St. Vincent Care Homes Limited

St Vincent House - Gosport

Inspection report

St Vincent House
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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 caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 1 and 2 March 2016. St Vincent House – Gosport provides personal care and accommodation for older people including older people living with dementia. The home is registered to accommodate up to 34 people. During the inspection 29 people were living at St Vincent House – Gosport.

The service had a registered manager. 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.

The service was last inspected in January 2015. At this time the provider had four requirements relating to breaches in regards to medicines, risk management, supporting staff and quality assurance processes. At this inspection we followed up on these concerns. We found that although improvements had been made in all these areas, there remained some repeated and some new breaches.

Some people had risk assessments but these had not always been completed when a risk had been identified. This meant people could have risks, but staff maybe not have been aware of the risks to people. Staffing levels were consistent and staff had the skills to be able to meet people's needs. There was a training programme but not all staff had in date training in all area, which meant all staff may not have the knowledge to meet people's needs . Recruitment checks had been completed before staff started work to ensure the safety of people. Staff had a good understanding of how to keep people safe and what action they should take if they had any concerns. Medicines were administered and stored safely.

Staff had a limited knowledge of the Mental Capacity Act and people's records did not show people's capacity to make specific decisions had been assessed. This meant people did not have their mental capacity assessed and restrictions may have been placed on people without an assessment. Most people enjoyed the meals and were offered a choice at meal times, although this was limited at lunchtime. People were supported to access a range of health professionals.

People did not always have their individual needs met in a personalised way, which reflected their choices had been considered. This meant staff may not always have the best information on how to meet an individual's needs to meet the person's preferences and needs. People felt confident they could make a complaint and it would be responded to. Complaints were logged and there were recordings of investigations into complaints.

The home had an open culture where staff felt if they raised concerns they would be listened to. Staff felt supported by the registered manager and were clear about their roles and the values of the home. Records were not always accurately maintained and this was not an effective part of the quality audit process.

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.

Risks regarding individuals care had not always been identified and assessments were not always in place

Recruitment procedures were in place.

Staffing levels were planned to ensure the needs of people could be met.

Staff had a good understanding of how to safeguard people and what action to take if they thought people were not safe.

Medicines were safely stored, administered and recorded.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received training or regular supervision, to ensure they could meet people's needs.

Staff did not have a good knowledge of the Mental Capacity Act 2005 and of working in people's best interests and records were not reflective of these considerations.

People received support to ensure they ate a balanced diet.

People were supported to access a range of healthcare professionals.

Is the service caring?

Good

The service was caring.

People were supported by caring staff who respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care, which was in line with their needs or preferences.

People felt they could complain and complaints were investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

The home had a positive open culture with staff who were aware of the homes values.

Quality audits were completed by the manager and provider but there needed to be further analysis of incidents and accidents.

Records were not accurate or well maintained.

St Vincent House - Gosport

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 comprehensive inspection took place on 1 and 2 March 2016 and was unannounced, which meant the staff and provider did not know we would be visiting. One inspector and a specialist advisor in nursing and the care of frail older people, especially those living with dementia, carried out the inspection. We visited the service between the hours of 9.30am and 8:00pm over the two days

Before the inspection, we reviewed previous inspection reports, action plans from the provider, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, the provider completed 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.

During the inspection we spent time talking to seven people, four visitors, a health professional, five members of care staff, deputy manager, registered manager, a member of the provider's management team and the nominated individual. We looked at the care records of eleven people and staffing records of four members of staff. We saw minutes of staff meetings, residents meetings, policies and procedures, monthly reports by the provider and the complaints log and records. Certain policies were sent to us following the inspection. We were given copies of the duty rota and the training matrix for a month, which included the week of the inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed interactions between people and staff.

Requires Improvement

Is the service safe?

Our findings

At the comprehensive inspection in January 2015 we identified a breach regarding staff not following risk assessments. An action plan was received from the provider telling us they would ensure staff would follow people's risk assessments.

During this inspection we found risks regarding individuals care had not always been identified and assessments were not always in place. For example in one person's records there was information which identified the person did not sleep well, got up and down throughout the night and was confused day and night. The care plan identified the person was at risk of falls. However, there was no specific risk assessment which identified this risk to guide staff on how they could support the person and minimise these risks. This was more important as the person was in a bedroom, which opened onto a steep staircase which could have been more of a risk at night. When looking at the records of someone who smoked we found there was no specific risk assessment relating to the risks to the person, the staff or the home. In one person's room we saw they had a bed side support. However, there was no associated risk assessment relating to this aid, to ensure staff were aware of the possible risks in terms of injury to the person.

