

Avens Ltd

St Anthony

Inspection report

St Anthony
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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Summary of findings

Overall summary

We inspected St Anthony on the 23 February 2017 and the inspection was unannounced. St Anthony is a residential care home which provides support and personal care for up to 29 people who have a learning disability. At the time of our inspection there were 25 people using the service. The service is accommodated over three floors and arranged into three flats. 'Beacon view' which accommodated six people; 'Forest view' which accommodated six people and tree top flats which accommodated five people. The service also had a variety of single studio rooms and flats which people lived in.

The service had 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. The registered manager was not present on the day of the inspection and had been off for a period of time due to sick leave. An acting manager was overseeing their post.

At the last inspection on the 18 July 2016, the service was rated Good overall and Requires Improvement in the 'safe' domain. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach of Regulation 12 of the Health and Social Care Act Regulated Activities Regulations 2014, Safe care and treatment. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Anthony on our website at www.cqc.org.uk

At this inspection we found the service had made improvements to the management of medicines. However, we found new concerns in relation to the management of risk and supporting people to remain safe. The rating for the safe domain of this service will remain as 'Requires Improvement'

The service had made improvements since the last inspection to the management of medicines. Medicines were administered safely and medication administration records (MAR) had no unexplained gaps or omissions. Medicines were stored safely and at the correct temperature. There were clear guidelines in place when people needed medicines and 'as and when' basis. However, we have made a recommendation on the management of pain for people with limited communication.

Before the inspection, we received information of concern that the management of choking was potentially not robust. We found that a range of risk assessments was in place. However, clear guidelines were not consistently in place to manage the risks associated with choking, skin breakdown, moving and handling and hot water. We have identified a new breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of the report.

Staff knew how to recognise and respond to abuse. There had been no safeguarding incidents since our last inspection. Regular health and safety checks were undertaken to ensure the environment was safe and equipment worked as required. Regular fire drills were completed.

There was enough staff to keep people safe. Staff were checked before they started working with people to ensure they were of good character and had the necessary skills and experience to support people effectively.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

We found that action had been taken to improve the management of medicines. However, robust risk assessments were not consistently in place. For example, risk assessments failed to provide sufficient guidelines for staff to follow and not all risks associated with skin breakdown, choking, moving and handling and hot water had been mitigated.

Regular checks were carried out on the environment and equipment to ensure it was safe and fit for use.

There was enough staff to keep people safe. Thorough recruitment procedures were followed to ensure staff were suitable for their role.

Staff had received training and knew how to recognise and respond to different types of abuse.

Requires Improvement 

St Anthony

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of St Anthony on 23 February 2017. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our 18 July 2016 inspection had been made. The team inspected the service against one of the five questions we ask about services: is the service safe? This was because the service was previously not meeting some legal requirements. This inspection was carried out by two inspectors.

The provider had not completed a Provider Information Return (PIR), because we had not requested one before this focused inspection. This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. Before the inspection we reviewed all the information we held about the service; we looked at previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the acting manager, the director of operations and four staff members. We looked at six care plans and the associated risk assessments and guidance. We looked at a range of other records including medicines records and audits, maintenance records, two staff recruitment files and staff rotas. We observed people receiving their morning medicines. Some people were unable to tell us about their experience of care at the service so we took time to observe how people and staff interacted.

We last inspected this service on 18 July 2016. Breaches in the regulations were identified at this inspection and the service was rated as 'Good.'

Is the service safe?

Our findings

Due to communication needs, some people were verbally unable to tell us if they felt safe living at St Anthony. Observations of care demonstrated that people were comfortable in the presence of staff. People's behaviour also showed us they felt safe. For example, the interactions and communication with all of the staff were open and warm. People freely approached staff and responded to staff with smiles. Despite these positive interactions, we found areas of care which were not consistently safe.

At our last inspection in July 2016, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because medication administration records (MAR) charts contained unexplained omissions and the provider's medicine reference guide was out of date. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by August 2016. At this inspection, we found improvements had been made and the provider is now meeting the requirements of the regulation.

Medicines were stored, administered, recorded and disposed of safely. Since the last inspection, improvement had been made to the storage of medicines. Medicines were now securely stored on each floor which had been approved by the supplying pharmacist. The pharmacist had also provided dedicated bags for staff to use to safely transfer medicines from the storage room to people's individual bedrooms. Observations of medicine administration demonstrated this was done safely and discreetly. When supporting people to take their medicines, staff brought along the MARs and signed these once people had been supported to take their medicines. People's individual MAR charts included information on any allergies, their GP and how they liked to receive their medicines. There were no gaps or omissions in people's MAR charts. For people prescribed anti-psychotic 'as required' (PRN) medicines, clear protocols were in place which provided guidance to follow before administering the medicines and the maximum dosage which could be provided in a 24 hour period. However, for people prescribed 'as required' pain relief, clear protocols were not consistently in place. Pain assessments were also not in place to demonstrate whether people with limited communication could express if they were in any pain, or the signs to look out for which may indicate they were experiencing pain.

