St.Antony's Ltd

St Antony's Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 2 March 2016 and was unannounced. The last inspection of this service was on 28 May 2014. At that inspection we found the service was meeting all the regulations we assessed.

St Antony's Care Home provides accommodation for up to 12 people who require personal care and support on a daily basis. The home can accommodate people living with dementia and/or older people living with mental health issues. At the time of our inspection there were 11 people living at the home most of whom were living with dementia.

The service has 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 found the recreational and social activities limited particularly for those people who wished to remain in the home, or who were unable/unwilling to leave the home.
We saw staff were caring and they treated people with dignity, respect and compassion. Staff were well trained and supported to undertake their roles. Training was refreshed regularly so staff were up to date with current best practise. We saw staff were knowledgeable about the people their cared for and how to meet their diverse needs.

People had their health needs met. This included having access to healthcare professionals when they needed them. People received their medicines as they were prescribed to them. Staff were suitably trained to care for people nearing the end of their life.

People's nutritional needs were assessed and monitored. Although we noted on the day of the inspection it appeared little thought had been given to the lunchtime meal.

People were asked for their consent before care was provided. If people were not able to give consent, the provider worked within the framework of the Mental Capacity Act 2005. The Act aims to empower and protect people who may not be able to make decisions for themselves and to help ensure their rights are protected.

People were safe living at St Antony's. Staff were knowledge about what to do if they suspected anyone was at risk of harm. The provider had ensured suitable checks were undertaken prior to any member of staff being employed by the service. There were also a number of audits and checks in place to ensure the safety and people who used the service and staff who worked there. Staff were employed in sufficient numbers to meet people's needs.

The registered manager ensured that people were able to participate in activities of daily life as

independently as possible and if this was not possible, then risks were identified and strategies developed to assist people as much as they were able to.

The provider strived towards continuous improvement. They sought feedback from people who used the service, their relatives and staff. People told us they felt comfortable raising issues and concerns with the registered manager, and these would be taken seriously and addressed. The provider had engaged an external auditor to monitor the quality of care provided.

We made a recommendation regarding activities for people who use the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service safe. Staff were knowledgeable about keeping people safe. This included ensuring they received their medicines as they had been prescribed.

The provider undertook checks prior to employment so that only appropriate people were recruited. There were sufficient staff employed to meet people's care needs.

The provider completed risk assessments to ensure people and others were safe. Any accidents and incidents were recorded and analysed by the registered manager so the risks of any re-occurrences were minimised.

Is the service effective?

Good

The service was effective. Staff received training that was relevant to their roles and this training was refreshed regularly. Staff were supported by the registered manager by regular meetings.

The provider met the requirements of the Mental Capacity Act 2005 to help ensure people's rights were protected. People's consent was sought prior to care being provided.

People's nutritional needs were effectively met. They had access to a range of health professionals as and when they needed them to support them with their healthcare needs.

Is the service caring?

Good

The service was caring. Staff were knowledgeable about the people they were caring for and were able to meet their diverse needs. We saw staff treated people with dignity and respect.

Friends and relatives could visit people living at the home with no restrictions.

The provider was able to offer appropriate end of life care to people if it became necessary.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were offered a limited range of activities particularly if they chose to stay within the home, so the risks of social isolation were increased.

People received care that was personalised and met their needs.

People felt able to raise any issues or concerns with the registered manager and they were confident their views would be listened to and acted upon.

Is the service well-led?

Good

The service was well led. There was a registered manager in post who worked with other professionals to achieve the best outcomes for people.

There were systems in place for monitoring the quality of the service to ensure there was a drive towards improvement.

People and staff were positive about the registered manager and the way in which they managed the service.

St Antony's Care Home

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 took place on 2 March 2016 and was unannounced. The inspection was completed by one inspector.

Prior to the inspection we asked the provider to complete 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. We also reviewed other information about the service such as notifications they are required to submit to CQC. Notifications are significant events the service is required to inform us about.

On the day of the inspection we spoke with two people who lived at the home and a relative who was visiting the home. As some people living at St Antony's were living with dementia, they were not able to easily share their experiences of living at the home with us. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help understand the experience of people who cannot talk with us.

