

Speciality Care (Addison Court) Limited

Addison Court

Inspection report

Addison Street
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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Addison Court is a purpose built residential and nursing home providing personal and nursing care to up to 50 people. At the time of the inspection there were 44 people living in the home. There were three floors for; residential, nursing and dementia care. Accommodation was provided in single bedrooms. There were several communal areas and a secure garden area. There was a lift. People could move between floors if they chose.

People's experience of using this service and what we found

Some people were at risk of harm because medicines had not been managed safely. Some people were at risk of harm because modified diets to prevent choking risks had not always been followed. Some people may not have had the right support to maintain their hydration because they regularly did not drink enough fluid and the service had not taken action to address this. Some people with diabetes had been at risk due to their care plan either not being present or not being followed. The governance systems in place had not identified the concerns we had found.

Records showed staff had been provided with training and had been supported by supervision from a senior member of staff. People told us staff knew what they were doing and seemed to have good skills. We saw training had been planned to ensure people were up to date. The service was compliant with the Mental Capacity Act and associated Deprivation of Liberty Safeguards.

People we spoke with were happy with the quality of the care they received and praised the kindness and friendliness of the staff. People were happy with the cleanliness of the home and told us how thoroughly the domestic staff cleaned their rooms. The home was well maintained and tidy with no unpleasant odours. People told us they were happy with the food provided and the choices available. People had a variety of activities and outings available which reflected their preferences and interests.

The service had clear values and were committed to providing person centred care, though this had not always been achieved. Staff we spoke with felt confident in the management team and able to raise any concerns with them. We could see there had been some improvement in leadership in the home. The manager in post at the time had been there for under three months. People's views were sought through surveys and meetings. The service worked with other agencies to provide consistent quality care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at the last inspection and update

The last rating for this service was requires improvement, (published 8 August 2018)

Some people were at risk of harm because medicines had not been managed safely. Some people were at risk of harm because modified diets to prevent choking risks had not always been followed. Some people may not have had the right support to maintain their hydration because they regularly did not drink enough

fluid and the service had not taken action to address this. Some people with diabetes had been at risk due to their care plan either not being present or not being followed. The governance systems in place had not identified the concerns we had found.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of the regulations.

We have identified breaches in relation to safe care and treatment, supporting people to eat and drink and how the service was managed. You can see what action we have told the provider to take at the end of this report.

Follow up

The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good ●

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Addison Court

Detailed findings

Background to this inspection

The 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 checked 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.

The inspection team

This inspection was carried out by three adult social care inspectors and one medicines inspector.

Service and Service type

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

The service did not have a manager registered with the Care Quality Commission. There was a manager in post who had applied to register. This was completed before this report was published.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. They had raised some concerns about the management of medicines and health needs. We considered this when conducting our inspection.

During the inspection

We looked at the care records for six people, the recruitment records for five staff. We looked at the medicine records for 14 people. Reviewed the risk assessments around food and drink for 8 people. We spoke with four people, two relatives and eight members of staff. We met with the manager, director and quality leads.

After the inspection

We considered the services response to our initial concerns and returned for a third day to evaluate the effectiveness of their actions.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

- Risks relating to modified diets had not been properly assessed or mitigated. We found one person had been assessed as needing a modified diet, but this had not been provided. The person was eating a normal diet. The service had failed to refer them for a speech and language assessment to establish their choking risk. We discussed this with the manager who was unable to provide an explanation. Another person's choking risk assessment was not available to staff. We discussed this with the manager who was able to print it off but could not say how long this had not been available for staff to reference.

This demonstrated a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- At our last inspection we found medicines were not managed safely. At this inspection we found medicines continued to be unsafe. The care plan for one person with diabetes had not been followed, they had been exposed to the risk of severe harm. We discussed this with the manager who could not explain how this had happened. We found no record of safe blood sugar ranges for a further two people with insulin dependent diabetes. We discussed this with the manager during the inspection and they responded in a timely way. However, between the first and the final day of inspection the home had admitted another person with insulin dependent diabetes. The care plan in relation to diabetes for them had not been completed, the persons competence to manage their own insulin had not been assessed, though this would have been completed by community-based health professionals, due to the person being residential, the home had not ensured these were in place prior to their admission.
- Time sensitive medicines had not been administered as prescribed. Times had not been recorded when some medicines had been given which meant there was a risk of doses being too close together.
- Medicines which were prescribed to be given either before or with food had not been properly administered. We saw one person had been given a medicine with food which should have been given before food. We saw two people had no reference made on the medicine records about when to take antibiotics.
- Not everyone who needed medicines on an 'as required' basis, had a protocol in place to describe when to give these medicines. This meant staff had nothing to support them decide whether or not these medicines were needed.
- Some equipment including the syringe driver for end of life medicines had not been serviced. There were

not two giving sets as recommended by good practice guidance.

