Health & Care Services (NW) Limited

Potton House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 20 October 2014 and 24 November 2014 and was unannounced.

Potton House is a nursing home that provides accommodation and nursing care for up to 24 older people living with dementia.

The registered manager had recently left Potton House. The home is required to have a registered manager. 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.

During our last inspection In April 2014 we found that the provider failed to comply with their legal requirements in respect of consent, care and welfare, cleanliness and infection control, staffing and quality assurance processes. During this inspection we found that the

Summary of findings

provider had made improvements in regard to consent, cleanliness and infection control and quality assurance processes. However the required improvements had not been made in respect of staffing or care and welfare.

Robust recruitment and selection processes were also in place; however we found that there was still insufficient staff to provide safe care and support that people living at the home required. Also, staff training and development was ineffective and staff did not receive regular supervision.

We found that the systems in place to protect people from harm or abuse were insufficient. People's privacy and dignity was not always protected and they did not always receive their care when they wanted it.

We found that people did not get a choice of what they ate, were not offered drinks and did not get the support that they needed to eat their food.

Care was not delivered in accordance with people's care plans and people had little to occupy their time. People did not feel listened to and the provider's complaints system was ineffective.

People's medicines were managed and administered appropriately and people were supported to maintain their health and well-being.

The requirements of the Mental Capacity Act 2005 were met and where appropriate applications to deprive people of their liberty for their own safety had been made. Processes were in place for personal risks to be identified and managed to enable people to have as much independence as possible whilst keeping them safe. Processes were also in place to manage risks in connection with the operation of the home.

People were involved in the planning of their care and visitors were welcome at any time. There was an advocacy service available for people who had no friend or relative to support them. Staff felt supported and able to raise matters with the management.

During this inspection we found that there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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 safe?
The service was not safe.

There were insufficient staff to provide the care and support that people needed.

People's alarm bells were out of reach.

Staff did not understand safeguarding or make all appropriate referrals to the local authority.

Inadequate

Is the service effective?
The service was not effective.

People were given insufficient choice of food and drink.

Staff training was ineffective.

Staff did not receive regular supervision.

Requires Improvement

Is the service caring?
The service was not caring.

People's privacy and dignity were not always maintained.

Staff failed to interact with people when providing care and support to them.

People's friends and relatives were free to visit at any time and an advocacy service was available to support people.

Requires Improvement

Is the service responsive?
The service was not responsive.

People did not receive the care and support at the times they needed this.

Support plans were not always effective.

The complaints system was ineffective.

Requires Improvement

Is the service well-led?
The service was not always well-led.

There was no registered manager in post.

People did not know the name of the temporary manager supporting the home.

The quality assurance system was ineffective.

Requires Improvement

Potton House

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.

This inspection took place on 20 October 2014 and 24 November 2014. Both visits were unannounced.

The inspection team was made up of three inspectors, a Specialist Advisor and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience in caring for a person living with dementia.

Before the inspection, the provider completed 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. We looked at the notifications that the provider had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with nine people who lived at the home and two relatives of people who lived there. We also spoke with the deputy manager, the provider's operational manager, five care workers, a nurse, the activities officer, the maintenance person, who also did the cleaning, and a GP who was visiting people who lived at the home. We reviewed the care records for five people who lived at the home and the recruitment files for two members of staff. We also reviewed management records on premises and quality.

We carried out observations and used the short observation framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex needs.

Inadequate

Is the service safe?

Our findings

When we carried out our last inspection in April 2014, we found that appropriate standards of cleanliness had not been maintained. During this inspection we found that the provider had implemented new cleaning schedules and employed staff to fulfil this role without impacting on the delivery of care.

Staff we spoke with were able to demonstrate a good knowledge of infection control procedures, including hand washing and the use of personal protective equipment, such as gloves and aprons. We observed that contaminated waste was disposed of appropriately.

We noted that one large reclining wheelchair had a torn cover on the footrest. This had exposed the foam filling which posed a risk of infection as it could not be cleaned effectively. We brought this to the attention of the provider's operational manager who arranged for a temporary cover which could be cleaned to be placed over the footrest immediately. Later in the day they showed us confirmation that a replacement chair had also been ordered.