During the inspection we talked with the registered manager and two other staff. We looked at various records including care records for four people and three sets of staff records relating to how they were recruited and trained. We also checked information about to how the home was managed including how medicines were managed.

After the inspection we telephoned a further two relatives and two healthcare professional who had contact with the service to get their views about the home.

Good

Is the service safe?

Our findings

Relatives we spoke with were positive about the care their relatives received. One person told us, "This home was recommended to me. Not like a care home its family home, very welcoming and relaxed atmosphere." Another person said, "I feel comfortable leaving my mum here."

The records we looked at showed staff had received training in safeguarding adults at risk of abuse and this training was regularly refreshed. We spoke with staff to ensure they understood what action they needed to take if they considered anyone was at risk of harm. We were assured that staff and the registered manager were aware of the possible signs of abuse. They were also knowledgeable about the process they were required to undertake if they thought anyone was at risk of harm. The registered manager told us that as well as completing safeguarding adults at risk training, some staff had also completed safeguarding children at risk training. We were told this was because children often visited relatives in the home and they wanted to ensure risks to any visitors were minimised. The home had a whistle blowing policy and staff were aware of what action they could take if they considered people to be at risk of harm.

We looked at some recruitment checks for staff. This was to ensure only suitable people were employed to work at the home. We saw checks undertaken included employment references, proof of identity and police checks. There were also documents such as the person's application form and notes from interview. In this way the provider was ensuring they had a full employment history of the member of staff, and there were no unexplained gaps.

The home employed sufficient numbers of staff to meet people's care needs. We saw staff were present throughout the day and were able to respond to people's request for assistance. The registered manager told us they employed a small staff team who worked effectively together. The home was able to cover any absences due to leave and sickness from within its own staff team. They were also able to increase staffing levels if there were particular activities taking place such as visits to the church or healthcare appointments.

People received their medicines as they had been prescribed. We checked the storage, recording and administration of medicines. We saw the medicines administration records (MAR) had a photograph which related to each person and a list of known allergies. In this way the risk of errors occurring were minimised. Medicines arrived from the community pharmacist on a 28 day cycle. Many of the medicines arrived in blister packs, this was for ease of administration and to minimise the risk of errors. We saw there were protocols for 'when needed' (PRN) medicines. There were regular audits of medicines so any errors could be identified and rectified quickly. This included a daily audit by staff, weekly audit by the registered manager and an annual audit by the community pharmacist. We were able to see a report of the last community pharmacist audit which was undertaken in July 2015. All areas requiring improvements identified in the report had been actioned by the provider.

We saw records that showed assessments had been undertaken to identify risks to people's health and welfare. These risk assessments were updated monthly and more often if required, so they reflected people's current and changing needs. The risk assessments covered areas such as the risk of falls, pressure

sores and poor nutrition and hydration. By the process of identifying possible risks and detailing strategies for managing them, the provider was minimising the possible risks to people and staff.

The provider also kept a record of all accidents and incidents and was able to give us examples of action that had taken place as a result so the risk of re-occurrences were minimised. The registered manager told us about someone within the service who had recently fallen in the bathroom and was wary of it happening again. The home had developed a strategy in conjunction with the person and agreed that the bathroom door would not be locked from the inside, and a member of staff would wait aside the bathroom door and give verbal re-assure. In this way, the person retained their independence, but if an accident was to occur, staff could quickly access the bathroom.

Good

Is the service effective?

Our findings

People were supported to eat and drink sufficient amounts to maintain their health and well-being. People's nutritional needs were assessed and recorded. We saw people's weight and nutritional risk assessments were monitored monthly and more often if required. If there was a significant change in people's weight then action was taken to address this with a referral to relevant healthcare professionals.

On the day of our inspection the lunchtime meal compromised of boiled potatoes and cauliflower and baked beans. One person said of the meal, "There's not even a piece of ham" at which point a member of staff went to the kitchen and offered people either sliced ham or cold chicken to accompany their meal. It was also noted the dessert compromised of Swiss roll and custard, which had been put into bowls ready to be served when required. This meant the bowls were left to stand for some time and the custard went cold.

