Pegmar Limited

St Annes Nursing 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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At our last inspection of 25 April 2017 and 2 May 2017 we rated St Annes Nursing Home 'Good' but the key question of Responsive was rated as 'Requires Improvement' due to people not having enough activities.

We undertook this unannounced focused inspection on 22 February and 1 March 2018. The inspection was in response to a number of concerns which were raised with the Care Quality Commission and by the local authority safeguarding team. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service effective and is the service well led?

St Annes Nursing Home is registered to provide accommodation and nursing care for up to 58 people. Many of the people using the service lived with dementia. On the first day of our inspection, there were 35 people living there.

There was a registered manager in place. 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.

St Annes Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Appropriate recruitment procedures were in place but not always followed by the registered manager. People received their medicines as prescribed but would benefit from staff having a deeper understanding of people's needs regarding the use of the medicines. Consent to care was not always sought in line with legislation and guidance. Infection control procedures were in place and the home was clean, with the exception of one piece of equipment. The provider did not always ensure that notifiable incidents were reported to the CQC. The provider had a quality assurance system in place to audit and monitor the quality of the service, however, this did not identify the issues of concern we found during the inspection. New staff received induction training and there was a training programme in place. However, some staff had not received up to date training. Staff were not always supported in their work through the use of supervision.

Procedures were in place to protect people from abuse and staff had completed training in safeguarding people. Risk assessments identified when people were at risk from every day activities. People were supported by sufficient numbers of staff.

People's needs were assessed and their preferences understood before they moved to the service. People were supported to eat and drink and most enjoyed their meals.
People had access to healthcare professionals when necessary. The building was purpose built to meet the nursing needs of people who lived there.

The registered manager demonstrated effective partnership working with other health and social care professionals. Lessons were learned and improvements made when incidents occurred in the home. The provider had sought the views of people living at St Annes Nursing Home.

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 always safe.

Appropriate recruitment procedures were in place but had not always been followed.

People received their medicines as prescribed but would benefit from staff having a deeper understanding of people's needs regarding the use of the medicines.

Procedures were in place to protect people from abuse and staff had completed training in safeguarding people.

Risk assessments identified when people were at risk from every day activities.

People were supported by sufficient numbers of staff.

Infection control procedures were in place and the home was clean, with the exception of one piece of equipment.

Lessons were learned and improvements made when incidents occurred in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

People's consent to care was not always sought in line with legislation and guidance.

New staff received induction training and there was a training programme in place. However, some staff had not received up to date training. Staff were not always supported in their work through the use of supervision.

People's needs were assessed and their preferences understood before they moved to the service.

People were supported to eat and drink and most enjoyed their meals.

People had access to healthcare professionals when necessary.

The registered manager demonstrated effective partnership working with other health and social care professionals.

The building was purpose built to meet the nursing needs of people who lived there.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not always ensure that notifiable incidents were reported to the Care Quality Commission.

The provider had a quality assurance system in place to audit and monitor the quality of the service, however, this did not identify the issues of concern we found during the inspection.

Staff understood the different roles of staff in the management team.

The provider sought the views of people.

The registered manager was open to learning and improving care following concerns or incidents.

St Annes Nursing Home

Detailed findings

Background to this inspection

At our last inspection of 25 April and 2 May 2017 we rated St Annes Nursing Home 'Good' but the key question of Responsive was rated as 'Requires Improvement' due to people not having enough activities.

We undertook this unannounced focused inspection on 22 February and 1 March 2018. The inspection was in response to a number of concerns which were raised with the Care Quality Commission and by the local authority safeguarding team. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service effective and is the service well led?

The inspection was conducted by two inspectors, a nurse 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.

Before the inspection, we reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law.

During the inspection, we spoke with eleven people, seven visitors, eight staff, the registered manager and the provider. We looked at records, which included medicine charts, training records, three care plans and three staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

Appropriate recruitment procedures were in place but not always followed by the registered manager. The provider sought references and completed checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS enables employers to make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, staff sometimes started work after the "adult first" check had been completed. This check allows staff to start working in a care home before the full DBS has been received. The adult first check for one new staff member stated, "Please wait for the DBS certificate before making a decision regarding this applicant." However, the staff member had started working at the home before this was received. We raised this with the registered manager, who was not able to explain why this had happened. This meant people might have been at risk from the employment of unsuitable staff.

