Mrs Bimla Purmah

Angel Court Residential Care Home

Inspection report

Manor Road Precinct
Walsall
West Midlands
WS2 8RF

Tel: 01922633219

Date of inspection visit:
26 April 2018
27 April 2018

Date of publication:
19 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 26 and 27 April 2018 and was unannounced. At the last inspection of the service in November 2017, concerns were raised around the provider's oversight of the service and the effectiveness of the governance systems in place. This resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found that although the provider had begun the process of improving the governance systems in place, these remained ineffective and the provider remained in breach of this regulation.

Following the last inspection, we met with the provider and asked them to complete an action plan to show what actions they would take and by when, in order to improve the ratings of the key questions of Safe, Effective, Caring, Responsive and Well Led, from requires improvement to at least good. At this inspection, we found that although some improvements were being made, these were not consistently effective and the provider had not evidenced that improvements were sustainable.

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

The home accommodates up to 25 older people who may have a diagnosis of Dementia. At the time of the inspection there were 25 people living at the home.

There was a registered manager in post who was also the registered provider. 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.

Following previous incidents that had occurred at the service, people did not always feel safe. Systems in place to manage risks were not always followed to ensure people were safe. Staff had been recruited safely. Although there were enough staff available to meet people's needs, people who required one to one supervision did not consistently receive this. Medications were given safely but there were some issues in the recording of medication. Infection control policies at the home were effective.

People were not consistently satisfied with the meals provided. People's dietary requirements were met and people had access to healthcare services where required. People had their rights upheld in line with the mental capacity act although further work was required around the recording of decisions made in people's best interests. The decoration of the service required improving to ensure this met people's individual needs. Staff received training to enable them to support people effectively.

People got along well with staff but some people had not developed trusting relationships with staff due to

previous incidents at the service. People's communication needs were being met and people were treated with dignity. People were encouraged to remain independent where possible and had access to advocacy services if needed.

There were a lack of activities available that met people's individual interests and hobbies. Complaints made had not been consistently recorded or resolved. People's care records were reviewed and held personalised information about people's preferences with regards to their care.

There was a high turnover of management staff at the service. Systems in place to monitor the quality of the service had been ineffective in identifying the areas of concern found at this inspection. Records held in relation to people's care were not always accurate or complete.

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.

People did not always feel safe and risks to people were not always well managed.

There were sufficient numbers of appropriately recruited staff to support people.

Medication was seen to be given safely although some medication recording errors were identified.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always happy with the choices of meals but did have their dietary needs met.

People's rights were upheld in line with the mental capacity act although records in relation to best interests decisions were not always complete.

The decoration of the service was not appropriate to support those with a diagnosis of Dementia in moving around freely.

People had access to healthcare services where required.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always trust staff following previous incidents at the home.

People's communication needs were met and people were treated with dignity.

People were supported to maintain their independence where possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have access to activities that reflected their personal interest and hobbies.

Complaints were not consistently recorded or resolved.

People's care records were reviewed and held personalised information about people.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems in place had been ineffective at identifying risks and making improvements to the service.

The provider had not identified where records were not accurate or complete.

There had been a high turnover of management staff at the home which raised concerns about stability of the management team.

Angel Court Residential 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.

The inspection was prompted following a rating of Requires Improvement being given following an Inspection in November 2017. The provider was rated as Inadequate in the key question of 'Is the service well led?' and remained in special measures.

This inspection took place on 26 and 27 April 2018 and was unannounced. The inspection was completed by two inspectors and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with nine people living at the service and three relatives. As some people were unable to tell us their views of the service we completed a Short Observational Framework for Inspection (SOFI). The SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with three members of staff, the deputy manager and the provider.

We looked at care records for six people and six medication records. We looked at staff recruitment files for three members of staff, as well as records including complaints, accidents and incidents and quality

assurance audits.

Requires Improvement

Is the service safe?

