Pondsmead (Shepton Mallet) Limited

Pondsmead Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 26 July & 01 August 2017. The first day of the inspection was unannounced. At the last inspection in March 2016 the service was rated Requires Improvement. All of the domains were rated Requires Improvement and there were two breaches of the Health and Social Care Act 2008. One related to mental capacity assessments and best interests decisions and the second related to care planning. We looked at these areas of practice as part of this inspection.

Pondsmead Nursing Home provides accommodation and personal care for up to 76 older people. At the time of our inspection there were 48 people living in the home of whom 23 needed nursing care. The home is arranged over three floors each floor having a communal living room and dining area. On the ground floor there is a recently refurbished dining room which is also occasionally used for activities. There are extensive grounds and garden with access from the dining area and lower ground floor.

There is a registered manager for this service. 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.

Records had not always been completed accurately to reflect how and when care had been provided to people in the home.

People told us there was not sufficient staff to respond to their needs in a safe and timely manner. Since the inspection the provider told us they had increased the care staff numbers on both morning and afternoon shifts. We have made a recommendation about staffing arrangements.

There had been an independent review of the fire precautions. The provider had put in place an action plan to address areas for improvement to ensure the fire prevention arrangements were safe and adequate. Whilst some of the work needed to bring the fire precautions to the recommended standard had been completed there remained areas, including one which had been identified by the review as "significant", which had not been identified in the action plan or completed.

People were confident about staff having the necessary skills however there were some staff who had not completed refresher or updating training in line with the provider's policy. We have made a recommendation related to staff training.

Whilst a system of quality monitoring was in place this had not always been effective in identifying shortfalls and ensuring improvements had been made in how the quality of service was maintained.

People told us they felt safe living at Pondsmead Nursing Home and staff understood their responsibilities in reporting any concerns about the welfare of people. As part of the recruitment process all potential

employees were vetted to ensure they were fit to work with vulnerable people.

The arrangements for managing and administering medicines were safe and protected the health and wellbeing of people. However, there needed to be improved arrangements where people were administering their own medicines.

People had mixed feeling about the meals provided in the home. Some said there was not enough variety whilst others were satisfied with the menu and meals. Changes had been made to the menu and a questionnaire given to people had resulted in some positive comments and noted improvements. However it was recognised continued improvements needed to be made.

People described staff as caring and kind. One person told us that being caring "Was a strength" of staff. Another said, "They treat me with respect and are so caring. They always ask if I am ok just thinking about me." Staff were observed supporting people in a caring and sensitive way.

There was a range of activities available and people spoke positively of the activities. However, there were difficulties in ensuring everyone was supported to take part in activities. We have made a recommendation about activities.

There was a welcoming environment where people were able to maintain their relationships with family and friends. People and relatives told us there were no restrictions on visiting.

People felt able to voice their views or concerns about the service. There were opportunities for people living in the home to give feedback about the quality of care provided in the home.

People spoke of a registered manager and staff who were approachable and promoted an environment where people felt listened to and able to voice their views.

We have recommended staffing arrangements are kept under review, staff refresher training system is improved to monitor arrangements for such training and the arrangements for the providing of activities are reviewed.

We have identified one 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.

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

People's health and welfare was potentially at risk because arrangements to ensure adequate fire prevention measures were not in place.

Staffing arrangements required some improvement to ensure they met people's needs in a timely and safe manner. There was a need to ensure ongoing review of these arrangements.

People benefitted from the safe management of medicines however, the arrangements for people to self-administer their medicines were not robust in ensuring their welfare was protected.

People benefitted from staff who understood their role and responsibilities in protecting people from abuse.

Is the service effective?

Good

The service was effective

People's rights and safeguarding of those rights were protected and upheld.

People had access to community health service as part of protecting their health and welfare and meeting health needs.

People could be confident staff received the training the required however, updating and refresher training was required by some staff.

Is the service caring?

Good

The service was caring

People benefitted from staff who were caring and respectful.

People were supported to maintain friendships and relationships which were important to them.

