Leonard Cheshire Disability

St Anthony's - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service on 2 August 2016 to see if the provider had met the requirements as set out in the warning notice. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to staffing and ensuring people were protected from potential abuse. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Anthony's - Care Home with Nursing Physical Disabilities on our website at www.cqc.org.uk

The service is registered to provide accommodation and nursing for up to 34 people, who have physical disabilities. At the time of the inspection 33 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.

We saw there were not enough staff to support people, this is a continued concern raised at the last inspection. People told us they had to wait to receive the support they needed and the use of agency staff was impacting on the care people received. The provider on occasions was working below the recommended numbers as identified using their dependency tool. People were not receiving their medicines as prescribed and we could not be sure medicines were administered on time. Risks to people were not managed in a safe way and risks were not assessed or reviewed when needed. People were at risks of not receiving medicines they needed to keep them safe.

People were protected from abuse and potential harm as staff had received training in safeguarding and the provider understood how to raise concerns and report them appropriately.

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 the 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?

Inadequate

The service was not safe.
Risks to people were not managed in a safe way and when needed risk assessments were not in place or had not been reviewed. People were not receiving their medicines as required and some people had been placed at risk through lack of knowledge of how to administer prescribed medicine. There was not enough staff available to meet people's needs. Staff were aware of safeguarding procedures.

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 2 August 2016 and was an unannounced focused inspection. We carried out this inspection to check that improvements to meet the legal requirements set out in the warning notice had been made. The inspection visit was carried out by one inspector. We inspected the service against one of the five questions we ask about the service: is the service safe?

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 and other health care professionals. 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 three people who used the service, two care staff and two registered nurses. We also spoke with the care supervisor, the registered manager and a visiting health professional. We did this to gain people's views about the care and to check that standards of care were

being met.

We looked at the care records for four 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 medicines administration records and rotas.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of St Anthony's on 25 April 2016, we found medicines were not managed in a safe way. People were not receiving their medicines as prescribed, medicines were not stored in line with the manufactures guidance and there were no safe systems in place to ensure people's needs regarding 'as required' (PRN) medicines were met. We also found the service was secondary dispensing; this is a practice which is seen to be unsafe as it increases the risks of the medicine being administered to the wrong person. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We issued the provider with a warning notice to improve the way medicines were managed. We told the provider that improvements must be in place by 16 July 2016.

At the comprehensive inspection we also found that people had to wait for support with their care needs. Procedures for reporting potential abuse were not always followed and we could not be sure people were protected from abuse. This constitutes Breaches of Regulation 18 and 13 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

At this inspection we found further concerns that people did not received their medicine safely. We saw that a daily stock check was completed for each medicine. We looked at the medicine administration record (MAR) we saw gaps on the MAR sheet and a daily total of the medicines, some of these did not add up accurately. For example, one person had one tablet per day; the total administered for this medicine was 20. The next day the MAR showed one tablet had been administered and the total was now 22. This medicine had been signed for each day on the MAR as administered. A member of staff told us, "This should have been picked up by the next nurse who administered the medicines". They confirmed this had not been identified. We counted this medicine and there was one extra tablet available than the MAR stated had been administered. Following this we completed further stock checks and found four other medicines had more tablets in stock than the records showed us there should be. We spoke with a member of staff about this who confirmed the errors had not been identified. They told us, "We don't have time to check". We looked at audits that had been completed on medicines since our last inspection and these errors had not been identified. This meant we could not be sure people's medicines were administered as prescribed.

We also identified at our last inspection, when people were prescribed medicines for the management of epilepsy they did not receive their medicines as promptly as they should. We saw a new protocol had been introduced to reduce the time it took to administer this medicine. We looked at the epilepsy records since the last inspection and saw two seizures had occurred, which required medicines. The information recorded in the person's file stated the time the seizure had occurred and in the controlled drug book it stated the time the medicines were administered. On both occasions we found the time recorded for the medicine administered was before the time the seizure had occurred. We spoke with the registered manager about this who told us this was due to the inaccuracy of the clocks within the home. This recording error had not been identified in the audits or by the provider. This meant we could not be sure this protocol was effective and that the medicine was administered as prescribed.

We looked at records for one person and it identified they required a medicine for a health condition to keep

them safe. We spoke with staff about this medicine. One member of staff told us that the person did not require this medicine anymore. They said, "I know they don't have it as we don't have it in stock". We looked at the MAR for this person and saw the medicine was listed. The MAR stated this was for 'prolonged seizures'. We spoke with staff about this and when this medicine would be administered. They confirmed there was no guidance in place for when this medicine was required. They went on to say, "I don't know when we would give it". We saw that the medicine could not be instantly located by the staff member. This meant that this person was at risk of not receiving the medicine they may require to support their medical condition.