For one person who was at risk of choking it was found they did not have a necessary risk assessment. It was recorded in their care plan, "Staff should contact SALT (speech and language therapist) if they feel (person) has changes to their swallowing". We could not locate a SALT assessment or a dysphagia (swallowing difficulties) care plan. When asked a senior care staff member told us "They had SALT years ago; I cannot remember when but ages ago, I don't think there has been one since". This meant there was no baseline for staff in terms of the person's swallowing, which meant it would be difficult for staff to tell when a person's swallowing was deteriorating. The catering list held by the chef did not include this person as requiring a pureed diet. This meant there was conflicting information about the person's diet and the lack of a risk assessment meant there was no guidance for staff about how they should respond if the person choked or aspirated food or fluids.

The lack of effective risk assessments in place to ensure the safety and welfare of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The service had clear information and procedures of what action to take in the case of environmental emergencies. These included electrical power failure, water leakage lift failure and needing to evacuate the home. A fire risk assessment was available in the home.

Staff had knowledge of what constituted abuse and what action to take if they suspected abuse. Staff had undertaken training on safeguarding people and were aware of the policies and procedures relating to keeping people safe. Staff were confident if they reported any concerns to the manager they would take appropriate action and report concerns onto the appropriate authorities.

The registered manager did not use a tool to assess and show how staffing levels were sufficient to meet the needs of people. However, they said they would increase staff on duty if this was required to meet people's needs. The registered manager said the usual duty pattern was to have six staff on duty in the morning and

four care staff until eight o'clock. The manager and deputy manager also worked Monday – Friday and were on call at weekends. A member of staff also worked specifically in relation to serving breakfasts, snacks throughout the day and making hot and cold drinks. In addition there would be a cook and domestic staff. Three waking staff worked a night duty. The duty rotas from 19/2/16 – 12/3/16 recorded consistent staffing levels in line with what we were told by the registered manager. The skills and experience of staff had also been considered when the staffing rotas were planned. Staff responded to people in a timely fashion during our inspection. A health professional advised us when they had arranged to go in and give those people who had consented to the flu jab; extra staff had been arranged on duty to ensure people had the necessary support.

Recruitment records showed relevant checks had been followed to keep people safe. Checks with the Disclosure and Barring Service were made before staff started work. Application forms had been completed and where available staff's qualifications and employment history including their last employer had been recorded.

At the comprehensive inspection in January 2015 we found there was a breach regarding medicines not being managed well in some cases. An action plan was received from the provider telling us they had taken the necessary action. During this inspection medicines were managed well. There was a new medicines/clinical room which was tidy and well organised. Medicines were stored, administered and recorded appropriately. The temperature of the medicines refrigerator was recorded daily, together with the room temperature. There was an efficient system of ordering new stock and medicines were not over stocked. A medicines disposals book was maintained. When people had been prescribed topical medicines, these were recorded on the MAR (Medication Administration Record) chart. These all had the date they had been opened recorded on them. One person told us, "I always get the help I needs with my pills." Another person told us "The girls give me my tablets on time every day and as I am diabetic this is important".

Requires Improvement

Is the service effective?

Our findings

At the comprehensive inspection in January 2015 we identified a breach regarding staff not receiving regular planned supervision. We received an action from the provider telling us they had planned supervisions for staff. Staff told us they were supported in their roles and could access the registered manager and deputy at any time. However, staff were still not receiving planned supervision at regular intervals or an annual appraisal, which meant there was a continued breach. The impact of this was low and the provider told us a plan would soon be in place with the newly appointed deputy manager helping with this. Staff records we viewed identified supervision was given on an unplanned basis. The registered manager told us there was plan to ensure all staff would be offered formal supervision on a regular basis and this would be planned in advance. New staff were given an induction, which included shadowing experienced staff, so they got to know people living in the home.