Relatives and others were not restricted when visiting the home and were made to feel welcome.

People were treated with patience and kindness especially when they were upset or distressed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Records did not always reflect how the service responded to people's care needs and how care had been provided to ensure responsive care.

People did not always benefit from a full and comprehensive activities programme suited to their abilities or interests.

Care plans provided information specific to the person however, there was no evidence of people's involvement in care planning and reviewing of their care arrangements.

Is the service well-led?

Requires Improvement

The service was not always well led

The quality and auditing system were not always effective in ensuring improvement were made.

People benefitted from an open environment where they felt listened to and able to voice their views.

Pondsmead Care 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. A new organisation acquired Pondsmead (Shepton Mallet) Ltd in January 2017.

This inspection took place on the 26 July& 01 August 2017 and was unannounced. This meant the provider had not been given any notice we were going to carry out an inspection. The inspection was carried out by one adult social care inspector, a specialist nurse and one Expert-by-Experience (ExE) on one day of the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with twelve people who lived at Pondsmead Nursing Home, three relatives and 10 staff which included care and nursing staff, kitchen staff and activities co-ordinator. We observed care and support in communal areas and around the home and in some bedrooms after obtaining people's permission. We undertook general observations in communal areas and during mealtimes. We reviewed a range of records about people's care and how the home was managed. We looked at care records for people, recruitment, training and induction records for five staff, people's medicines records, staffing rosters, staff meeting minutes and quality assurance audits.

We reviewed information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send to CQC.

Requires Improvement

Is the service safe?

Our findings

People across the home consistently told us they felt there was not enough staff reinforced by staff members we spoke with. People said, "I don't think there is enough of them on." and "They need to employ more staff here" and "I have complained many times about the lack of workers here" and "For the staff's sake I wish there was more of them." When asked how they had come to this conclusion i.e. there not being enough staff, people responded with statements such as: "Sometimes they rush me in the morning, not because they are bad people, because they have so much to do" and "The staff tell me all the time how manic they are."

Staff told us they felt there was not enough staff particularly on Tulip and Bluebell where people with nursing needs were cared for. One staff member said, "The thing that lets us down is the staffing." On the days of our inspection there were people who remained in bed at 11:30 and 12pm. They were still needing care and support to get up at these times. Staff had not been able to provide the care to people earlier because of the needs of people and numbers of care staff on duty. This meant people were not receiving care in a timely manner or at the time of their choosing.

In discussion with the registered manager it was not clear how staffing arrangements were decided other than based on the number of people living in the home. However, we were subsequently told by the regional manager dependency assessments were undertaken to assist in making decisions about staffing. An assessment provided to us did not reflect the current level of occupancy in the home in that the result was based on occupancy of 39. There were 48 people living in the home. There was no indication when the assessment had been completed or how often dependency and needs of people were reviewed. This meant a more realistic assessment was possible of people needs and how this impacted on staffing arrangements in the home. Following our inspection we were told by the provider staffing had increased by one staff on each shift (morning and evening).

We recommend that staffing arrangements are kept under review based on current best practice.

Annual fire risk assessments had been undertaken since 2015. These had identified a number of areas for improvement some of which had been completed including staff fire safety training and drills, additional emergency lighting and updating of evacuation plans. However, a number of areas for repair or attention remained outstanding and were actioned for completion by September 2017. There was one item which had not been completed which was identified as "significant risk" in 2015 and had not been included in the action plan provided to us by the provider. This related to a fire service override switch being repaired. This meant that whilst improvements to make people and staff safe from the risk of fire had taken place some areas of risk remained.

There were personal emergency evacuation plans (PEEP) in place. These identified people's needs so that staff and emergency services could respond as necessary in the event of an emergency.

There were good arrangements for the management of medicines. Stock records were accurate including

those medicines which required additional security. There was secure storage for medicines with daily checks of fridge and clinic temperatures to ensure they were stored safely.

At our last inspection in March 2016 there were improvements needed in the management of topical creams and eye drops. On this inspection we found the required improvements had been made.