We saw from the menu board the meal that should have been provided was baked potatoes with beans and/or cheese with salad. We discussed this with the registered manager who was unable to provide an explanation for the change in the menu plan. The registered manager agreed to discuss the issue with the member of staff who had prepared the meal and to ensure there was no re-occurrence.

People were cared for by staff who had received regular training and support to undertake their roles. The registered manager told us about the induction process for all new staff. This included a period of shadowing more experienced staff whilst they undertook their role so they understood the needs of people and how best to meet those needs. We saw records and spoke with staff about the training provided at St Antony's. Staff had attended courses or completed computer based training for subjects such as first aid, dementia awareness, health and safety and fire training. The provider was also aware of the Care Certificate, which is a nationally recognised qualification which sets a baseline for staff employed in care settings. The provider had plans in place to introduce the Care Certificate for any new staff. We saw evidence that training was refreshed regularly. In this way the provider was ensuring the staff team maintained their existing knowledge and were keeping up to date with best practice.

Staff were supported to undertake their roles. Staff told us they had a one to one meeting with the registered manager every three months. This gave them an opportunity to consider their professional development and future training needs, as well as an opportunity to discuss any areas which may affect their work within the care home. There was also an opportunity for the staff team to meet every month to discuss aspects of their work. Staff told us St Antony's compromised of a small staff team of ten people, they found they regularly worked alongside each other and the registered manager, so issues could be raised and discussed. In this way, staff told us they worked effectively together and could address the needs of people quickly.

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. 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.

We saw evidence that staff received recent training regarding MCA and DoLS. They were also able to tell us about the impact of DoLS on individuals living within the home and how they would manage fictional scenarios. We saw the registered manager had made four applications to the local authority to deprive people of their liberty. Two of which had been granted and two were pending assessment from the local authority.

The staff team always sought consent from people prior to them providing care. We heard and observed a number of interactions throughout the day which confirmed this. For example, we heard staff ask, "Can I help with that?" and "Do you want to come through to the table for lunch today?" If people were not able to give consent, then this information was recorded in their care plan. Instead we saw 'best interest' meetings were held. These meetings comprised of relatives, representatives and health and social care professionals who were involved directly with the person. These meetings would consider the persons best interests, how the best interests could be achieved and what the person may have wanted for themselves. This information was then recorded and actioned accordingly.

People had access to healthcare professionals as and when they needed them. Within people's care plans we saw professionals recorded visits they made to the service and any action taken. The service had involvement from a number of healthcare professionals. This included the GP, chiropodist, district nurses and palliative care nurses. Professionals told us the service was "prompt and responsive" and contacted them appropriately.

Good

Is the service caring?

Our findings

We received positive comments about the care provided at St Antony's. One person told us, "It's alright here, they look after us." Whilst relatives told us, "I feel comfortable leaving my mother here," and another person said, "They deal with [relative's name] extremely well given how difficult I know [relative's name] can be. Relatives also told us how they could visit the home whenever they wished and were always made to feel welcome.

Throughout the day we saw staff maintained people's privacy and dignity. Staff knocked on people's bedroom doors and waited before entering. We saw staff gently direct people into completing tasks in an unhurried way, for example whilst they were assisting people to move around the building or when people required help with meals. Staff were also able to tell us how they ensured people had privacy and dignity when they provided personal care.

Staff were kind and compassionate in their interactions with people. Many of the staff team had worked in the care home for a number of years and were knowledgeable and experienced about how they could best meet the needs of people living in the home. One member of staff was able to tell us how they could identify if a person was becoming agitated through their behaviour, and what measures they would sequentially take to alleviate the person's anxiety.

The home was able to meet people's diverse needs. We saw that people's cultural and religious needs were documented in their care plans, and that needs could be met. The home was able to meet people's dietary needs, this included buying specific food such as yams and dried fish for some people. They were also able to provide staff to accompany people to attend a temple if they chose.

We saw the home was able to provide end of life care to people. Staff had all received appropriate Gold Standard Framework (GSF) training. GSF is nationally recognised training for frontline staff to provide a standard of care to people nearing the end of their lives. The home also had contact with a palliative care nurse who was providing support to someone who had chosen to remain at the home.