During our previous inspection in April 2014, we found that there was insufficient staff to provide care and support to people. The provider told us that they would review the levels of staffing to address this. However on this inspection we found that, although staffing levels had been increased, there was still not sufficient appropriately trained staff on duty at all times.

People we spoke with told us that they felt safe at the home although they did not think there was enough staff to meet all their needs. One person told us, "The staff are always too busy to talk." A relative told us, "I come every day. If I didn't come what would happen?" Staff also told us that there was not enough staff. One member of staff said, "Staff are very good but there are not enough of them. It seems very disorganised."

Minutes of a senior team meeting in August 2014, showed that the required staffing level had been determined as one care worker for every three people who lived at the home, unless people had been assessed as requiring one to one care. The deputy manager told us that there should be eight care workers on duty as well as a nurse. However there were only five care workers available on both days of our inspection because staff sickness and other absences had not been covered. In addition, one of the five care workers on duty had been unavailable for much of one day as they had escorted a person to hospital. A relative said, "The big problem here is understaffing. There are only four today."

The deputy manager told us that two of the 23 people who lived at the home required one to one support because they displayed behaviour that had a negative impact on others, and a number of other people also displayed such behaviour. We noted that one of the two people, who required one to one support, was left alone and without the appropriate level of monitoring and support for much of one morning. They wandered around the home unaccompanied, which increased the risk of incidents occurring which harm them or others. A member of staff told us, "My main concern is staffing levels. It's not fair on residents or staff."

Throughout our inspection there was little visible staff presence. There was a delay in a care worker attending to an individual after they had used their call bell and we could hear that they were becoming distressed as their needs became more urgent. We also noted that at times people in one of the lounges were left alone, apart from a care worker who was on one to one duty with a person who was in the lounge. One person told us, "They put the television on and then they go. You don't see them again." We saw that the care worker had to leave the individual they were caring for to attend to another person who had fallen in the lounge. A member of staff said, "The biggest challenge is being able to give 100 per cent within the existing staffing levels."

The lack of sufficient staff to meet people's needs was a continued breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that there was a noticeboard that had a range of information for people and their relatives including information on safeguarding and the name of the lead person for safeguarding at the home. This information was, however, out of date as the named person no longer worked at the home. We asked staff about their knowledge of safeguarding procedures. Staff we spoke with were able to demonstrate only a very limited knowledge of safeguarding, the procedures or the types of abuse that people may suffer. We also found that people were not protected from the risk of neglect. We noted that people could either not always reach their call bells, or call bells

Inadequate

Is the service safe?

were not visible in people's rooms. We saw that in some rooms the call bells were situated at the foot of people's beds and in others on the opposite side of the room. One person was heard to be calling out for attention for quite a while without being responded to. During a review of accidents and incidents we found that the provider had failed to notify the safeguarding authority or CQC of all incidents that had occurred.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had developed risk assessments and management plans with people to enable them to have as much independence as possible whilst keeping them safe. We saw that a number of people exhibited behaviour that had a negative impact on others or put others at risk. For these people, risk assessments identified the triggers to the behaviour as well as strategies to cope with it. The risks assessed included those connected with people's health conditions as well as those in connection with their care, such as the use of bed rails. Where this was required we saw the risk was assessed and discussed with people and their relatives and alternative methods, such as the use of crash mattresses by the side of the bed were agreed. Each person also had a personal emergency evacuation plan in place that had been reviewed regularly.

We saw that there were processes in place to manage risk in connection with the operation of the home. These included areas such as fire risk assessments and a fire drill had been completed in July 2014. This tested the personal emergency evacuation plans in place for people. These risks had been reviewed and updated regularly. Necessary checks were in place to reduce risks, such as the testing of emergency lighting and fire alarms, and had been completed on a regular basis. This demonstrated that the environment was managed in such a way as to keep people safe.

People's medicines were managed and administered appropriately. We observed as people were given their medicines at lunch time and noted that the nurse responsible for administering medicines was constantly interrupted to assist in supporting a person who was distressed. This distraction presented an increased risk of errors occurring. We checked the medicines administration record (MAR) for one person and found that this had been completed accurately.

