Leonard Cheshire Disability

St Anthony's - Care Home with Nursing Physical Disabilities

Inspection report

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Date of inspection visit:
23 September 2016

Date of publication:
08 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At the last comprehensive inspection on 25 April 2016, we asked the provider to take action to make improvements. We found concerns that people had to wait for support with their care needs and risks to people were not managed in a safe way. We found people did not receive their medicines safely. We also found when people were unable to consent capacity assessments and best interest decisions were not always completed. We could not be assured the provider was notifying us about significant events that occurred within the home and we did not see how information was used to bring about improvements to the service. At this inspection we found some areas of improvement however more improvements were needed.

The service was registered to provide accommodation for up to 34 people. At the time of our inspection 29 people were using the service.

There was a registered manager 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 2008 and associated Regulations about how the service is run.

Risks to people were not always fully considered. When people displayed behaviours that may harm themselves or others the actions that were in place were not always effective in reducing the risks. We found evidence to suggest that other health professionals did not devise or agree with the strategies that were being used.

When people lacked capacity to make decisions for themselves we saw capacity assessments were sometimes unclear. When people were being restricted unlawfully this had not always been considered by the provider. We could not be assured the provider was working with in the principles of MCA or fully understood this.

The values of the service did not always offer a person centred approach and concerns with the culture of the home were identified, for example people's privacy and dignity was not always upheld.

The systems that were in place to monitor the quality of the service were not always effective. When concerns had been identified we could not always see this information was used to drive improvement.

People felt safe and staff knew how to recognise and report potential abuse. Staff shared knowledge of people to help offer them support. The provider ensured staff suitability to work within the home. When needed people received support from health professionals and they were happy with the food and the choices available. People were given the opportunity to participate in activities they enjoyed.

Medicines were managed in a way to protect people from the risks associated to them. There were enough

staff available for people and they did not have to wait for support. When people were able to mobilise independently they told us they made choices about their day and were encouraged to be independent

Staff felt listened to and were given the opportunity to raise concerns. People knew who the registered manager was and how to complain. The provider understood their responsibility with us and notified us of significant events with in the home.

We found breaches 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 this 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.
In some instances risks to people had not been fully considered. When people had behaviours that may cause harm to themselves or others the actions that were put in place were not always effective to reduce the risks. There were enough staff available for people and they did not have to wait for support. Medicines were managed, administered, stored and recorded to ensure people were protected from the risks associated to them. People felt safe and were happy with the way they were treated. Staff knew how to recognise and report abuse. The provider ensured staffs suitability to work within the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.
People's capacity assessments were not always clear. When people were being unlawfully restricted this had not always been considered. Staff received training and induction that helped them to support people. Choices of food and drink were offered to people. People received support from health professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.
People's privacy and dignity was not always upheld. When people were able to mobilise independently they made choices how to spend their day and were encouraged to be independent. People and relatives were complimentary about the staff and people were treated in a kind and caring way. Relatives and friends felt welcomed and were free to visit at any time.

Is the service responsive?

Good

The service was responsive.
People were involved with the reviewing of their care. People were given the opportunity to participate in activities they enjoyed. People were happy with the care they were given. People and relatives knew how to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well led.
The systems in place were not always effective in identifying areas of improvement. When improvements had been identified we did not see action had been taken. Records were stored securely and we were notified about significant events that had happened within the home. Staff felt supported and people knew who the registered manager was.

St Anthony's - Care Home with Nursing Physical Disabilities

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 visit took place on the 23 September 2016 and was unannounced. It was carried out by two inspectors. We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public. We used this to formulate our inspection plan.

On this occasion we did not ask the provider to send us 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. However we offered the provider the opportunity to share information they felt relevant with us.

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We spoke with eight people who used the service, two relatives, three members of care staff, a registered nurse and an agency staff member. We also spoke with the registered manager. We spoke with five healthcare professionals on the telephone to gain their views about the care and to check that standards of care were being met.

We looked at the care records for five people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including

quality checks.

Requires Improvement

Is the service safe?