Requires Improvement

Is the service responsive?

Our findings

The service offered some activities to people who lived at the home. One relative we spoke with was positive about the activities and told us, "Always pleased with what's going on. One time we went in and they were doing some painting and there was a big grin on his [relative's] face."

Notwithstanding the positive comment we received, the evidence we saw was a limited range of activities on offer, particularly for those people who wished to remain in the home. Three days a week people could choose to attend a coffee morning, lunch club or a service at the local church. Within the home people had a choice of a weekly arts and crafts session or a visit by representatives from the local church. Other than this there appeared to be limited opportunities available to people. We saw the home had a set of dominos, playing cards and the television available to people. We also observed one person flicking through a children's colouring book, but with no encouragement from a staff member to colour in the pictures if they chose or, to find a more age appropriate activity to engage in.

People received care that was personalised to meet their needs. Prior to admission to the home, information was gathered from various sources including from the person themselves, relatives and health and social care professionals. The home completed an assessment of the person's needs. This included detailed and significant life story work designed to recognise people's past, present, and future and used as part of reminiscence work. The assessment also included a life history so staff could understand people's background and perspectives and use the information to initiate points of discussion with people. This was particularly useful if people were living with dementia and may not remember some of their own histories.

We saw the care plans were personalised, up to date and accurate. There was key information about people's likes, dislikes and abilities. For example, in one care plan it stated the person needed prompting to change their clothes, but they could choose for themselves what they wanted to wear. We saw care plans were reviewed monthly and in this way the provider was ensuring people received care that met their current needs. A relative told us how the home had adapted to the changing needs of their parent by the provision of specialist equipment and regular visits from healthcare professionals who provided the nursing element of their relatives care.

There were systems in place to address any complaints. Relatives told us they felt comfortable raising any issues with the registered manager or other staff within the home. They considered any issues would be taken seriously and addressed. The home had a complaints policy which outlined the process of making a complaint and timescales for the provider to deal with the complaint. The home kept a record of all complaints made and this showed they were dealt with in a timely and appropriate manner.

We recommend that the provider review the provision of activities in the home according to national guidance including the social care institute of excellence (SCIE) guidance called, "Activity provision benchmarking good practice in care homes."

Good

Is the service well-led?

Our findings

We received a number of positive comments about the registered manager from relatives and staff members. They included, "She [the registered manager] is always very open with me and if there's the slightest concern about anything she's on the phone." A member of staff said, "Very confident to talk to [registered manager's name]. She doesn't sit on stuff."

The service had a registered manager in post. The registered manager notified CQC of significant events in the home in line with their legal requirements of being a registered provider. Staff were aware of their roles and responsibilities within the home and willing to work within this environment to provide a quality service. The registered manager constantly reviewed whether staff were aware of the direction and vision of the home. This was achieved by the registered manager making staff aware of changes of legislation and procedures and deciding how the service should be run. There were also reminders at team meetings of various policies that staff were expected to adhere to.

The provider was continually seeking feedback about the service and considering ways it could be improved. People who used the service, relatives and staff had been asked to completed a questionnaire and outline any improvements they considered would improve the service. The questionnaire had last been completed in the summer of 2015 and the results were available for us to view. The registered manager had recognised their dual role as provider and manager of the service may compromise their impartiality, therefore they had employed an external auditor as part of their quality monitoring. This audit had been completed in November 2015 and a copy of the report was available for us to view. It was positive to note all the action that had been identified by the external auditor had been progressed.

There were a number of other audits and checks in place designed to ensure the continued standards within the home. For example, the registered manager completed a monthly audit of medicines, care plans and risk assessments to ensure people's needs were safely and appropriately met. Other checks relating to the premises included weekly fire checks, fire drills and call bell checks. Unannounced out of hours visits were completed by the registered manager to ensure and monitor the quality of care provided to people over a 24 hour period and at weekends. Records showed the last of these visits had taken place at 11 pm the previous month and there had been no concerns or issues raised.

Staff were aware of their roles and responsibilities within the home. This was through supervision and direct observation of practice by the registered manager. If issues were identified there was a period of supervision and/or training. In this way the manager was constantly seeking to drive improvements.