The service supports people with a wide range of needs including some people who have a diagnosis of dementia, with associated behaviours which at times are challenging to staff and other people. We were given a copy of the training schedule. Training listed included safeguarding, manual handling and moving people safely, food hygiene, medicines, Mental Capacity Act and Deprivation of Liberty (DoLS), fire safety, first aid, Dementia awareness/ communication and person centred care. From the information recorded on the training schedule we could not be assured all staff had the necessary and up to date training required to meet the needs of people. There were gaps for care staff in the areas of challenging behaviour, end of life palliative care, infection control and Mental Capacity Act meaning staff did not have the knowledge to meet people's needs. From the training matrix it was not possible to evidence all care staff had up to date training in any area.

The lack of staff training to ensure they could meet people's needs and the lack of regular supervision and annual appraisal was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Staff had a basic knowledge about mental capacity and how it affected people who lived at the home. 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. Records did not always reflect the Mental Capacity Act had been considered.

The registered and deputy manager told us about two people who had left the home without advising staff. We were told these people were at risk if they left the home alone and as a result the locks and codes to the home had been changed. When we looked in these people's records we found there had been no mental capacity assessments. No considerations had been given to arranging a best interest decision meeting. This reflected it had been assumed these people did not have capacity without there being an assessment to test their capacity. Other parts of the care plan for one person reflected they 'had no difficulty communicating and was able to communicate my needs'.

In another example a person's movement was restricted by the (Hydro tilt) chair they were sat in. We were advised this was for their safety but there had been no assessment of the person's capacity to see if they could agree or disagree to this restriction. The registered manager told us people's cigarettes were locked away and dispensed as and when, for the people who smoked. However, there had been no capacity assessments to see if people had the capacity to hold their own cigarettes. As a result people had to wait for staff to become available to escort them outside through a fire door to the gazebo to have their cigarette. One person told us they got "Fed-up" of having to wait for staff.

The lack of assessing people's capacity and regards of the Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

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 whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had an understanding of the Deprivation of Liberty Safeguards (DoLS) and some staff had received training to support their understanding. Applications to deprive people of their liberty had recently been made to the local authority responsible for making these decisions.

People were offered drinks and snacks frequently, with a member of staff having direct responsibility for this role. Some people found it difficult to eat on their own and staff supported them in a kind and patient manner. People could choose where they ate their meals and some people chose to walk around whilst eating sandwiches and snacks. People made positive comments about the meals they were offered. People who had identified problems with eating were referred to the relevant professionals, to ensure they got the support they needed. Records showed people's weight was monitored on a regular basis and part of the Malnutrition Universal Screening Tool (MUST). The must is a five step screening tool, to identify adults who are at risk of malnutrition.

People were referred to health professionals as necessary. Details of the referrals and appointments were maintained in people's records. A health professional advised us staff were able to follow their advice and they felt they were called into the home appropriately. They told us the home was responsive to their suggestions for example with the prevention of people needing hospital admissions.

Good

Is the service caring?

Our findings

Two visitors told us they only had good things to say about the home and all the staff who worked in the home. They told us staff were caring and patient with people.

There were many examples of positive staff interactions with people. Staff responded quickly when they were asked for assistance and staff were friendly and when they spoke with people and they did so in respectful ways. Staff ensured people's privacy was protected because all aspects of personal care were provided in people's own rooms.

Staff had good knowledge of individuals and knew what their likes and dislikes were. For example when people were offered drinks throughout the day, staff knew what they liked. When people had a drink in front of them for some time or when the volume reduced, staff offered an alternative and they seemed to know what else the person would prefer for example 'tea' or 'milk'. Staff used people's chosen names and people in return seemed to know the staff names. People responded warmly to the senior staff who administered their medicines.

The home had a calm and well organised atmosphere and staff were friendly and smiled a lot. The staff did not rush people. People were encouraged to be independent and were supported with maintaining their independence. Efforts were made to ensure people had freedom of movement around the home and into the home's gardens. People who smoked before coming into the home were enabled to carry on with this activity.

Some considerations had been made to the environment to ensure it supported people. For example all toilets and bathrooms were identified by a bright yellow door. In the lounge there was a range of items for people to pick up and explore or provide mental stimulation. For people less mobile there were knitted mits for people to put their hands in, which had things stitched in for people to touch. Staff often encouraged people to use these items and people would pass these items onto other people.