Our findings

At our focused inspection of St Anthony's on 2 August 2016, we found concerns that people did not receive their medicines safely. This was a continuing breach of Regulation 12 (2) (g) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We also found that people had to wait for support with their care needs and risks to people were not always managed in a safe way. This constitutes breaches of Regulation 18 and 12 (2) (b) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

At our last focused inspection risks to people were not always identified and managed in a safe way. At this inspection some improvements had been made; however, we identified further areas of concern. At the last inspection we found when people did not have access to support or call bells, risks had not been considered and risk assessments were not in place. At this inspection we found that when people did not have access to call bells risk assessments had been completed and checks introduced to ensure people were safe. However, the provider had not considered that because they had increased the staffing levels this had eliminated the risks to people and were still implementing the checks. This meant we could not be sure the provider understood when people were at risk. Furthermore at the last inspection we observed that one person wore a call bell around their neck. There were no risk assessments in place for this person and the person did not have the physical dexterity to use this alarm. At this inspection we saw that it was still around the person's neck. We spoke with the registered manager who told us this alarm was for this person's visitors so they could summons assistance if needed. We looked at the risk assessment for this person it did not state that the person's visitors should summons assistance using the alarm, if needed. During the inspection there were staff present in the communal area with this person. Therefore, the person had a hazard around their neck which served no purpose in reducing risk. This demonstrated that in this instance risks to people had not been fully considered.

At this inspection we found that when people had behaviours that may cause harm to themselves or others the actions that were put in place were not always effective to reduce the risks. For example, we saw a behaviour management plan was in place for one person which included information about how certain behaviours should be managed. This included information such as 'if [person] refuses [medicines] when they are due to do go out then they shouldn't go out'. We could not see how the information in the plan would help staff to investigate what the triggers for the behaviour were, or how to ensure that they did not recur. Records we looked at confirmed that the person continued to cause harm to themselves. We spoke with the registered manager about this plan and they told us this had been implemented by other health care professionals.

We spoke with the healthcare professionals who stated that the behaviour management plan was not something they implemented or promoted. One health professional told us, "We are concerned about the punishment strategies that the service have implemented". They also said, "Until the service and staff have understanding of the behaviours it will be difficult to reduce the risk associated with this". They commented about recent training that had taken place for staff at the service. They said, "They wanted to know how to stop the behaviours. It's about managing these behaviours and reducing the risks for the person and not stopping them". Another health professional told us that they were working with the service to complete a

behaviour management plan but had found this problematic due to the culture of the home and the lack of communication. They said they were, "Not confident" with a behaviour management plan in place the service and staff would be able to offer a consistent approach for this person and therefore unsure if the risks to this person would be reduced. Therefore we could not be sure the behaviour management plans, staff understanding and the communication systems that were in place would be effective in reducing the risks to the person.

This is a breach of Regulation 12 (a) (c) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

At our last inspection people had to wait for support and the high use of agency staff was impacting on the care they received. At this inspection the provider had made the necessary improvements because they had increased the staffing levels. We saw and the registered manager confirmed there were now an extra two care staff on each shift. The registered manager confirmed this would be increased to three when the people who were absent from the service returned. The registered manager also told us they had recruited permanent staff and were reducing the amount of agency staff that was used within the service. People and relatives we spoke with told us about the positive impact this had on them. One person said, "Things have improved so much, just look around its so much better. These additional carers have made so much difference. Everything is so much quicker". Another person told us, "Staffing levels have drastically improved and there is not so many agency staff". A relative said, "I thought it was okay before, but now there are more staff I realise it wasn't. There is always someone around now if you need them and there seems to be more going on for people". Staff told us how the increase in staffing had improved things for people. One staff member said, "For us as staff it's better, you feel you have time. You don't feel like it's a conveyor belt. We have time for people now, just to listen and have a chat and that is priceless". We observed that staff were available for people and spent time with people chatting. When call bells were pressed we saw these were responded to in a timely manner. One person said, "We don't wait as long now when we buzz, it's much better". This showed that there were enough staff available for people and they did not have to wait for support.