The provider had sought references from applicants' previous or current employers to assist their decision making when they employed new staff. One staff member had worked for a social care provider previously but a reference had not been sought. Where staff have worked within health and social care settings in the past, satisfactory evidence of their conduct and the reason why their employment ended, must be obtained.

Potential new staff were asked about their employment history, but some records showed gaps in employment, which had not been explored during the recruitment process. One file showed the applicant's employment dates were different to those showed on their reference and this had not been explored with them.

The lack of an effective recruitment procedure was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were prescribed medicines to take "when needed", for example for pain relief or to help the person's breathing. Care plans were in place which described the medicine, what it was being given for, and the desired outcome. Where people were prescribed medicine when needed for pain management, staff used a pain scale to monitor how effective the medicine had been.

However, two people were prescribed medicine "when needed" for agitation, anxiety, or the display of behaviour which might challenge others. One person's care plan said staff were to "administer if required for agitation/aggression only if [person] poses danger." There was no further description of what danger there would be or to whom. The medicine had recently been given to the person every day or every other day. Out of the eight dates shown, only three dates showed why the medicine had been given and only one date showed how effective the medicine had been. Another person was prescribed medicine to take if they displayed aggressive behaviours when supported with their personal care. The care plan noted that if the person became aggressive, care staff should tell the nurses so that medicine could be given to "calm them down". Records showed the medicine had been given four times in one week. The outcome of giving the medicine was recorded as the person "calmed down". The care plan did not explore or identify any reasons

why the person may respond to personal care the way they did and there were not any alternative strategies noted to reduce the need for the use of this medicine. This meant that people may be at risk of taking medicines to calm their agitation instead of being supported through the use of other strategies. Medicines should only be offered after other attempts have been made to support the person.

One person received their medicines covertly, crushed in their food. There was not a written care plan in place to show which professionals had been involved in making the decision. We spoke to staff about this, who all recalled that they had seen the relevant document but it could not be found on the day. Staff contacted the GP surgery during the inspection to create a new document and sent us a copy of this after the inspection.

People told us staff gave them their prescribed medicines. One person said, "I take whatever they give me, I've had some this morning" and another said, "The nurses come around and give [medicines] to you." A relative said, "I've seen the nurses give out the pills."

Medicines were stored safely. The supplying pharmacy carried out an annual audit of the storage of medicines at the service and there were in-house monthly audits.

People told us they thought the home was clean. Their comments included, "It's very good. The bedrooms and the lounges are all clean. They work very hard to keep it so", "All the time, they're cleaning here, even my [relatives] comment on how clean it is", "My room's clean and tidy", "The place is very nice and clean. Someone comes around and cleans the windows outside. They use a long pole and I love watching it being done" and "It's beautifully kept, there's no unpleasant odours here." One person commented, "Here comes my clean laundry, look how nicely [the staff member] does it and puts it away for me."

Relatives agreed that the home was clean. One said, "Yes [the home is clean]. Just look around and you can see that it is." Other comments included, "This room is always clean" and "[Relative] has got a lovely room, it's lovely and clean." A visitor said, "The washing is done beautifully, [my relative's clothes are always returned nicely."

We observed that the building, including communal areas, appeared clean, however, we saw that a shower chair which included a commode pan was not. The frame of the chair was covered in white sediment and it had a grey plastic seat, which was cracked and stained. The commode pan contained a small amount of water which contained brown sediment. We brought this to the attention of the provider who said the chair had some rust which accounted for the brown colour we found. By the second day of the inspection, the provider had removed the chair.

People were supported by sufficient numbers of staff. Comments from people included, "I think [there's enough staff], they talk to me when they're in here", "They look after you here, they wash and dress you", "They are all nice girls and women", "Oh yes, they chat with me, it's like talking with my daughters" and "They've got a good quantity of nurses and staff here."

Staff told us they were allocated to work on a specific floor when they came onto shift. One said, "The staffing levels feel fine, no two days are the same" and another said they had time to chat with people. One staff member told us how the staff worked as a team, which included two nurses per shift and seven care staff in the morning. Staff also said staff numbers increased when there were more people living in the home.

People told us they felt safe living at St Annes Nursing Home. People's comments included, "Yes, I feel safe

here", "Yes, very. This is a very quiet part of Southampton and we are all have our own rooms" and "Yes and I'm comfortable here, I can still look after myself, I'm quite safe." A relative said, "Yes, the environment is very good here, it's nice and safe."

The provider had policies and procedures in place designed to protect people from abuse and staff had completed training in safeguarding people. The registered manager knew how and when to use safeguarding procedures appropriately.

Risk assessments identified when people were at risk from every day activities, such as moving around the home and detailed what action was taken to minimise those risks and to deliver care and support which met people's needs safely. Where necessary, people were provided with equipment to meet their needs, such as special cushions and pressure relieving mattresses to reduce the risk of damage to their skin. Where people had pressure area wounds, records showed appropriate wound management had been provided and demonstrated advice had been sought from the Tissue Viability Nurses. Where people had catheters, records showed how staff managed these safely and included a record of the amounts of fluid in and out, which was appropriate management for the type of catheter. Moving and handling assessments were in place which detailed how staff should support each person to move. Staff had been trained to support people to move safely and we saw staff supporting people using a hoist and talking to them to reassure them. All safety equipment such as hoists and specialist baths were subject to regular maintenance contracts and had been serviced and inspected in February 2018. All individual safety equipment, such as personal slings and wheelchairs were checked quarterly.

Personal evacuation plans had been developed and included details of the support people would need if they had to be evacuated from the building in an emergency. These were kept in a file which was easily accessible if necessary.

The registered manager ensured that lessons were learned and improvements made when incidents had occurred in the home. Information was passed to staff through handovers and team meetings so that all staff were aware.

Requires Improvement

Is the service effective?

Our findings

People's consent to their care was not always sought in line with legislation and guidance. 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.

We checked whether the service was working within the principles of the MCA. Mental capacity assessments were in place along with details of best interest decisions for some people. However, we found that one person had a sensor mat in their bedroom which would sound an alarm if the person got out of bed, to alert staff. The person was said to not have capacity to consent to the use of the mat but there was not a capacity assessment or a best interests decision recorded around this decision. Another person had their bed rail raised to prevent them falling out of bed but they were still able to get out of bed independently. Records showed the person had agreed to this. However, the care plan showed the person was living with dementia, but there was not a capacity assessment or a best interests decision in place to support the use of the rail.

We found that one person had their property removed without their permission and they had been assessed as having capacity to make decisions. We were told this had been done because staff suspected that allowing the person to keep their property was having a negative impact on their health, but there was no evidence to support this theory. Daily records showed that there had been some discussion with the person and their family but did not show there had been an agreement by either party. Records also showed the person continued to ask about their property but was told enquiries would be made.

The lack of consistent application of the relevant legislation regarding gaining consent from people was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. The registered manager was aware of the procedures to follow and had obtained authorisations where necessary. Where authorisations were due to expire, the registered manager had made new applications for the authorisations to continue, when necessary.

Care staff and nursing staff we asked did not know who had a Deprivation of Liberty Safeguard authorisation in place. Although staff had training in this regard, staff were not sure what it would mean for the way people were supported on a daily basis. Staff should know the legal status of all people in their care and in particular of any legal restrictions upon their movements which could potentially impact upon the person's care or safety, for example if the person could only leave the building with supervision.

People's needs were assessed and their preferences understood before they moved to the service.

Assessments were also completed which helped identify where people were at risk, for example, from pressure area injuries or malnutrition and set out a plan to meet their needs.

New staff completed a week's training course provided by an external training company which resulted in them achieving the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. It provides assurance that care workers have the skills, knowledge and behaviours to provide compassionate, safe, high quality care and support. One staff member told us, "[When I started], I was experienced in care, I had done the Care Certificate before and I have [a national vocational qualification]. I did the Care Certificate here as well for a week, it was absolutely brilliant, I even learnt new things. My moving and handling training was updated as well."

The provider offered a training programme which included moving and handling, infection control and dementia awareness. The provider had recently signed up to a training package whereby staff could choose what topic they would like to study, completed a work book and received support from a mentor. A staff member told us they had signed up for their first one and were keen to get started. However, records showed there were some gaps in training. For example, one staff member who prepared food had completed food hygiene training, but was about a year and a half overdue for their refresher, therefore their knowledge may not have been up to date. Another staff member was overdue by about five months. One care staff member had not undertaken any moving and handling training and therefore may not have had the knowledge to transfer people safely.

Some staff were supported in their work through supervisions and staff were due to receive annual appraisals when they had worked there for a year. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. Supervision records showed most care staff had received a supervision session in January or February 2018, but prior to this, some staff had received only one supervision since March 2017. The nursing staff had not had any supervision and the registered manager was aware they needed to do this. Not all staff had annual appraisals in 2017. A staff member told us there was a, "lot of support and help, you can always go to reception [desk] to ask for help."

People were supported to eat and drink and most enjoyed their meals. Comments from people included, "The food's out of this world. I think the cooking is like home from home if you know what I mean", "I had a nice lunch to-day but I can't remember what I had though", "I've no complaints about the food. I get plenty to eat." One person talked about a recent evening when they had been sat downstairs in the lounge when the night staff came on duty. They said, "I don't usually ask for a drink or food extra in the evening, I don't need it, but one evening the night staff made me a cup of tea at 8.30 before I went upstairs, that was nice." A relative told us the home provided food for visiting relatives. A staff member told us that one person was awake and up during the night, so staff stayed with them, gave them a cup of tea and did a puzzle with them.

Some people were offered a choice of meal. Staff asked people what they would like for tea that day and lunch the next day. Some people who were living with dementia were not asked what they would like to eat and records showed they always ate the main meal option. We brought this to the attention of the registered manager and the provider who said photographs were available. However, the photographs were small, with several images on one page and people living with dementia might not understand the images.

We observed how people were supported at lunchtime. People sat at dining room tables in groups of four to six and some people told staff where they would like to sit. People were offered a choice of soft drinks or water. We saw a staff member assisting a person to wipe their hands at the table with wet wipes to ensure their hands were clean before they ate their meal.

Staff served meals from a hot trolley in the dining room. The food was served with care and portion sizes were given according to the person's preference. Salt and pepper pots were available on each table and people were offered gravy from a china gravy boat of a type they might have used in their own homes. Where people had their meals pureed, food items were pureed separately which made the meal more attractive to eat.

Staff told us some people needed their food soft or fork mashable and said the chef cooked soft fish meals with sauces, for example, instead of fish in batter, and chicken would be minced.
We saw staff assisting some people to eat their meal. Staff chatted to people, did not rush them to finish their meal and were aware of people' specific needs, such as if they were at risk of choking.

Some people needed extra nutrition and this was provided in the form of prescribed shakes and fortified foods. The chef told us how they used cream, butter and cheese to make food like mashed potato more calorific. They also said if people were "off their food", they would ask them what they would like and perhaps use photographs if people were less verbal.

People told us they received ongoing health care support. Comments included "I did have the doctor in this week", "A doctor came in two or three weeks ago to see me", "The chiropodist was here last week, they cut my toenails" and "I've had new glasses two or three months ago. [Optician's name] I think it was, came in." Relatives told us they knew the local GP could be asked to visit the home and during the inspection we heard the registered manager telling a relative that staff would arrange a home visit with an optician.

Staff told us if people appeared unwell, they reported this to the nursing staff who monitored them and asked for the doctor to visit when necessary. The home was also able to access other healthcare professionals such as physiotherapists, occupational therapists and speech and language therapists.

The registered manager demonstrated effective partnership working with other health and social care professionals, for example, the local authority adult services and the Tissue Viability Nurse. This meant the registered manager sought and acted upon specific professional advice.

The building had been purpose built in phases, ultimately replacing the original Victorian building. This meant that communal areas had been designed to accommodate a number of people and there was enough space in the building for suitable equipment, such as specialist baths and wet rooms. Everyone had their own bedroom although some bedrooms had been designed to offer shared accommodation to people who made a choice to live with someone.

