Parkview Care Homes Limited

Asher Nursing Home

Inspection report

33 Wilbury Gardens, Hove, East Sussex,
BN3 6HQ
Tel: 01273 823310
www.macleodpinsentcarehomes.co.uk

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Ratings

Overall rating for this service	Inadequate
Is the service effective?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 30 June and 2 July 2015. After that inspection we received concerns in relation to the management of people's nutritional and healthcare needs. As a result we undertook a focused inspection to look into those concerns. Many people living at Asher Nursing Home had lived there for many years. Support and input was required to monitor and manage their mental health needs but as people were becoming older, management of people's healthcare and nursing care needs was required. We spent time looking at whether people's healthcare needs were effectively managed. This report only covers our findings in relation to those/this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Asher Nursing Home on our website at www.cqc.org.uk.

Based on the evidence we have seen, we have revised the rating for the key question, is the service effective? To' Inadequate'. This therefore means the overall rating has been revised from 'Requires Improvement' to 'Inadequate'. This means that Asher Nursing Home has been placed into 'Special measures' by CQC.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

Summary of findings

will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Asher Nursing Home is a mental health nursing home providing care and support for people living with enduring and complex mental health needs. The home can accommodate up to 17 people and on the day of the inspection, 17 people were living at the home. The age range of people varied between 35 – 86 years. Predominately people required support with their mental health; support was also needed in relation to diabetes, pressure care and physical disability

Accommodation was provided over three floors with a lift and stairs connecting all floors. Located in Hove, the home provides access to the city centre and seafront. There is good access to public transport. During the course of the inspection, people were seen coming and going, going out to see friends, shopping or meeting family.

A registered manager was not 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 and associated Regulations about how the service is run. An acting manager was in post whilst a registered manager was being recruited.

The management of diabetes required improvement. Nursing staff did not have an oversight of people's blood sugars, placing people at risk of high and low blood sugars. Where the need for daily blood sugar readings had been identified, this was not being carried out. Care staff identified that care plans failed to provide sufficient guidance on how to manage people's diabetes.

Care plans also failed to recognise the interaction between people's healthcare needs and mental health needs. Where people were living with diabetes, staff members felt there was not sufficient guidance on how to effectively manage their diabetes when their mental health needs were prevalent.

Mechanisms were not consistently in place for assessing people's nutritional needs. Consideration had not been given to providing fortified diets and promoting people's nutritional intake. Where people were struggling to eat, staff had not considered adapted cutlery or whether the person was having trouble swallowing. For people who required a soft diet, guidance was not in place to assess any potential choking risks and how to ensure their nutritional needs were met whilst on a soft diet. Where people had lost weight, documentation failed to reflect what action if any had been taken and if concerns had been escalated.

People had mixed opinions about the quality and variety of food. One person told us, "The meals were ok I guess but they give me what I want, the portions can be a bit small." Another person told us, "It's rubbish." Staff members also felt improvements could be made to the quality of food. One staff member told us, "People need more fresh vegetables."

Staff were dedicated to ensuring the lunchtime meal met people's preferences. A wide variety of meal options were provided and people ate at various times in accordance to their individual lifestyles. Staff members ate alongside people promoting the lunchtime experience to be a social event. With compassion, staff members spoke about the people they supported. Staff members had a firm understanding of people's individual needs, personality traits and how best to support people.

We found a breach 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.

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 effective?

Inadequate 

Asher Nursing Home was not effective. People's diabetes were still not always being managed safely and effectively, despite assurances given to us when we previously visited the service.

Improvements had not been made since the comprehensive inspection on 30 June and 2 July 2015. Staff did not consistently have oversight of people's diabetes. Regular blood testing was not taking place. Based on the evidence we have seen, we have revised the rating from 'Requires Improvement' to 'Inadequate'

Where people were losing weight, documentation failed to record what if any actions were being taken. People's nutritional needs were not consistently assessed and care plans implemented.

Staff members had knowledge of people's care needs and spoke with compassion for people they supported.

Asher 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 carried out an unannounced comprehensive inspection of Asher Nursing Home on the 30 June and 2 July 2015 at which numerous breaches of regulations were identified. Following this we undertook an unannounced focused inspection on 31 July 2015. This inspection was done to follow up on concerns we had received that peoples nutritional and nursing care needs were not being met. The team only inspected the service against these concerns which are reported under one of the five questions we ask about services: is the service Effective.

The inspection team consisted of an Inspector and Inspection manager. During the inspection, we spoke with eight people who lived at the home, three care staff, one registered nurse, the acting manager, deputy manager and the area manager. We spent time observing meal time practices and the individual meal time support some people received.

Before our inspection we reviewed the information we held about the home including information which had been shared with us by the local authority and statutory notifications which had been submitted. A statutory notification is information about important events which the provider is required by law to tell us about.

During the inspection we reviewed the records of the home. These included weight records, eight care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Asher Nursing Home. This is when we looked at people's care documentation in depth and obtained their views on how they found living at Asher Nursing Home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service effective?

Our findings

People had mixed opinions about the variety and quality of the food provided. One person told us, "Its rubbish." Another person told us, "The meat was a bit tough today." One person was positive about the food, commenting, "The food is quite nice." Another person told us, "The food is ok when there is lots of stuff and you can help yourself to as much as you want." Staff members also felt the food could be improved. One staff member told us, "People need more fresh vegetables." Staff members also raised concerns regarding the management of people's healthcare needs. One staff member told us, "The clients are now ageing and their health needs are getting greater which we have not always been clear on how to support them."

At our last unannounced comprehensive inspection of Asher Nursing Home on the 30 June and 2 July 2015, we identified that the management of diabetes required improvement and the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because one person's pre-admission assessment identified they suffered from unstable diabetes and their blood sugars needed to be taken twice daily. However, since the person moved into the home, this had not happened. When we completed our focused inspection we found this person's blood sugars had still not been taken since the 7 July 2015, despite management assurances that it would be addressed immediately at the previous inspection. The care plans for two other people also identified the need for daily blood sugar testing which had not been carried out. This demonstrated the staff could not identify when people were at risk of experiencing high and low blood sugars and take the relevant corrective action.

We spent time talking with nursing and care staff on the management of diabetes. Staff were consistently aware that four people were diabetic. One registered nurse told us, "We encourage people to cut down on portions of sweet food." Another member of staff told us, "We have now implemented a weekly blood sugar monitoring chart for people who are diabetic to ensure we have oversight and provide support when necessary." However, we spoke with staff about the mechanisms in place to support people with diabetes and complex mental health needs and how the two care needs interact. Staff members informed us that due to people's mental health needs, they could experience days where they did not recognise they were diabetic, therefore eating high levels of sugar and placing themselves at risk. One staff member told us, "It's very difficult to enforce their diabetes due to their delusions." One person was living with alcohol related dementia which meant they often forgot they were diabetic. Their care plan recorded for, 'high sugar foods to be avoided, promote a well-balanced diet' and the signs and symptoms of high and low blood sugars were available. However, clear guidance was not available on how to manage the person's diabetes when their mental health needs were prevalent or they were psychotic. We asked staff members what guidance was in place to support them. Staff members acknowledged that they felt guidance was not in place. One staff member told us, "Guidance is not there to tell us how to manage people's diet and diabetes."

Alongside living with diabetes and mental health needs, people with diabetes can often have other health problems. They are particularly susceptible to infection and diabetic foot disease. We spent time reviewing care plans to ascertain how the implications of diabetes were managed and that they received regular input from healthcare professionals to manage their diabetes. Monitoring of eye care needs and podiatry is also vital. One staff member told us, "Recently we identified concerns with a person's foot; therefore we have now been soaking the foot and applying cream. We are also chasing up eye appointment and the diabetic clinic." Despite the concerns identified with the person's foot, the individual care plan failed to record that their feet should be regularly monitored and failed to provide guidance for staff to follow. Documentation also failed to reflect that the eye appointment was being chased along with the diabetic clinic.

Due to the above concerns in relation to poor management of diabetes, we have identified an on-going breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014. The provider has sent us an action plan detailing the steps they intend to make to meet the requirements of the regulations.

Mechanisms were not consistently in place to assess people's nutritional needs. Management acknowledged that staff had not received training on dysphagia (swallowing difficulties) but felt staff would identify if people were experiencing swallowing difficulties. One registered nurse told us, "When people are eating, we do observe and sit down with people, we would identify if they

were coughing or struggling to swallow." We spent time observing lunchtime. One person had just arrived back from a shopping trip when lunch was being served. Upon arrival, staff brought their meal out and placed it on the table. By the time the person had taken their coat off and sat down, their meal had been sitting on the table for four minutes. Instead of allowing the person to leisurely take their time before sitting down for their lunchtime meal, the meal was placed on the table, enabling it to go cold. Staff members also informed us that this person was a slow eater. They had fried egg, chips and beans for lunch. A member of staff was seen sitting next to them having their lunch and they were discussing their recent shopping trip. However, the person was seen to be struggling to eat with only one hand. With time they ate their egg and beans but they didn't eat the chips. At no point did the staff member offer to cut up the chips or provide adapted cutlery to promote independence. Their individual weight records demonstrated they were losing weight. We asked the staff member if they were aware why the person didn't eat the chips. The staff member was unaware and agreed when we suggested it may have been because of difficulty cutting the chips with the use of only one hand. We also enquired what action had been taken following their weight loss. Staff members were unable to advise and documentation failed to reflect what action had been taken.

For people whose nutritional intake was poor or required support to maintain a healthy diet, we questioned what support was provided to meet those needs. One person told us, "I'm losing weight." For lunch we observed, they had a jacket potato, a few prunes and a choc ice. We asked staff if people received a fortified diet, so that the little food they did eat was fortified with calories. Staff members acknowledged that the food was not fortified and recognised this would be of benefit. Whilst observing lunchtime, it was clear that individual likes were catered for and people received their meal at various times in accordance with their preference. However, it was not clear what consideration had gone into ensuring people received a healthy and nutritious diet. Vegetables were not provided and for people living with diabetes, it was not clear what consideration had gone into making the meal as nutritious and filling as possible. Staff members also commented that they felt people needed more vegetables and healthy meals. One staff member told us, "The chef needs more guidance on specialist diets and more fresh food. Many people eat independently and this can be a huge challenge to support them to eat properly."

We were unable to speak with the chef, but we spoke with the area manager who identified work needed to be undertaken on ensuring people received nutritious and healthy meals. They confirmed they would be liaising with the chef and implementing new menus.

We spent time observing the lunchtime meal and engaging with people about the meals provided. One person told us, "The meals were ok I guess but they give me what I want, the portions can be a bit small." One person commented that they go out for meals regularly as they didn't like what the chef cooked. Another person told us that they felt they had put weight on since moving into the home as there was little fresh food. During the lunchtime meal there was positive warm interactions between people and staff. Staff sat down and ate their meal with people as well. One person became unsettled during lunchtime; staff were polite and supportive and encouraged them to remove themselves from the dining area to relax.

Where people required a soft diet, sufficient guidance was not available. Such as why the person required a soft diet, how to provide a soft diet that met the person's nutritional needs and was based on their nutritional likes. Staff members told us of one person required a soft diet and occasional support to eat. Their care plan however failed to identify they required this level of support or detail any choking risks the person may experience if a soft diet was not provided. Staff members told us of one choking related incident whereby an ambulance was called and staff requested the person be admitted to hospital. Documentation and the individual's care plan failed to reflect this incident. We asked the management team for further clarification regarding this incident but they were unable to provide insight. Therefore it was not clear if the person was at risk of choking and required input to manage the associated risk. One person's daily notes also identified an incident whereby they 'choking on their cereal, staff provided back slaps with good effect.' The care plan for the individual lacked any guidance on choking risks or what action had been taken following this incident. This demonstrated that potential choking risks were not always assessed or addressed.

Inadequate

Is the service effective?

Weight records demonstrated that most people were maintaining a stable weight or putting weight on. However, where people had lost weight, they had lost a significant amount of weight and documentation failed to reflect what actions had been taken. Staff members spoke about two people in particular they had concerns about. One person had been losing weight over a six month period. Staff members told us they had been referred to the GP and taken to appointments but records did not reflect this. A nutrition care plan had not been implemented to identify the risk and what mechanisms could be implemented to promote weight gain. Another person had been losing weight and registered nurse told us they felt they were experiencing problems swallowing. They told us appointments had been organised with the GP but they had refused to attend. However, documentation failed to reflect this. Therefore where people were losing weight, it was not evident that appropriate referrals to healthcare professionals were being made. There was also no consideration again to fortified food or what mechanisms could be implemented to promote weight gain.

Where people had lost weight, we were unable to find any documentation which confirmed people had been weighed since May 2015. We identified two people who had lost considerable weight, but staff were unable to demonstrate whether they had been weighed since May 2015 to monitor for further weight loss and ensure appropriate action was taken. The daily notes for one person who was losing weight and had been for six months reflected they often did not eat or refused meals. In July 2015, the daily notes reflected they were unable to eat and drink; however, there was no assessment undertaken or consideration as to whether food and fluid charts should be implemented to monitor the person's nutritional intake.

Throughout the inspection, drinks were readily available for people and staff were continually pushing fluids due to the hot weather. However, mechanisms were not in place to assess whether people were at risk of dehydration. The daily notes for one person recorded they were suffering from excessive dribbling and their fluid intake was minimal. Staff members commented they had not been completing fluid charts and would be unsure of when one would need to be completed. We asked what mechanisms were in place to ensure the risk of dehydration was minimised. Staff members told us they monitored fluid intake but did not record how much the person had drunk throughout the day. Therefore, assessments were not in place to monitor, review and minimise the risk of dehydration.

Due to the above concerns, in relation to poor management of people's nutritional needs, we have identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Although care plans lacked sufficient guidance for staff to follow, staff members held in-depth knowledge about the people they supported. Staff members were clearly aware of people's healthcare needs and could inform us how people living with diabetes, often neglected their diabetes and the impact of their mental health needs on the diabetes. Staff members were also clear where they felt people were losing weight. One staff member told us, "We got a couple of residents who have been losing weight over the past couple of months." Staff members commented they would inform the nursing staff with their concerns, but were unable to comment if their concerns were acted upon. Staff members spoke with compassion and kindness for the people they supported.

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 for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs.** **Regulation 14 HSCA (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs. The nutritional and hydration needs of service users had not been met. Regulation 14 (1)**