At our last inspection we found medicines were not managed in a safe way. At this inspection we found the provider had made the necessary improvements. One person said, "The nurses have always looked after my tablets for me, they are the best placed people to do this as they know what they are doing. I always have them when I should, they never forget". We saw staff administering medicines to people in a safe way. Staff spent time with people ensuring they had taken them. We saw that when people were prescribed medicines on 'as required basis', there was guidance in place for staff to show when these should be given. Since our last inspection the provider had introduced systems to ensure any medicine errors were identified. The registered manager told us that they completed checks weekly. On the day of inspection a full audit was being undertaken by a staff member. They told us the areas they were looking at. They said, "We check the stock levels to make sure they are correct, we also check the medicine administration records (MAR) to ensure there are no gaps. We document any concerns and report them to the senior managers". The provider had also arranged for the pharmacy to complete an audit and were following the action plan produced from it. We saw there were effective systems in place to store administer and record medicines to ensure people were protected from the risks associated to them.

People felt safe and were happy with the way they were treated. One person said, "I am well looked after here". A relative told us, "I can go home and not worry". Staff knew how to recognise and report potential abuse to ensure people were protected from harm. One staff member said, "It's making sure people are safe. Looking for changes like bruises or scratches or if they are quiet". Another staff member told us, "I would report any concerns to one of the managers or nurses. I know they would report it". We saw there was a

safeguarding policy in place advising staff what to do if they had concerns. We saw that when needed, concerns had been raised appropriately by the provider and safeguarding referrals had been made and this was in line with the provider's procedures.

There were safe recruitment processes in place. One member of staff who had recently started working at the service told us, "I had my DBS check they took a copy". The DBS is the national agency that keeps records of criminal convictions. The registered manager confirmed that they were waiting for checks from the staff they had recently recruited before they could start working within the home. This demonstrated the provider ensured staff were suitable to work with people who used the service.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection of St Anthony's on 25 April 2016, the provider was not working within the principles of The Mental Capacity Act 2005. When people were unable to consent, capacity assessments and best interest decisions were not always completed. At this inspection the provider had made some improvements however further improvement were needed.

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 or 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. People can only be deprived 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).

We checked to see if the provider was working within the principles of MCA. When people lacked capacity to make important decisions for themselves we saw that capacity assessments had been completed. However, some areas of the capacity assessments were unclear. In some mental capacity assessments, we saw that the same questions were asked to people to assess different areas of capacity. The mental capacity assessments did not always clarify whether people lacked capacity or not. Therefore, best interest decisions were agreed without clear capacity assessments. For example, to manage personal finances when the assessment had been about care and treatment.

For another person, we saw in their capacity assessments that they had been assessed as having capacity to consent to their care in relation to their care plans. One of the areas that had been assessed was in relation to the person wearing a lap strap, when in their wheelchair. The capacity assessment stated this person had capacity to make the decision to wear this. However, records we saw showed that the person often undid this lap strap and refused to wear it. Information recorded in the best interest's decision stated, 'staff have to do it up for them'. We spoke with the registered manager about this who told us the person did not have capacity in this area. As this was therefore a restrictive practice we asked if this had been considered as a DoLS. The provider had not considered this, nor considered that they were restraining this person. There were other areas identified for this person where capacity had not been considered. This meant we could not be sure the provider was always working within the principles of the MCA.

This is a breach of Regulation 11 and 13 (5) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014

People told us they enjoyed the food and there were choices available. One person said, "Meals are always good". Another person told us, "Its better food than I had at home". At lunch time we saw people were offered choices. When people were unable to make verbal choices staff told us how they offered support. One staff member said, "We have pictures and we show people". There were cold drinks available in the communal areas for people to access and hot drinks were offered to people at various times throughout the

day. We saw that there were snacks available and there was a range of sandwiches in the fridges for people to access. When people had specialist diets such as soft diets we saw this was provided for them to ensure their needs were met.