Administering records were completed accurately with no gaps. One person had consistently declined their medicines and this had been discussed with the person's GP to look at medicines being administered covertly i.e. without the person's knowledge. This can be put in place where people lack capacity with regard to making a decision about the taking of their medicines if it is considered in their best interests.

One person was self-administering their medicines. This person had capacity to manage their medicines safely. Staff told us the person would tell staff if they had not taken their medicine as required. However, there was no formal system for the monitoring of this arrangements and no risk assessment had been completed to ensure these arrangements were safe.

A pharmacist advice visit had taken place in March 2017. They had identified areas for improvement and these had been undertaken. The deputy manager was in the process of implementing improvements in the management of medicines to ensure consistency throughout the home.

People told us they felt safe living in the home. The reasons included: "I have my buzzer if I get in trouble." and "Staff are there for me if I need them." and "Someone checks on me when they can." One person told us "It just knowing I am not on my own and staff treat me so well I trust them."

Staff were able to tell us how they would respond if they had any concerns about possible abuse. Staff were confident the registered manager would respond to any concerns. One told us "I would not hesitate in reporting any worries I had. I know the manager would deal with it." They were aware they could report any concerns to an outside organisation such as social services or the police. This meant people could be assured staff understood their responsibility to report any concerns about possible abuse and safeguard the health and welfare of people living in the home.

Staff confirmed that as part of their recruitment criminal record checks and references were obtained including references from previous employers. Records confirmed these arrangements. The required checks were undertaken to ensure employees were fit to work with vulnerable adults.

Risk assessments had been put in place in response to people's care needs related to falls, nutrition and moving and transferring people. These outlined specific needs of people in relation to the risks such as use of specific equipment when moving or assisting with transfers.

Good

Is the service effective?

Our findings

All staff undertook competency assessments and nursing staff had undertaken specific skills training in areas which included catheterisation and syringe driver awareness. The training matrix showed since the new provider of this service in March 2017 only one nurse had completed medication and advance first aid training. In addition the matrix showed no senior care assistants had completed advance first aid or medication training. This meant the provider and registered manager could not be assured staff had the necessary up to date knowledge to undertake some of their responsibilities.

All nurses had been observed as part of competency assessment of their practice when administering and managing medicines. One nurse had failed in one aspect of their assessment dated November 2016. It was indicated that they "Need to complete medicines training." They had not completed this training.

We recommend that the training provision is monitored to ensure staff skills remain up to date and reflect current best practice.

Staff told us they had undertaken a range of training and felt confident in undertaking their role. One staff member said, "The training is very good and has helped me get the knowledge I needed." Records confirmed staff had completed skills training in areas such as infection control, safeguarding adults, moving and handling, food hygiene, and fire safety. Some staff had completed the care certificate a nationally recognised training for care assistants. For others this was in progress being part of ongoing training for all care staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

There were arrangements in place to gain consent from people where they required equipment which could be viewed as restrictive such as bed rails and pressure mats. Where it was assessed people were unable to give informed consent because of lack of mental capacity a best interests decision had been made. This meant people's rights were protected and upheld where decisions needed to be made to protect people's health and welfare.

Since the last inspection improvements had been made when assessing people's mental capacity and where best interests decisions were needed.

People can only be deprived (or restricted) of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service had made a number of applications for people and to date one had been authorised with no conditions. The provider was acting within the principles of the MCA to protect people's legal rights when restricting their liberty.

People had mixed views about the meals and food provided in the home. People told us "It used to be good, now its chicken everyday." and "Oh yes very good." and "It is fabulous." The food menu was very varied with a multitude of choices available with only one chicken choice appearing on the weekly menu. The menu consisted of a main meal for lunch of two choices, then more of a lighter evening meal usually a choice of soup or sandwiches.

The quality of the meals had been raised in a meeting for people living in the home. As a result changes had been made by the chef and we saw where the menu had been altered to provide different meals. A recent audit and comments from people indicated that these improvements were having an impact and people were more positive about the meals. However, there remained some dissatisfaction with the choices for the evening meal and the chef was aware of this and looking to make further changes.

Staff told us they received regular one to one supervision and records confirmed this. This is where the staff member's performance, any concerns, individual training and development needs can be discussed. Staff also spoke of being able to raise any concerns or worries informally. Nursing staff undertook clinical supervision to discuss any nursing concerns or matters they wished to clarify as to their clinical practice.

People told us they had access to appropriate health professionals. Their comments included "I can see my doctor whenever I want." and "Staff are very good I only have to say I would like to see the doctor and they arrange it." Records showed that people were reviewed regularly by the GP and other community health services such as optician and podiatrist. The GP visited the service each week and reviewed those people who had been identified by nursing staff. Nursing staff would also contact the GP in between these visits if someone required medical assistance.

Good

Is the service caring?

Our findings

People spoke of staff being caring and kind. When asking people if they felt cared for they answered with such statements as: "They are so caring here." and "All the staff are wonderful." and "I would call them first class in that regard." and "That is their strength."

Staff were observed treating people with respect and kindness. In one instance staff responded in a patient and kindly way to someone who was shouting out. A staff member went in to the person's room saying "Hello (name) what can I do." they then sat with the person and spoke with them so calming the person. On another occasion a person was distressed and upset and the staff member said "Do not worry (name) let us go make to your room and I will get you a nice cup of tea." This calmed the person. Staff were observed knocking on people's doors before entering and importantly waiting for an answer before entering the room.

Staff ensured people's privacy and dignity was respected. One staff member said they always made sure the person they were helping was comfortable and "When I give personal care I always cover the person." We observed one staff member supported a person to go to the toilet they did so quietly and unobtrusively.

People were supported to maintain relationships with their family and friends. One person said, "My daughter visits every day at any time." This was also evidenced by talking to a relative who visited regularly who told us "They are very welcoming and lovely here, and I would know the amount I visit." Relatives said they could visit anytime they wished.

People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included such items as furniture, ornaments and photographs. One person when we commented on their room and the photographs and pictures they had said, "Yes this is what makes it my home. I choose to spend most of my time here and it is very nice."

Requires Improvement

Is the service responsive?

Our findings

People were at risk that their care needs and wishes would not be met because their records lacked important details or contained errors. In one instance there was no dates recorded on a person's fluid and food charts. This meant staff would be unable to monitor accurately what they had received and when. Another record documented there had been wide differences in the person's weight. This was an error through the incorrect use of weighing scales however, no record had been made of this reason for the differences. In a third instance there was no record of a referral having been made through the persons GP for specialist advice and support. In a fourth instance weight differences were not accounted for (the person had had a serious infection which had affected their retention of food and fluids)in the reviewing of the person care plan.

Records about the treatment of a person with a pressure wound did not provide sufficient detail about the treatment given and state of the wound to enable staff to monitor changes accurately. For example it was recorded "Almost healed" and "Wound healing good." There was a record for one person which was very generic rather than specific: "Skin condition.....Grade 1 and broken/spots (Grade 2-4) There were no photos or body maps providing visual evidence of these wounds and to provide guidance about treatment.

A pre-admission assessment for one person stated an air mattress was required. No record of the person's weight and mattress pressure setting was commenced until 34 days after admission. For two people there was gap of seven days where no recording of their air mattress pressure setting had been made. The correct mattress pressure setting is important to ensure that the mattress operates effectively.

These shortfalls in recording meant there was potential for the monitoring and response to health and care needs to fail placing people's health and welfare at risk.

This was a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us there was a range of activities and these were displayed throughout the home as well as people receiving a weekly programme of activities. These had included singing for fun, flexicise, games afternoon, cookery club, film afternoon and music. People spoke positively of the efforts made by the activities co-ordinator: "She keeps this place running." and "She is so lovely always comes and talks to me" and "I feel like she knows me." Relatives described her as an "Absolute star." and how she "Does all the activities by herself, no one is left out."

Some staff told us there were not enough activities especially for those who were not able to take part in the group activities. Whilst the activities co-ordinators undertook one to one time with people this was limited because of her capacity and there was a lack of support from care staff when undertaking group activities. Staff told us they would have liked to take part and support activities but were not able to "Find the time." Previously there had been two activities co-ordinators but this had been reduced to one.

We recommend the service review the activity arrangements particularly in light of increasing number of people over the past few months who have chosen to live in the home.

Care plans provided information specific to the person. They provided staff with guidance about meeting people's needs. In one instance the person's care plan set out how the person liked to have their meals and changes had been made to ensure the person was better able to enjoy their meals. As a consequence whilst there were continued concerns about the person's nutritional needs being met there had been some improvement. A referral had been made through the person's GP for a nutritionist assessment. In another care plan it stated how the person preferred one female and one male rather than two males. This was confirmed by a member of staff.

Care plans provided information about the communication needs of people particularly where they were living with dementia. For one person the plan said how staff needed to explain in a non-complex way what was being asked. For another person how staff should use "simple terms" and not complex or lengthy questions and choices.

There were records of regular 'evaluation' which provided updates to people care needs. However, there was no evidence of people or their representatives being involved in these "evaluations" or reviews of their care arrangements. This meant people did not have an opportunity to discuss their needs and the providing of their care.

Meetings had been held regularly with people being given an opportunity to talk about the care provided. One person said how they had attended the meeting and "It was good and the manager was there to hear what we had to say." From these meetings people had raised their unhappiness about some of the meals being provided and as a result changes had been made to the menu. This had also been raised through a questionnaire issued to people.

People told us they knew how to make a complaint. One person said, "If I am not happy about anything I know I can make a complaint but never had the need to do this I always talk to staff and they do something." Another person said "I always talk to staff do not like complaining though I know I can." There was a complaints policy in place and a number of complaints had been made. These had been responded to in a timely way and changes made to address the area of complaint.

Requires Improvement

Is the service well-led?

Our findings

There was a system of auditing and monitoring the quality of care provided in the home. These included audits looking at care plans, medicines, infection control and fire safety. An audit matrix provided in percentage terms for example 71% Meals/Nutrition and 98.5% Care Planning. There were no action plans or an overall improvement plan identifying areas where shortfalls had been identified and evidencing how they had been addressed. The failures around records, training and arrangements for people self-administering their medicines had not been identified This meant the system was not robust in ensuring areas of weakness potentially impacting on the quality of care were addressed through the quality monitoring and auditing arrangements.

People told us they found the registered manager was someone they could talk with and was approachable. People told us how the registered manager was: "Considerate and caring." and "I know him very well, always checking up on us all." This was re-iterated by staff who described him as someone they could talk to about anything. One staff member said, "He is very good always about on the floor and will help out if we need extra help." Another said, "He (the registered manager) is well thought of and puts families at ease." However staff spoke of how some changes which had taken place had not been always discussed with staff and one staff member said, "It is more about this is going to happen rather than being discussed."

The registered manager told us they wanted to promote a culture where staff "Are here for the people we look after." and everyone had a role to play and all staff were part of a team. Staff when asked about the culture of the home spoke of the home being "Somewhere where people are respected." and "Everyone cares about the residents that is why we are here." This meant people were supported by staff and registered manager who had a shared view of the quality of care they wished to provide. However, there needed to be more engagement with staff about changes in practice.

There was a management structure in the home which provided clear lines of responsibility and accountability. The registered manager had overall responsibility for the home. They were supported by a deputy manager, qualified nurses, care manager and a team of care and auxiliary workers.

The registered manager told us they felt well supported by the provider with regular visits from the regional manager. The regional manager told us they spoke with people and staff when visiting the home. It was part of their role to review the audits and discuss with the provider and registered manager any areas of concern.

There were audits in place to look at falls, accidents and incidents. These were used to identify any themes or improvements in practice. For example changes to people's environment or referrals to GPs for falls assessment.

The home had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to maintain accurate and complete records of the care provided and how care was to be provided.