We also completed a stock reconciliation of one person's medicines and found that the stocks held matched the information in the records. We found that medicines were stored appropriately and at suitable temperatures. Controlled drugs were stored, administered and recorded correctly. We saw that a number of people were given their medicines covertly as they would not otherwise take them. We saw that, where this was the case, there was a record of the best interest's decision and the involvement of relatives and the GP in making it. There were also records of consultations with the pharmacist and healthcare team about the decisions.

We looked at two staff files and noted that robust recruitment and selection processes were in place. We found that pre-employment checks had been completed to ensure employees were suitable for the role in which they were employed.

Requires Improvement

Is the service effective?

Our findings

When we inspected the home in April 2014 we found that it was not clear whether consent to care had been obtained in line with guidance and legislation. During this inspection we found that consent had been obtained appropriately.

CQC is required by law to monitor compliance with the Deprivation of Liberty Safeguards (DoLS) requirements of the Mental Capacity Act 2005 (MCA). The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. Records showed that staff had received training on MCA and DoLS. When we spoke with staff they were not always able to demonstrate an understanding of either. One member of staff told us, "I don't think I have done training in MCA or DoLS."

We did, however, see that the requirements of MCA were being implemented. People's capacity to make and understand the implication of decisions about their care was assessed and documented within their care records. We saw that one person had been assessed as lacking capacity to make decisions about their care and treatment. Best interest decisions had been made in consultation with their relatives, healthcare team and GP which were documented within their care records. Staff were clear that where people had capacity to make decisions, their wishes should be respected. For example, one person chose to stay in bed all day. A member of staff told us they were, "…respecting choice and that is what [they] wanted to do."

We found that the provider was meeting the requirements of DoLS and the manager had made appropriate applications to the local authority.

People had mixed opinions about the food and drink that they were provided with. One person told us, "Sometimes the food is good, sometimes it is terrible, really terrible. We used to have a choice but not anymore. We just have what we are given." Another person told us, "You just have to take what they give you."

We observed that lunch appeared to be very disorganised. Only four people sat at tables. The remainder were either sat on chairs and settees which made it more difficult for them to eat their meal. People were not offered any choice of either main course or dessert. Only the four people seated at the table were offered any drink before, during or after their meal. People's food was placed in front of them and they were not told what it was unless they asked. People were presented with large amounts of food on their plates, and were not given time to eat it before they were offered more. Jugs of fresh juice were available, but these were just left on the trolley on which dirty plates, cutlery and food waste were placed after people had eaten. One person was given their food but left it and went for a walk instead. No attempt was made to encourage them to return to their meal.

We observed that there was little interaction between staff and people who required assistance to eat their meals. One person sat at one of the tables asked for help to eat their dessert. No one was available to give them the support requested, and the food was eventually spilled on the floor.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not confident that staff were well trained. One person told us, "They don't know much" but went on to say, "They are okay I suppose. A relative commented, "They don't seem to have much experience. That's the trouble, they don't understand."

Staff we spoke with told us that they had received various training to develop their skills, including training in the care of people living with dementia which had been included in their induction programme. One member of staff told us, "I have an induction folder which I am working through at the moment. I have spent time shadowing a Senior Carer. I am learning on the job. I have done all my mandatory training apart from dealing with challenging behaviour, but this is partly covered through dementia training." Another member of staff said, "I am on my induction at the moment. I am working alongside [staff] who is very experienced. It's going fine." We saw that staff operated procedures in accordance with their training when they assisted people to safely move around the home. However, there was evidence that some of the training received had been ineffective. Two of the four staff we spoke with had told us they had received training in safeguarding but were unable to demonstrate a sound knowledge of this.