This is a continuing breach of Regulation 12 (2) (g) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

At our last inspection people told us they had to wait for support with their care needs, at this inspection we found the provider had not made the necessary improvements to comply with the regulation. People told us they had to wait for support one person said, "There are just simply not enough staff". Another person told us, "When you press the buzzer you have to wait, the nice girls come and tell you they are busy. They tell me I have to wait my turn, sometimes it takes ages". People went on to tell us they felt their dignity was now compromised due to the lack of staff within the home. A person told us, "I am meant to have two staff to support me, but sometimes I have to have one as there aren't enough". A relative said, "They have never got enough staff, they can't get them to stay". Staff confirmed they were not enough of them. One staff member said, "There are not enough staff it's always short". Another staff member explained about the pressures they felt they were under due to this. Throughout the inspection we heard call bells ringing for long periods of time, on one occasion we heard this ringing continually for 10 minutes; this meant people were not being responded to in a timely manner. We asked to see the call log records for the call bell system to check how long, on average, staff took to respond to people. The registered manager told us there was fault on the system which meant the records were inaccurate. They told us they had reported the fault. The provider had told us in their action plan they provided after our last inspection that they were going to complete an audit of the call bell logs to monitor the time people waited to receive support. The fault on the system had prevented the provider from completing their action plan but no other checks on response times had been implemented.

We spoke with the registered manger about the action they had taken since the last inspection. They told us they had reassessed the hours for people using their dependency tool and had an increase of 200 hours. They told us these hours would be used to employ care staff. They told us this was to cover shortfalls and the amount of staff within the home would not increase. There were the same number of staff on duty, on the day of inspection as there were at the last inspection. The registered manager told us they were working below the recommended number of staff as identified by the provider. They told us that on occasions they had used agency staff to cover the shortfalls. One person told us about the impact the amount of agency staff was having on their care. They said, "I'm not happy with it. They don't know me. Some have been before but most we just see once or twice….. I am lucky I am able to talk and tell them what to do, most people here can't do that, those I worry for". We looked at the staff rotas and these confirmed that on occasion the provider had worked below the recommended numbers they had identified and that agency staff were used.

This is a continuing breach of Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

Risks to people were not managed in a safe way. At our last inspection we found that there were people in communal areas without the support of staff and without access to the call bell system. At this inspection, on arrival we saw that some people were again, in the communal areas (lounge and dining room) without

access to the call bell system. We spoke with the registered manager who told us that since our last inspection they had introduced a check system of the communal lounge to ensure people were safe. Records confirmed this check was taking place. They confirmed that risk assessments had not been completed and people's needs had not been assessed to identify the levels of support or checks required. They told us that, "Risk assessments are in my head and not on paper". This meant we could not be sure that people were receiving the appropriate level of support to reduce their risk or ensure they were safe. We discussed our findings in relation to people in the communal areas with the registered manager they told us that the people in the communal lounge, we had observed were, "Mobile and could access the call bells". However, we had observed that some people in the communal dining room were unable to mobilise independently, this room was adjacent to the lounge. We spoke with the registered manager they told us that checks were only completed on the lounge and not the dining room as there were no risks to people in there. Furthermore during the course of the day we observed that one person wore a call bell around their neck. We spoke with staff and the relatives of this person about this; both confirmed that the person did not have the capacity or physical dexterity to use this alarm. The registered manager confirmed that no risk assessment had been completed in relation to the use of the alarm. This demonstrated that there continued to be concerns to people's safety and that in some instances risk to people had not been assessed.

People's care was not reviewed to protect them from harm following the occurrence of an incident. For example, before the inspection we had received a notification that a safeguarding incident had occurred. We looked at records for this, it was an altercation between two people. We spoke with the registered manager about what action had been taken to reduce the risk of this situation occurring again. They told us, "We have asked [person] not to retaliate and to move away". They also told us this person did not have a history of physical aggression and, "It was out of the blue". We looked at records for this person. The care plan stated 'sometimes I will hit out at other people'. Following this incident we did not see this had been reviewed to ensure the risk of it reoccurring was considered. A member of staff confirmed this had not been reviewed. Records showed this person had been involved in a similar incident two weeks previously and this had also not been reviewed. This meant that people were at risk of further harm as action had not been considered following incidents.

This is a breach of Regulation 12 (2) (b) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.
We found following our last inspection, action had been taken to ensure medicines were effective and safe to administer. We saw a new fridge had been purchased and when required medicines were stored in here. The temperature of the fridge was recorded twice a day and the records we looked at confirmed that the temperature range of the fridge was within the recommended guidance of the medicines that were stored in there. The nurse told us, "If the temperature isn't within the range we would report this straight away".

Some people living in the home were receiving medicines for pain relief or to settle them when they became anxious, on an 'as required basis'. At our last inspection we found there was no information, to provide guidance for when a person may require these medicines, this guidance is known as a PRN protocol. We found that for most people these were now in place with clear guidance for staff stating when these medicines should be administered.

At our last inspection we observed when medicines were being administered one staff member dispensed the medicine to another staff member who took this medicine to the person and then they administered the medicine. This practice is known as secondary dispensing. At this inspection we did not observe this practice was taking place. We spoke with a nurse who told us, "No, this is something we don't do". The registered manager showed us records which reflected this had been discussed with the nurses as part of a

meeting.

At our last inspection we found procedures for reporting potential abuse were not always followed and we could not be sure people were protected from abuse. At this inspection we found the provider had made the necessary improvements. Staff told us they had received training on safeguarding since our last inspection and gave examples of the procedures they would follow. One member of staff said, "It's for the safety of the residents and to keep people safe. It might be checking equipment and putting lap straps on people or it might be if someone is hurt or bruised". Another staff member told us, "Any concerns I would report straight away to the manager, if it was severe I would go all the way to the safeguarding team and the CQC". We saw that procedures were in place to report concerns appropriately and when needed these procedures had been followed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not managed in a safe way.