Staff received an induction and training that helped them support people. One staff member told us they were supporting new staff. They said, "We have lots of new staff so we are showing them the ropes. They watch us and then we help them and show them the way. We tell them about people so they know them". This showed staff shared knowledge of people. Another staff member told us they had recently undertaken training, They said, "It was useful it gives you a new way of looking at things for people. New ideas too".

People received support from healthcare professionals when needed. One person told us how they had recently had a swallowing assessment. We saw that, when needed, referrals had been made to health professionals including the GP.

Requires Improvement

Is the service caring?

Our findings

At our comprehensive inspection of St Anthony's on 25 April 2016, we found people were not always treated in a kind and caring way. At this inspection the provider had made some improvements however further improvements were needed.

People did not always have their dignity and privacy upheld. We saw that some people required their medicines via a percutaneous endoscopic gastrostomy (PEG). A PEG refers to a flexible feeding tube which is placed through the abdominal wall and into the stomach. Staff administered medicines to these people in communal areas. Due to the positioning of people's PEG's, staff had to adjust people's clothes in front of other people, staff and sometimes relatives. We also saw that there was a clothes rail in the communal area. On this rail were various items of people's clothing, including people's underwear, which had been misplaced in the laundry. There was a notice asking people to claim the items of clothing. This meant that people's dignity was not upheld. We observed a physiotherapy session taking place. People were receiving therapeutic support in the same area; at one point during the session we saw that five people were present. The door was left open and other people and visitors who were walking past the room were able to observe what was taking place. This demonstrated that people's privacy was not upheld.

This is a breach of Regulation 10 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

Where people were able to mobilise independently they told us they made choices about their day and were encouraged to be independent. One person said, "I choose to eat in my room". Another person told us, "I can go where I like, there are activities going on so I come up and have a look. I'm tired now so I am going to spend some time in my room". Staff gave examples of how they encouraged people to be independent. One staff member said, "Now we have more staff it's easier, we can spend time with people encouraging them to do things for themselves, even if it does take a few minutes longer. Like putting their socks on, this would be something we would do now, I say you can do that yourself". We saw that people were encouraged to be independent. For example one person requested a drink and they were encouraged to pour it for themselves.

People and their relatives were complimentary about the staff. One person said, "The staff are good. We have had new nursing and care staff who are coming on nicely". A relative told us, "The staff are good and friendly which is reassuring". We saw that people were supported in a kind and caring way. Staff asked people questions like, "Are you warm enough?" and, "Is the open window okay?" People were given the opportunity to respond and the relevant action taken was when needed.

Relatives we spoke with told us the staff were welcoming and they could visit at any time. One relative told us, "I come anytime I like, I have to travel quite far but I have never been asked to leave or anything". Another relative said, "They're always friendly to me when I pop up". We saw and staff confirmed that relatives and friends visited throughout the day.

Good

Is the service responsive?

Our findings

At our comprehensive inspection of St Anthony's on 25 April 2016, People were not involved with reviewing their care and we could not be sure complaints were responded to. At this inspection the provider had made the necessary improvements

People and their relatives were encouraged to be involved with the reviewing of their care. Since our last inspection the provider was working alongside a user group to review people's care. We saw information was displayed in the communal reception area showing the work that had been completed with people. The information included, 'What was working for people' and ''what was not working well'. The provider had an action plan that they were working towards completing. One person commented about the piece of work, they told us, "It's a different way of getting our opinions across, and it was an enjoyable day".

People knew how to complain and felt happy to do so. One person said, "I would have word with a staff member or manager". A relative confirmed they knew how to complain. We saw the provider had a complaints policy in place. We saw that when complaints had been made the provider had responded to these in line with their policy.

People told us they were happy with the care they received. One person said, "I'm very well looked after there are no mistakes". Another person told us, "There are lots of new staff, they are learning from the more experienced ones, I listen and you hear them telling them about me which is nice". This demonstrated staff shared important information about people. Staff told us they had a handover where they shared information. One staff member said, "It's a catch up so you are up to date on what happened since you have been home. It's good there are no excuses then when people say they don't know things".

People were given the opportunity to participate in activities they enjoyed. One person said, "I enjoy computers". Another person told us how they were involved with a poetry class which they enjoyed. We saw activities taking place including a bingo session. We observed one of the people who lived at the home was the bingo caller. Another person told us, "I've been persuaded to make up the numbers but I don't mind". Some people were currently absent from the service as they were on holiday on a cruise. There was information displayed in the communal areas about up and coming events people could participate in.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection on 25 April 2016 we found there were systems in place to monitor the quality of the service; however we did not see how this information was used to drive improvement. Systems in place to monitor and review care were not always effective. This was a breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found some improvements had been made but further improvements were needed.

Since the last inspection we found further quality monitoring and audits had been introduced. This included monitoring of call bells and medicine management. However, we did not see how this information was used to drive improvements to the service. For example, a monitoring of call bells had been introduced. The registered manager explained this process. They told us they looked at the call bell logs and reviewed them. They said that if a call bell was recorded to be going off for a long period, such as ten minutes plus, then they would speak to staff and find out the reasons for this. There were no records in place to confirm this and this information was not used to make changes to the service. Therefore we could not be sure this system was effective and that information was reviewed to bring about improvements to the service.

At the last inspection we could not be sure people were receiving prescribed medicines for epilepsy as promptly as they should. At the last inspection we found there were inaccuracies with recording of when these medicines were administered. At this inspection the registered manager told us that a new system had been introduced. They explained that all staff now had to wear a watch and the handyman completed weekly checks on all the clocks within the home. The registered manger confirmed these checks were not recorded. At this inspection we looked at epilepsy records for one person. We saw that since the last inspection on 2 August 2016 it was recorded that the person had three seizures. On two of the three occasions the documented time that had been recorded in the controlled drug book did not coincide with the protocol for this medicine. For example, on one occasion it was recorded in the persons file they had a seizure at 0346, It was documented in the controlled drug book that the medicine was administered four minutes later. The protocol for this person states that the medicine should only be administered after five minutes. We did not see that these recording errors had been identified through any audit. This meant we could not be sure the system that had been put in place to identify recording errors that were occurring within the home were effective.

The provider was displaying their rating, however this was not conspicuous as it was displayed in the corridor at the far end of the building. The report was displayed however the poster was at the back of the report and could not be seen. We discussed this with the registered manager who agreed this would be addressed.

At our comprehensive inspection on 25 April 2016, we could not be assured the provider understood the responsibility of their registration with us as they had failed to notify us of reportable incidents. This was a breach of Regulation 18 (4) (B) of Care Quality Commission (Registration) Regulations 2009. At this inspection we found the provider had made the necessary improvements. We reviewed the information we held about the service before the inspection and we saw that the service had notified us about significant

events that had occurred.

Staff we spoke with were happy to raise concerns and knew about the whistle blowing process. Whistle blowing is the process for raising concerns about poor practices. One member of staff said, "It's about raising anonymous concerns". We saw there was a whistle blowing procedure in place. This showed us that staff were happy to raise concerns and were confident they would be dealt with.

People told us they knew who the registered manager was and they were approachable. One person said, "Yes they are around I can pop in the office if I need anything". Staff told us they felt listened to and had the opportunity to raise their concerns. One staff member said, "We have team meetings. We have talked about the report [CQC] and the changes that have come from that". Staff confirmed they received supervision from their line manager. The registered manager understood their responsibilities around registration with us and notified us of significant events that had occurred at the service. This meant we could check the provider had taken appropriate action.

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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent When people lacked capacity to make important decisions for themselves we saw that capacity assessments had been completed. However, some areas of the capacity assessments were unclear. Best interest decisions were agreed without clear capacity assessments

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been fully considered. When people had behaviours that may cause harm to themselves or others the actions that were put in place were not always effective to reduce the risks

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We could not be sure the provider was working within the principle of MCA. When people were

being unlawfully restricted this had not been considered.