Although one staff member, who was in their induction period, told us that they had received supervision, we found no permanent staff had received an individual supervision since July 2014. The records showed that group supervision had taken place in September 2014, for which there was a standing agenda. The records indicated

Requires Improvement

Is the service effective?

that there was no contribution to this session from staff or actions for team development recorded. The operational manager told us that staff were supposed to have individual supervision on a regular basis so that their performance and areas for development and improvement could be discussed. Staff had not received effective training and development or supervision.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that they were supported to maintain their health and well-being. One person told us they could see a doctor if they wanted to and if they had an appointment, "…someone would take me." We saw that staff had accompanied one person to their hospital appointment on the morning of our inspection. One person told us they were to see their dentist later in the week. We spoke with the GP who visited people at the home regularly. They provided positive feedback about the staff and the home. People's care records showed that they had access to other healthcare professionals, such as an optician and records showed that people's weight was monitored and, where appropriate referrals, had been made to a dietician and speech and language therapists.

Requires Improvement

Is the service caring?

Our findings

We saw that people's dignity was not always protected. We saw that after breakfast people had been left sitting in the dining area with congealed plates of unfinished food for at least 45 minutes before they were cleared away. We also noted that people were left wearing the soiled clothes protectors for a long time after their meal was finished. People who needed assistance to wipe their faces after they had eaten also waited for quite a while before this assistance was given to them.

We observed two staff assist a person to move without any communication, they failed to explain what they were doing or where they were moving to. We also observed staff were talking with each other rather than engaging with the people they were supporting at meal times. We noted that some staff were abrupt and dismissive in their approach to people. For example, as one person was being given a cup of tea and some biscuits, this was just put in front of them and the staff said, "Cup of tea." Staff failed to acknowledge or speak with people as they passed them in rooms or corridors. People told us that they did not know the names of the staff who cared for them. One person said, "I don't know their names. They just wear uniforms."

We saw that people's privacy was also not always protected. Throughout our inspection staff failed to knock on people's doors and entered rooms without permission.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

However in contrast, observations of some staff showed that some interactions were positive. People were taken to their room for personal care and were well presented. One relative told us, "My [partner] is kept spotless. I come every day. Overall, I think the care is good." We observed two staff as they assisted people. They clearly explained to them what they were going to do and talked with them as they assisted them. We spoke with one member of staff who told us one person who lived at the home was, "…just like a member of my family."

People told us that the staff were kind and caring. One person told us that staff, "…were quite nice." Staff we spoke with were able to describe how they cared for people appropriately, understood their needs and treated them with respect. One member of staff told us, "I treat people how I want to be treated. For example I find out how people like to be addressed. I am aware of triggers [for behaviour that had a negative impact on others or put others at risk] and am discreet when providing personal care."

Records we looked at contained evidence that, where they had been able to, people or their representative had been involved in making decisions about their care and developing their care plans. Relatives told us that they were welcome to visit the home at any time. One relative told us that they came every day at lunchtime and the home provided meals for them. Another relative told us, "I have the code to the front door so I can come and go whenever I want." The care records included information on people's life histories, personal preferences and significant relationships. When people did not have a friend or relative to support them, they had access to advocacy services. Information about the advocacy service was included on the noticeboard for people and their relatives. The deputy manager told us that the advocacy service attended the home once a month and spoke to everybody who lived there. They talked to people and their relatives and attended meetings on their behalf.

Requires Improvement

Is the service responsive?

Our findings

During our previous inspection in April 2014 we found that people did not receive the care and support they required at the time that they wanted it. During this inspection we found that this situation continued.

We observed many people stayed in bed all morning with little or no contact from staff, while they waited for assistance to get up. Some people were still being assisted at 1.30pm. One relative told us, "My [partner] didn't get up until 1.00pm." Another relative expressed concerns that if someone became distressed the staff had to deal with it and that meant there was a risk that other people's needs would not be met.

Before people moved into the home their needs had been assessed to ensure that the home could meet them. However they did not always receive the care and support they needed. Although records accurately reflected people's individual needs and were updated regularly with any changes as they occurred, one staff member told us that these were impracticable and unrealistic, and we observed that people were left without the care and support they required. We also saw that some people wandered around the home and entered other people's rooms. One person, who was alone despite having been assessed as requiring one to one care, was seen exiting someone else's room although they should have been under constant care and supervision.

We saw that there was little to keep people occupied. One person told us, "I stay in bed all day because there is nothing to do." Another person said, "There's nothing much to do." A third person told us, "I don't do much with my time." We noted that one person remained seated at the table for over four hours and another was slumped on a settee for most of the day, although staff did try to make them more comfortable by using cushions to support them.

