours or regular checks during the day. Three members of staff told us different things. One staff member said, "Yes, uses a call bell," another staff member said, "No, can't use a call bell, they call out" and another said they didn't know. This person was distressed and was calling out throughout the inspection. These were fully discussed and acknowledged by the manager. We were told that care plans were soon to be rewritten which would remove any misleading information and further mitigate risk.

Risk assessments specific to health needs such as mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency were in place. They looked at the identified risk and included a plan of action to promote safe care. However on the first day not all people received the care required due to last minute staff shortages. For example, on the 01 November 2016, people who needed regular position changes and continence checks did not get them as detailed in their care plans. We also identified that there was no rationale given or documented as to why one person was now to remain on bed rest. Staff were unsure of the reasons why the decision was made. Peoples' turn charts and position changes did not

correspond with our observations, this was fed back to the manager during the inspection so that appropriate action could be taken. Staff told us that the manager had spoken with them regarding completing documents and that training sessions had been planned.

Accident records and the overview of accidents and incidents were available. There were some irregularities in the recording of two specific accidents as the people's names were incorrect and as yet there was no record of the manager's investigation outcome. The reports for accidents and incidents in October 2016 were yet to be audited.

There were discrepancies on fluid charts that were discussed with the manager. These included inaccurate amounts of fluid people actually drank. Staff were documenting a full glass or beaker (250 mls) on initially giving it to a person, but were not recording only sips taken or not drunk when taking away the drink. On the second day we saw that these had been discussed with all staff and an action plan put in place to ensure that the risk of dehydration was mitigated. This included a new fluid chart for staff to use which included the total amount of fluid intake to be aimed for that was specific for that person and a running total which would encourage staff to record more accurately.

The overall cleanliness of the home had improved significantly. However not all areas of the home were clean and hygienic. The sluice room on the garden floor has an unpleasant smell and there was a pile of commode pots that were dirty. The floor of the sluice room was unclean and not impermeable to spills. There were also specific rooms that had unpleasant odours that were tracked to mattresses that were not fit for use as the covers were worn and urine had soaked through to the inner part of the mattress. The mattress issue was immediately dealt with and an action plan was put in to place to ensure all mattresses were checked and replaced as necessary.

People who lived with behaviours that may challenge themselves or others had a mental health care plan which detailed they did not accept that they required care and treatment. There were specific behaviour management plans in place and evidence that staff had sought advice from health professionals. We saw at times during the inspection that there were people who had behaviours that may challenge and staff dealt with them in a professional manner. There were times however that the management strategies for two people were not successful and this caused the people and people in the vicinity to become distressed. On the second day however the approach was more person centred and people were calm and content.

Whilst there was an organisational policy and procedure for the use of covert medicine (disguising medicine by administering it in food and drink) these were not always being followed. For example one person had a letter from the GP dated 10 May 2016 to confirm that their medicine was to be given covertly. However there was no care plan containing details whether the medicine was safe to be crushed and how to administer it apart from a sentence 'place tablets in food/drink (circle equivalent)' and this had not been completed. The agency nurse reported they gave it with yogurt, but there was no documentation to support this. There was also no evidence they had checked with the pharmacist that the medicine was effective if given with yogurt. Another person's MAR showed they were on three different drugs but there was nothing in respect of this in the medicine care plan to support the monitoring of the effectiveness of these prescriptions and for the possible side effects that staff need to be aware of, such as drowsiness.

The management of diabetes raised concerns at this inspection. One person's care plan for diabetes management was misplaced but was found by the manager. It contained information that stated 'liaise with surgery' if blood sugars 'too high' or 'unusual behaviour. . However there was no information about the appropriate blood sugar levels for the person or what staff were do if the blood sugar was outside these levels. Records showed that the person declined to have blood sugar levels done at times but actions staff

were to take when this happened were not documented in the care plan. We found that on several occasions that blood sugars were taken after supper and after breakfast which then gave a high reading which staff did not get recheck to ensure their health was not placed at risk. There was no rationale or action recorded for this practice. This does not reflect the guidance for diabetic monitoring with the National Institute for Health and Care Excellence (NICE). This had not mitigated the risk to people's health.