This demonstrated a continuing breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staff had been recruited safely with the necessary checks being completed prior to staff starting work. The home had recently recruited three permanent nursing staff following a long period of needing agency nursing staff. Where possible the home had used regular agency nursing staff.
- People were supported by sufficient numbers of staff. People's needs had been assessed and reviewed using a system to ensure there were enough staff. One member of staff felt it would be better if there were more staff in the afternoon. We saw people were responded to in a timely way. The nurse call system did not appear to ring too long before staff responded.

Preventing and controlling infection

- People were protected from the risk of infection. The home was clean and tidy with no unpleasant odours. A relative we spoke with praised the thoroughness of the domestic staff who had recently cleaned their spouses' room. Personal protection equipment including hand cleaning facilities, gloves and aprons were available in all bathrooms, toilets and bedrooms. Staff were observed to use these when supporting people with personal care.
- There were safe systems in place to maintain the hygiene in the home.

Learning lessons when things go wrong

- We found evidence of continued breaches and concerns around managing choking risks. Systems in place to learn lessons when incidents occurred had not ensured people were safe from reoccurrence.

Is the service effective?

Our findings

Effective - this means we looked for evidence that people's care, treatment and support achieved good outcome and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good at this inspection this key question has deteriorated to Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet.

- People's needs had not always been accurately assessed. We found conflicting information in one person's assessment and care records, which placed them at potential risk of harm.
- Handover documents had been designed to provide a quick overview of each person's needs. We found it lacked an important diagnosis for one person. This meant a newly admitted person was at risk of harm because staff had not been provided with necessary information.
- People had not been supported to eat safely. A choking risk assessment was not available for one person. We spoke to the manager who printed one off but could not be certain how long it had not been available for staff.
- One person had been assessed as needing a modified diet prior to admission. The staff were not aware of this and the person had a normal diet. The service had not assessed the risk in relation to the person having a normal diet or referred them to speech and language for an assessment. We raised this with the manager who ensured this was done straight away.
- Fluid targets had not been met for some people. There was a space on the handover sheet to record what action had been taken should a person not achieve their fluid target. This had not been completed. We discussed this with the manager who advised they had reviewed this practice and removed the fluid targets for people who were assessed not to be at risk of dehydration. We discussed with a nurse how they responded to a person who might be dehydrated and they described in detail how they recognised signs and what they did. We witnessed a handover where people's fluid intake was discussed and recommendations made should someone need more. We were satisfied people had not been at risk of dehydration.

This demonstrated a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they enjoyed the food and had been asked their preferences. People had a choice of meal and could request something else if they did not want what was on the menu.

Staff support: induction, training, skills and experience

- People had been supported by staff who had the right skills though they had not always been provided

with accurate information about people's needs. Training for nurses on induction was underway during the inspection. The induction programme was thorough. Agency staff had access to induction materials. The training matrix showed some people needed refresher training, we could see some had already been arranged and more training had been planned.

- Staff had regular supervision, supervision is a one to one meeting with a senior member of staff to discuss staffs development needs and skills. Staff reported feeling well supported. Annual appraisals had also been completed.

Staff working with other agencies to provide consistent, effective, timely care

- Staff worked closely with the district nurses who were supporting people on the residential unit. Staff appeared to work well together. We attended a morning handover and found people's needs and presentation were discussed in detail and any appointments that were planned or needed arranging were allocated to staff to complete. However, not everyone had been referred for assessments from speech and language therapists when required.

Adapting service, design, decoration to meet people's needs

- Addison Court is a purpose-built home. There are three floors with a variety of communal areas available. Bathrooms are adapted and accessible. The home appeared to be well decorated and maintained. Pictures and memory boxes outside some rooms assisted people living with dementia to find their rooms. There were accessible gardens off the lounge downstairs.

Supporting people to live healthier lives, access healthcare services and support

- People had been supported to access health services. Professional visit sheets in care records showed a variety of appointments with doctors, district nurses, opticians and other community-based health services. Not everyone had been referred as required.

Ensuring consent to care and treatment in line with law 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.

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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was supporting people in line with the MCA. The service had applied for appropriate authorisations from the county council. Staff were knowledgeable about consent we saw staff asking people before supporting them with personal care. People told us staff asked their views and gave them choices.

Is the service caring?