We recommend that the provider seeks guidance on nationally guidance pain assessments.

A robust medicine policy was now in place and staff's ability to administer medicine safely had been assessed. Staff's competency assessments in medicines were reviewed annually. Medicines were labelled, dated on opening and stored appropriately. Medicine fridge and medicine room temperatures were monitored daily to ensure they remained within safe levels. Medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of following safe procedures. A member of staff completed weekly medicine audits and where people were prescribed emergency medicine (to be administered in the event of seizure), systems were in place to ensure this medicine was in date. Where it was necessary for medicines to be taken out of the home, appropriate arrangements were in place for logging them in and out of the home. Systems were also in place to manage and reflect on any medicine errors. Following any medicine error, an investigation took place and the staff members' competency to

safely administer medicines was also reassessed. There had been four medicine errors since the last inspection. Documentation confirmed that all errors and outcomes were shared with staff members to learn and reflect on the errors.

A range of risk assessments were in place which covered areas such as hot water, swallowing cleaning products, injury to self, challenging behaviour and drowning. However, the provider had not consistently consulted nationally recognised guidance, such as the Health and Safety Executive Guidance (HSE), nor used assessment tools such as Waterlow Score (tool for assessing skin breakdown) and MUST tool (tool for assessing malnutrition). For example, where people required a hoist to move and transfer, a moving and handling risk assessment and had not consistently been completed. One person's care guidelines included guidance but failed to make reference to the sling size required and the loop attachments of the sling which should be used. Another person's care plan and subsequent risk assessment did not include information on a safe moving and handling plan. Staff demonstrated a strong knowledge of how to safely move and transfer people and confirmed people had their own individual sling which was kept in their bedroom. Staff also told us how they received face to face training on how to support people to move and transfer with the support of a hoist. People had individual bathing risk assessments, however, guidance not did always consider whether people's sensitivity to water temperature was impaired; if they would be able to advise if the temperature was too hot, if they would be safe to be left alone in a bathroom with the bath running, or if they are likely to add water if unattended or whether the person would be able to react to hot water.

Some people were at risk of skin breakdown and required input from the district nursing team to manage this risk. For example, one person had input from the district nursing team in November 2016 when they had a sore on their left heel. However, a pressure area risk assessment had not been completed. Therefore, guidance was not available on how to manage the risk of skin breakdown and what actions were required, such as application of barrier cream or when to seek advice from the district nursing team. Where people had been assessed as at risk of choking, the risk assessment advised, 'service user has been assessed by speech and language therapy as risk from choking on food/drink.' The analysis of risk included, 'service user care plan and guidelines to be followed in their room to prevent them from risk of choking/dehydration. This has been assessed by speech and language. Any changes refer to the GP.' However, information was not recorded on what these changes may look like or the signs staff should look for, such as coughing when eating and drinking. We brought these concerns to the attention of the acting manager who agreed there was a lack of guidance on when a speech and language therapist would need to be contacted. They were open to our concerns and started to update risk assessments during our inspection.

Staff were knowledgeable about people's individual needs and the risks associated with their care routine, however, failure to have robust risk assessments in place is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Guidance produced by the Epilepsy Society advises that epilepsy is more common in people living with a learning disability. People's care plans clearly indicated whether individuals were living with epilepsy, and this was also referenced in people's risk assessments under various headings. Staff were knowledgeable about the risks associated with epilepsy and how to spot the signs of a seizure. One staff member told us, "We are aware of people's seizure patterns. For example, we have one person who shows clear signs that indicate they are about to experience a seizure, once we spot those signs, we support them into a safe place and follow the necessary guidance." Epileptic seizure monitoring charts were in place along with seizure reports. This demonstrated that the overall management of epilepsy and seizures was safe.

Two new staff had been recruited since the last inspection. Recruitment practice remained safe and thorough to ensure that staff were suitable to work with people. Written references were obtained and

checks were carried out to make sure staff were of good character and were suitable to work with the people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff carried out regular health and safety checks of the environment and equipment to make sure it was safe to use. These included ensuring that electrical and gas appliances were safe. Water temperatures were checked to make sure people were not at risk of scalding. Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working properly. People had personal emergency evacuation plans (PEEP) and staff and people were regularly involved in fire drills. A PEEP sets out the specific physical and communication requirements that each person has to ensure that they can be safely evacuated from the service in the event of an emergency.

Staffing numbers remained sufficient to meet people's needs in a safe and timely manner. Our own observations supported that there were sufficient numbers of staff available. Staffing rotas indicated that enough care staff were deployed during the day, at night time and at weekends. Staffing levels consisted of nine staff members in the morning, eight in the afternoon and two at night. Staff and people confirmed that staffing levels were sufficient. One staff member told, "Staffing levels are good, we help each other out and never rush the 'residents.'"

There were policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment. Regulation 12 (2) (a).</p>