Whilst improvements had been made there were still improvements needed to embed safe care delivery and treatment to fully meet Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The organisation had worked extremely hard at recruiting new staff. The amount of agency care staff had decreased and the permanent care staff team increased. The closure of the nearby sister home will further decrease the use of agency staff and therefore improve the continuity of care. The recruitment and retention of registered nurses however was still a problem. There was only one permanent registered nurse currently working at Lindsay Hall on night duty and they were away for a month. To ensure a continuity of leadership the manager was working on the floor as a registered nurse supported by a registered nurse who had been working at Lindsay Hall continuously for two months five days a week.

On the first day of the inspection we found that there were two care staff down due to sickness. An agency care staff member arrived at 11 am and a care staff member from the sister home arrived at 10 am. This meant that there was only one permanent member of staff working on the ground floor and on the garden floor until 11 am there were two permanent staff but one was on their induction and had not completed moving and handling training to be able to assist in moving people. This impacted negatively on the care delivery as people did not get the positional changes and continence care they required. One person remained in one position in bed for six hours before staff attended to them. During this time they were not offered continence care, this placed the person at risk from tissue damage. The deployment of staff was unavoidable due to sickness but unfortunately staff took shortcuts in care delivery which could have been handled better if they had not felt under pressure to complete tasks. This was due to the inexperience of staff and from last minute staff changes which meant the skill mix of staff was not appropriate to meet peoples' individual needs.

Whilst the organisation has made staff training and recruitment a priority there was still a concern over the lack of permanent registered nurses and senior care staff to lead care delivery on a day to day basis. This was confirmed by the variable care delivery seen over the two days. Whilst improvements had been made there were still improvements needed to ensure that there were sufficient, suitably qualified and experienced staff deployed to meet peoples' needs to fully meet Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of the inspection the care staff team consisted of 90% of Lindsay Hall staff and an agency registered nurse. The atmosphere was calm and this had a positive effect on people and on the care delivery

Risk associated with the use of pressure relieving equipment and the use of bedrails had been assessed and used appropriately. All pressure relieving mattresses were set accurately and checked by staff daily.

The provider had arrangements in place for the management of medicines, we found the administration and recording of medicines were safe. This ensured people received their prescribed medicines. Medication administration records (MAR) were correctly completed and topical creams were signed as being

administered as prescribed. Staff had followed the home's medicine policy with regard to medicines given 'as required' (PRN), such as paracetamol. Records had been completed with details of why they had been given. Directives as to when PRN medicines should be administered, for example pain charts were in place.

People were protected from avoidable harm as staff used safe moving and handling techniques. We observed staff moving people safely in bed and ensuring people were safe whilst walking around the home. We also saw staff using appropriate moving and handling equipment (hoists) to move people with limited mobility.

Peoples' weights were monitored and there were people who had weight loss and their care plans and risk assessments had been updated to reflect this. We saw that there was information on the care plan to direct staff to offer fortified food and drink. There was also evidence that referrals had been to the appropriate health professional for advice and support.

Personal emergency evacuation plans (PEEP's) were in place and it was confirmed that all agency staff received an induction to the layout of the building and the emergency procedures in place. The agency nurse and two agency health care assistants confirmed that they had received an induction and that fire procedures had been explained to them before starting work.

Safeguarding policies and procedures were in place and were up to date and appropriate. Staff had received training in safeguarding adults at risk, and felt confident that they would recognise abuse and poor care and report it.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, that the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by the provider of Lindsay Hall Nursing Home and bank/agency nurses all had registration with the nursing midwifery council (NMC) which was up to date.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that was reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs.