

Avery Homes (Cannock) Limited

Alma Court Care Centre

Inspection report

Heath Way
Heath Hayes
Cannock
Staffordshire
WS11 7AD

Date of inspection visit:
21 July 2016

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01 September 2016

Tel: 01543273860

Website: www.restfulhomes.co.uk

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 14 October 2015. After that inspection we received concerns in relation to staffing levels and. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alma Court Care Centre on our website at www.cqc.org.uk

Alma Court can provide support and accommodation for up to 73 people with complex behaviours who require nursing care. There were 69 people living in the home on the day of our inspection.

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.

At the focused inspection we found that there were sufficient staff to care for people however some agency staff did not have all of the information they needed to provide people's care in the way it was planned. Some agency staff were unable to explain how they would support people to leave the home quickly in the event of an emergency or where to access fire fighting equipment. The provider had recognised there were shortfalls in their staffing levels and demonstrated they had plans in place to mitigate the risks this presented to the consistent care of people. A staffing review had been completed and a recruitment drive was in progress.

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 consistently safe. Some temporary or agency staff did not have the information they required to provide consistent care.

Requires Improvement ●

Alma Court Care Centre

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection of this service on 14 October 2015. After that inspection we received concerns in relation to staffing levels and. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alma Court Care Centre on our website at www.cqc.org.uk

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 focused inspection visit took place on 21 July 2016 and was undertaken by one inspector. We looked at the information we held about the service and the provider, including notifications the provider had sent us about significant events at the home. On this occasion we had not asked the provider to complete information for the Provider Information Return about their service. The PIR is a form that asks the provider to give us some information about their service, what they do well and any improvements to care they plan to make.

We were unable to speak in depth with some of the people who used the service on this occasion, so we observed the care being provided in communal areas to understand people's experience of care. We spoke with six relatives, four members of the care staff, seven agency staff, the acting manager and the regional manager for the provider. We did this to gain views about the care and to check that the standards were being met.

We looked at five care plans to see if the records were accurate and up to date. We also looked at records relating to the management of the service including staff rotas.

Is the service safe?

Our findings

We saw that there were adequate staff to meet people's needs and provide constant support when necessary. However we found that some agency staff had not been provided with sufficient information to understand people's needs and risks. Relatives told us they were concerned about the number of agency staff working in the home and the impact this was having on the care of people. One relative told us, "There's a high turnover of staff and far too many agency. It's unsettling for people". We saw from the rotas that there was a reliance on agency staff to supplement the core staff employed by the provider. A relative said, "I am concerned that some of the agency staff do not know my relation so well. I don't think they get told about people". We spoke with agency staff to gauge their understanding of people's needs. We found some staff had to ask other staff about people as they were uncertain why they were providing care on a one-to-one basis.

Some people had complex behaviours associated with their dementia and mental health. We saw that there were assessments in place and guidance for staff on the best way to support people and keep them safe. A relative told us, "The staff know how to support [name of person] when they get agitated. Sometimes the agency staff try a different approach but it doesn't always work". We asked two members of the agency staff to describe how they would support one person when they became unsettled and displayed behaviours that challenged. One member of staff told us they would ask other staff to take over. The other member of staff said, "I would speak firmly and tell [name of person] to stop it". Neither of these responses matched the guidance we had read in the person's care plan which stated, 'Speak in a soft even tone. Engage in conversation about their family'. The agency staff told us they had not had the opportunity to read the guidance in the person's care plan. Staff told us that only the nurses and team leaders attended the shift handover meeting. Other staff received updates on people's care by reading a handover book. We saw that there was a handover book on each unit and staff told us each member of staff should read this at the beginning of their shift and sign to show they had done so. We checked each handover book and saw that the number of signatures did not reflect the number of staff working on the shift. There were no management processes in place to ensure staff had read the most up to date information about people to enable them to provide a consistent approach.

There were arrangements in place to ensure the environment and the equipment used was safe for people. However some of the agency staff were unable to explain to us how they would ensure people were suitably supported to leave the building if an emergency, such as a fire occurred. One member of the agency staff could not tell us where emergency fire fighting equipment was stored. Another member of staff was uncertain how people receiving one-to-one care should be supported during an emergency. This meant that there could be confusion if an emergency, such as a fire occurred and people could be put at risk.

The regional manager explained to us that they would always have a need to use some agency staff to ensure they met people's changing needs in response to the funding they received from the organisations that commissioning their care. For example some people received extra funding support to have staff with them for all or part of the day as they had identified and increased risks which could affect their safety. People's risks could change on a day by day basis. This included an increased tendency to fall if they were

not observed or when they became unsettled, harming themselves or others from behaviours that are described as challenging. We saw that there had been a recent analysis of the balance of staff skills and the management structure. As a result of this there was an on-going recruitment drive in place. A team leader told us they were responsible for recruitment and had recently interviewed new staff who were going through the pre-employment process. The team leader told us, "We should have 28 new staff starting and others still to interview". We saw and new staff told us all of the recruitment processes were completed before staff were able to start working in the home to ensure they were suitable to work within a caring environment.

Permanent staff we spoke with told us that many of the agency staff had worked in the home for a long time. One member of staff told us, "We need a lot of staff including regular agency. We support the agency staff and they try very hard. The agency carer working on this unit today has been coming here for a long time and they're as good as the permanent staff".