One of the relatives told us that sometimes a few people got together in the activity room and took part in activities but there weren't any activities in the main room that they had seen. One member of staff told us, "There is not enough for people to do. I would love to do more activities but there is too much for us to do. People look bored."

We spoke with the activities co-ordinator who worked week days only, however we noted much of their time was spent carrying out care tasks. They showed us their timetable for activities with people which included the opportunity of one to one activities to support them with their hobbies or interests, although this time was limited to approximately an hour every four to five weeks. This was insufficient and did not provide an effective programme of meaningful activities for people.

They told us that the home shared a minibus with another home in the group and there had been regular outings, such as three trips to a local garden centre during the summer. However, the number of people who could participate in the outings was limited by the size of the transport available. The minibus could only accommodate one of the large wheelchairs that people used.

This was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that the provider had a complaints system, however this was ineffective. People and their relatives were provided with information on how to make a complaint. However, some people told us that they did not know who to complain to if they wanted to. One person said, "What's the point? It won't change anything." Another person, when asked if they had complained about anything, said, "No I wouldn't do that." One relative told us they had complained about the time their relative got up. They said this had not been resolved because, "They can't do anything about it. They have not got enough staff." Complaints that had been dealt with locally had not been recorded. According to the provider's policy, serious complaints were sent to the provider's head office but the manager confirmed that none had been received.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service well-led?

Our findings

Our findings

When we inspected the home in April 2014 we found that the provider's systems to identify, assess and manage risks to the health, safety and welfare of people were ineffective.

During this inspection we found that the deputy manager had regularly completed audits in a wide range of areas to identify, monitor and reduce risks, such as environment and infection control. They also completed checks on key areas such as the monitoring of people's weight, levels of dependency and the prevention of pressure ulcers, on a monthly basis. However, they had failed to maintain oversight of some aspects of care delivery and staff development. Where audits had taken place we saw that action plans were developed and monitored where appropriate. These recorded when and by whom the required action had been taken.

The home was going through a period of uncertainty. The provider had arranged a number of meetings that were to be held for people to discuss their concerns. The registered manager of the home had recently left and a temporary management structure was implemented to support the home through this period. Although none of the people we spoke with knew the name of the manager, staff we spoke with told us that they felt supported by them. One member of staff told us, "It's a nice team. I feel supported." Another described the manager as "…supportive" and "…fantastic." They described the deputy manager as, "…lovely and very supportive."

Staff understood their responsibilities and what was expected of them. They attended regular monthly meetings where they were encouraged to contribute to discussions about the home and driving improvements. Records showed that topics recently addressed had included the progress on the action plan sent to the CQC following our last inspection and best interest decisions. Staff were also aware of the provider's whistleblowing policy and knew how to raise any concerns about care practices which could put people at risk.

We saw that the provider held meetings for relatives of people who lived at the home. The minutes of these showed that there was an advocate who spoke on behalf of people who did not have a representative. The meetings covered topics such as the management of the home, activities, menus and suggestions for improvements. The operations manager told us that undertakings had been made following these meetings which included an increase in the portion size of people's meals and a care worker always being in the lounge area to supervise people. This latter undertaking was not being fulfilled and the provider had therefore failed to respond to relatives' concerns appropriately. There were periods when people were left totally unsupervised in the lounge area and subsequently had no one to assist them when they needed it.

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider failed to take reasonable steps to prevent abuse from happening by failing to provide effective training in safeguarding for staff. The provider also failed to respond appropriately to allegations of abuse.** **Regulations 11 (1) (a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The provider failed to provide a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs.** **Regulation 14 (1) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider failed to ensure that staff received effective training and supervision to enable them to provide care and support safely.** **Regulation 23 (1) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	The provider failed to ensure that people's privacy and dignity were maintained. Staff failed to knock on people's doors before entering and left them soiled for long periods after they had finished their meals. Regulation 17 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The provider failed to have an effective complaints system in place. Regulation 19 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider failed to take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to provide for people's needs. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider failed to ensure that the delivery of care met people's individual needs and ensured their welfare and safety. Regulation 9 (1) (b) (i) and (ii).