However, the main lounge was full on both days of our visit, which meant people were sat in chairs around the sides of the room and the middle of the room was used as a thoroughfare. As a result for people with cognitive impairment there may have been uncertainty about the purpose of the room. For example, people who were sitting along one side of the room could not easily have a discussion with people on the other side of the room. Because people were sitting alongside other people it was difficult for them to turn to have conversations with them. We noted there were failed conversations in this room as one person spoke to another but the other person did not quite hear. For some people this was an irritating experience and they showed this by the way they spoke and the things they said to other people. We heard people respond "What did you say". "Pardon"? "Oh for heaven's sake speak up". It was noted some people had their set chairs and they did not want to move, which may have made changing the layout difficult. Staff engaged people in social interactions on a regular basis and would show a caring attitude in assisting people to change chairs so there was no friction between people.

Requires Improvement

Is the service responsive?

Our findings

People had assessments before they moved into the home. From these care plans were developed, which were reviewed on an on-going basis. Care plans were written in the first person, for example "(Name) likes to choose what they wear in the morning". This demonstrated staff had tried to include people in the development of care plans; however we could not determine they had been included in on-going reviews of their care. People did not express any concerns when asked about their paperwork, telling us they did not wish to see paperwork.

The registered and deputy manager wrote the care plans and a brief summary was kept in people's rooms. In addition records were maintained relating to the day to day care of people. Many of these included the same information which meant they were not sufficiently personalised. There was space for these records to be made three times a day and the daily records were kept in folders which were completed by care staff. We found the summary maintained in people's rooms had not always been updated as people's needs changed.

Care plans did not detail sufficient information to ensure staff had the right information to know how to meet people's needs. For example five people were taking medicine to treat urinary tract infections; two of these were current and three long term. Their records did not have care plans which provided preventative guidance for staff, (such as fluid intake targets) or instructions about how staff could provide care and comfort for people.

The registered manager told us all people living at the home had a diagnosis of one of the forms of dementia. This meant it was to be expected at some stage people's behaviour would change. However, behaviour plans did not provide clear information for staff to know people's needs. In one person's 'Risk Plan', it stated, "(name) can come across as rude and aggressive when talking to staff and others at the home". There was no guidance for staff about how they should prevent and/or respond to situations which were potentially or actually confrontational. The action was recorded as "Staff to be aware of where B is at all times and to complete behaviour charts when B becomes aggressive to see is there is any pattern to the times." We were unable to find behaviour record for this person's behaviour despite there being a record of two physical aggressive incidents, in recent months. There was no plan to support the person, reducing the risks to other people and help support the person.

Pain assessments for people were not used. Senior staff told us "We know residents so well that we know when they need pain killers". Most people had been prescribed a PRN (take as necessary) analgesic, but there were only brief PRN protocols provided which were not individualised. As a consequence the signs a person could have been in pain were not specifically recorded and the staff therefore may not have been able to identify them. On the first day one person complained of pain to us. We alerted staff and after two different members of staff spoke to the person, they could not agree if the person needed PRN analgesia. Personalised pain care plans would have helped provide a consistent approach.

People were not always supported with choices to receive personalised care. The registered manager on the

first morning told us 11 people were "got up by night staff." The handover sheets at the end of the night shift on 29/02/16 recorded 17 people as being up and on 01/03/16, 12 people were recorded as being up. The records of seven people from those who were recorded as 'being up', did not record specific information about what time people got up or if this was their personal preference.

We could not be assured if this was these people's choice to get up early. The registered and deputy manager advised this related to the risks of people, but this did not reflect it was people's choice. We also noted the lunchtime menu consisted of sandwiches and or soup every day. This did not constitute a real choice. We were told if people asked for an alternative this would be provided, but this relied on people being able to express this preference, which all people were not able to do. One person refused the lunchtime sandwiches and was given tea and biscuits instead. A staff member asked the person why they did not want the sandwiches and they replied "I don't like them".

The care and treatment of people was not always person centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From records we could see people's chosen activities were recorded. Staff had worked hard to ensure there was a range of activities to meet people's choices. There was an activities programme which recorded a range of social activities which were on a group or individual basis. The home had designated staff to provide activities and also a range of outside entertainers who came into the home. People were given the choice of joining in activities and those who took part told us they enjoyed the range of activities.