Our findings

Caring - this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same, good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were supported by kind and caring staff. People's equality and diversity needs were recorded in their care records. We could see these had been reviewed and updated regularly. Staff we spoke with were able to identify protected characteristics as defined in the Equality Act. People were supported to attend religious ceremonies or be visited by local clergy.
- We observed staff interactions throughout the inspection and saw them taking time to listen to people and understand what they wanted. Staff responded to people and initiated chats. There was a lot of laughing and shared humour.

Supporting people to express their views and be involved in making decisions about their care

- People were able to express their views. Information was available in different formats, including large print and easy read. People had communication guides in their care records which ensured staff knew the best way to communicate and involve the person. People told us they were regularly asked what they thought about the service.

Respecting and promoting people's privacy, dignity and independence

- People were supported with dignity. There was a dignity in care board on display which identified important principles around supporting people to maintain dignity. Staff we spoke with demonstrated compassion and respect for the people they supported. We observed staff throughout the inspection including during meal services and early in the morning. Staff were kind and respectful at all times.

Is the service responsive?

Our findings

Responsive - this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same, requires improvement.

This means people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation

- Some people did not receive person centred care which was responsive to their needs. We found the service had not always referred people for assessments from community-based health professionals such as speech and language therapist or for medicine reviews when the person had not wanted their time sensitive medicines at the time prescribed.
- Most people received care which reflected their needs and wishes. Care plans contained personal information about what was important to the person about how they preferred to be supported. We saw positive interactions between people and staff. People told us they were able to decide when they got up and when they had support to bathe. Staff were skilled in supporting people who might experience distress and decline support. Staff understood person centred care, one staff told us, "It's about the care being individual for them. We found out what they like, it might be little things, like having a duvet not blankets or having tea and toast in bed before getting up."
- People had been supported to maintain important relationships. Visitors were welcome at any time. Some people's spouses would visit for several hours each day and were able to dine with them.
- People's interests and hobbies had been recorded and a programme of activities had been developed to reflect these as far as possible. Trips had been arranged to local markets, an art gallery and a garden centre. Theme days and activities within the home included an Elvis appreciation day and games. Where people had one to one support their activities were reflective of their preferences.

End of life care and support

- We found some concerns relating to medical equipment for people who were assessed to be end of life. This has been addressed in the safe domain.
- People had been supported at the end of their life. Staff had been trained to support people following good practice guidance. People had been supported to discuss their preferences in relation to end of life care and funeral planning. People who did not feel they wanted to discuss this had their wishes recorded and respected.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People had been supported with their communication needs. Information was available in a variety of formats. Communication guides in care plans identified how best to support people to communicate and express their views. We saw staff took time when chatting with people about what they wanted.

Improving care quality in response to complaints or concerns

- People's concerns and complaints had been responded to in a timely manner. The service had a policy which we could see they had followed. Information about making a complaint was provided in easy read formats including a pictorial guide. People told us they felt happy to raise a concern and were confident staff would respond.

Is the service well-led?

Our findings

Well-led - this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance systems had not identified significant concerns we had identified during the inspection in relation to medicines, assessing and mitigating risks and supporting people to maintain hydration. People had been at risk of severe harm. We discussed our concerns with the manager during the inspection. The service responded to address the concerns we have raised.

This demonstrated a continuing breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff understood their roles and responsibilities, handover meetings ensured staff were aware of what the majority of people needed and who was supporting them. However, we found information about some people's needs was not accurate.
- Staff told us they felt valued by the management team. The majority of staff we spoke with felt the service was well managed though one staff felt it would be better if there were more staff in the afternoon.

Continuous learning and improving care

- The service had failed to improve care sufficiently in response to concerns raised in four previous comprehensive inspections.
- Systems were in place to respond to incidents to improve learning and practice. Where incidents had been identified we could see this had been followed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff were committed to providing high quality care which reflected people's preferences, however this had not always been achieved. Interactions were positive and friendly between people and staff.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The service recognised their responsibilities to be open and honest. People had been provided with explanations and apologies when they had raised concerns. Notifications had been sent to CQC as required.

The last inspection ratings were displayed in the entrance to the home.

- The manager, director and quality leads were open and responsive to the concerns we have raised during this inspection and have sought to rectify these in a timely way.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People's equality characteristics were recognised, the service engaged with people appropriately and celebrated different events and festivals which reflected people's identity. People were able to let their views known, there were surveys for people, their relatives and staff. The results of the most recent of these was still being processed at the time of inspection.

Working in partnership with others

- The service was working in partnership with other organisations to provide consistent care and support and to improve the skills and knowledge of the team. Community health professionals we spoke with reported having a good working relationship with the service. However, not all necessary referrals had been made.