Requires Improvement

Is the service well-led?

Our findings

The provider did not always ensure that notifiable incidents were reported to the Care Quality Commission. We use this information to monitor services and ensure they respond appropriately to keep people safe. During the inspection process, we were made aware of two incidents which should have been reported to us. The registered manager thought the local authority safeguarding team would have automatically shared the information with us and so had not done so.

The failure to notify the Care Quality Commission of all incidents that affect the health, safety and welfare of people who use services was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider had a quality assurance system in place to audit and monitor the quality of the service. However, during this inspection, we found concerns around a number of areas which had not been identified by the provider or registered manager when they audited the quality and safety of the service. As we walked around the home, we found most people had their bedroom doors wide open. Some people were asleep and their dignity was compromised because they were visible to anyone walking around the home. We brought this to the attention of the registered manager who was unsure whether people had made a choice to have their bedroom doors open at 11am. We also saw that people's daily notes folders were in the corridor on the floor outside people's rooms. Any people or visitors walking past could access the notes. The registered manager was not aware that this was happening but agreed it was not good practice and arranged for the folders to be placed in people's rooms straight away. We also identified concerns around staff recruitment, medicines and mental capacity which have been detailed elsewhere in this report.

Monthly audits included checking the first aid boxes, suction machines and syringe pumps. Quarterly audits included checking paperwork around topical cream charts, individual sling checks and hand hygiene and six monthly audits looked at the environment, infection control, care plans, mealtimes and mattress safety. The provider completed a daily walk through the home as part of the infection control audit.

Relatives told us they knew who the registered manager was. One relative said, "[The registered manager] is very nice. Always approachable." Comments from other relatives included, "I'd recommend it [here] to anyone", "There's a happy atmosphere here", "As long as [my relative's] happy, that's all that matters" and "I'll give this place eight out of ten".

Staff understood the different roles of staff in the management team. One staff member said that the 'senior carer' was, "the first port of call, she allocates where we go [which floor they worked on that day]. [The clinical lead does the medicines, care plans and risk assessments. [The registered manager] runs the house, we go to her if we have concerns that the nurses can't deal with and she speaks with the relatives. The provider [organises] the day to day running of the home, such as making sure the equipment is fine." Another staff member said, [The provider] walks around, checks bedrooms, makes sure everything is ok, if there are any faults he will deal with them. [The registered manager] is lovely when talking to residents. [The

registered manager and provider] do it because they care for people." The registered manager told us how they felt it was important that they and their team was open and transparent. They said that being a good listener and being able to empathise with people and their families was a strength of the management team.

Staff also felt the registered manager and provider were approachable. One staff member said, "If there is anything wrong [in the home], you can tell them and they will act on it." Staff felt the home was a friendly place to work, as staff were friendly to each other and people living there. One said the registered manager and provider were supportive if they had any personal issues. Another told us how they had been supported after they had been involved in an accident in the home. They said, "The provider] sat me down and said 'we know it was an accident, we just need to sort it out'. A week after the accident, [the registered manager] and other staff were still asking me if I was ok. I knew I had the support of everybody, which was nice."

The provider sought the views of people living at St Annes Nursing Home and had completed two internal surveys of people using the service, their relatives and staff. The most recent questionnaires had just been returned and were awaiting analysis by the provider. The results of the surveys were published in a letter format and displayed in the staff room and discussed during staff meetings. The registered manager told us that people and their relatives were told about the survey results face to face by staff, although this was not recorded.

The registered manager was open to learning and improving care following concerns or incidents. One example was the introduction of laminated coloured signs to indicate if someone was at risk at mealtimes. Another example was the use of an induction and handover sheet to give to agency staff who may not know people well, so that people's needs could be seen at a glance.

The registered manager had working relationships with key organisations such as the local authority, safeguarding teams and GP surgeries.

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 18 Registration Regulations 2009 Notifications of other incidents The provider did not always ensure that notifiable incidents were reported to the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have an effective recruitment procedure in place.