The registered manager kept a log of all complaints which had been made. This included the details of the investigation and the outcome of the complaint. When looking at a recent complaint we saw this identified the learning from the complaint which had been shared with staff and other organisations. People and visitors told us they would be confident making a complaint and the complaints procedure was displayed in the home.

Requires Improvement

Is the service well-led?

Our findings

At the comprehensive inspection in January 2015 we identified a breach as the providers monitoring and quality system had not been effective in assessing and identifying and mitigating risks to people. We received an action plan from the provider telling us the action they would take; however during this inspection found there was a continuing breach with this regulation.

A member of staff told us, "Things have improved a lot since our manager came. We are more organised and things are calmer. I can go to her with anything which makes a huge difference". A second senior carer said "We have a great management team now, they know residents and staff really well and they always listen, they are a great team, it has made a real difference". The provider visited the home regularly and there was a monthly report made of these visits.

The home had a registered manager in post and in November 2015 a deputy manager had joined the management team. Staff had confidence in the registered and deputy manager and believed they shared the views and values of the home. The registered manager was aware of her responsibilities and sent notifications to CQC appropriately and had also in the past made appropriate safeguarding referrals to the local authority. The registered and deputy manager were visible around the home and had a good knowledge and rapport with people.

The home had a positive and open culture. People and relatives felt they could make comments to the registered manager and staff regarding any concerns or compliments they had. Service user, staff and family questionnaires had been carried out in December 2015. The analysis recorded how many surveys had been sent out and how many had been received. The results had been collated and it was clear the majority of the responses were of a positive nature. All relatives had given positive feedback on the staff and all knew how to make a complaint. A newsletter had been sent out to relatives with the results of the surveys. Staff were aware of the whistle-blowing policy. Staff meetings took place on a regular basis and this included changing the time, so night staff were included also. The minute's demonstrated staff could raise any issues or concerns they had. We identified the lack of choice at lunch time with only sandwiches and or soup being offered at lunchtime. It was noted the lunchtime menu of sandwiches and or soup was raised by staff in the November 2015 staff meeting. The provider had replied they would look into this but was satisfied people were not unhappy with the choices available.

During the inspection we found the registered manager and the provider responsive to our feedback and wanting to improve the quality of service to people. For example we discussed how people were identified as 'Do not Attempt Cardiopulmonary Resuscitation' (DNACPR) within the home. By the second day of the inspection this had changed and the information had been added to people's care summary. We advised how the storage of unwanted medicines could be improved and on the second day of the inspection the pharmacist had delivered two 'Doom pots' (to store refused medicines) to the home. They told us they were very happy to support the home which they regarded highly.

The registered manager sent a monthly report to the provider, which tended to be basic and focus on

admissions, deaths, hospital visits, safeguarding and pressure ulcers. We could see a range of regular audits took place which included looking and reporting on medicines, care plans, hoists, slings, kitchen and infection control. We could see there was learning from these audits. For example in the medicines audit in January 2016 it was noted a member of staff had not signed when administering a medicine. This had been discussed with the member of staff and checked they were aware of their mistake. Members of the management team, managers from other homes of the provider and the providers met on a regular basis to discuss how they can progress and improve the homes further.

Records were an area which needed to improve within the home. For example, a record was made of incidents and accidents in the home. However, there was no overall analysis of this information so no learning was possible. Topical medicines records did not demonstrate they were being applied as prescribed. People had basic continence care plans which were limited to the type of continence pads used but not how frequently they should be changed. When looking at one person's records over the previous eight days the records showed a mixed picture. On two days the records reflected there was only one pad change, on one day records showed there was no pad change and on other days records showed there was three or four changes. The registered manager advised us this was a recording error. Records regarding injuries or pressure sores needed to be improved. No photographs or measurements were routinely maintained, which made it difficult to evidence the seriousness of the wound/ injury and if they were healing.

In some people's nutritional care plans they identified staff were to observe food and fluid intake. This did not always result in people having food and fluid records. When fluid records were maintained, these did not always record a target intake and they were not always totalled. This meant staff would not know the total fluid intake they should support the person to have.

The lack of well maintained records was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a lack of assessing people's capacity and regard of the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of effective risk assessments in place to ensure the safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating to people were not well maintained and fit for purpose.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of staff training did not ensure staff could meet people's needs and staff were not

receiving regular supervision or an annual appraisal.