Our findings

Not all people living at the home felt safe. One person told us, "I don't trust anyone". Another person said, "I don't feel safe". We were aware of incidents that had occurred at the home, including people wandering into other people's rooms. Although the provider was aware of these incidents and had taken action to address this, it was clear that these incidents remained on people's minds and contributed to them feeling not safe. We raised these concerns with the deputy manager who provided assurances that action would be taken to support people to feel safer at the home; including speaking to people about how they are feeling and what support they require in order to feel safer. Staff we spoke with told us they had received training in how to safeguard people from abuse and knew the actions they should take if they were concerned that someone may be at risk of harm. One member of staff told us, "I know how to raise a safeguarding if I thought there was any abuse happening". We saw that where safeguarding concerns had been raised, these had been acted upon and reported appropriately.

We found that although risks to people were identified, these risks were not consistently acted upon to ensure people were safe. For example, we found that one person posed a risk to another person living at the home. Staff were aware of these risks and we saw that risk assessments were in place showing what actions should be taken to ensure people were safe. However, we found that these actions were not being taken and where risk assessments stated the person should receive one to one supervision from staff, this was not happening consistently. This meant that there were instances where the person was in close proximity to the person they posed a risk to and staff were not present to ensure both were safe. Further, It was also not clear that risk assessments in relation to pressure area care were being followed. We saw one person's care records state that to reduce the risk of pressure areas developing, the person should be supported to reposition every two hours. When we looked at records completed, we found occasions where this support had not been given two hourly as required.

We found that for one person staff had responded to an identified risk but in doing so, had caused the person to be at risk in a different capacity. One person who had previously been assessed as requiring a walking stick to support their mobility did not have access to this. Staff we spoke with told us, and records confirmed that this was taken from the person as they were using it to hit objects. We could not see that action had been taken to ensure this was safe to do by speaking with other professionals such as Occupational Therapists. This meant the person would be at increased risk of falls as they did not have the equipment they needed to walk safely.

People gave mixed feedback when asked if there were enough staff available to support them. One person told us that they felt that although they stayed in their room, they did see staff regularly and that if they used their emergency call bell, this was responded too promptly. Other people however, did not feel this way. One person told us about an incident where they required a member of staff. The person told us, "I pressed the buzzer and no one came and I had to shout loud to get help". Staff spoken with also gave mixed feedback on the availability of staff. One member of staff told us, "It depends on how the day is going. It can be difficult". Whilst another staff member said, "Yes I think there is enough staff".

Our observations through the day showed that staff were mostly visible within communal areas and that people had their care needs met in a timely way. However, we saw that one person whose care records identified that they required one to one supervision from staff, did not consistently get this support and we observed periods where staff were not visible to support this person. The provider had completed a dependency tool that indicated the safe number of staff required to support people and we saw that this was being implemented.

Staff told us that prior to commencing employment at the home, they had been required to complete recruitment checks to ensure they were safe to work. These checks included the provision of references and a check with the Disclosure and Barring Service (DBS). The DBS check would show if an employee had a criminal record or had been barred from working with adults. Records we looked at showed that these checks took place.

People received their medications safely. We saw staff supporting people to take their medication. Staff did this in a safe way, explaining that it was time for medication and staying with the person whilst they took this. We saw that medication had been stored safely, however temperature checks were not being completed in all areas that medication was stored. It is important to check the temperatures in these areas as some medications can be adversely affected by the temperature. We raised this with the senior member of staff who advised they would commence checking the temperature in this room with immediate effect. We looked at medication administration records (MAR) and saw that the amounts of medications recorded as being given, did not always match the amounts available. This meant we could not be sure that medication was given as prescribed. The senior member of staff informed us that this would be investigated.

Where incidents occurred, we found that learning took place but was not always implemented consistently. For example, we found that although the provider had identified that one person had been wandering into other people's rooms, their learning from this and the action they had taken had not been sufficient to prevent this happening again and we found that the person continued to wander. This meant that although the provider had displayed a willingness to learn from incidents, this learning was not always effective or consistently applied.

There were systems in place to control and prevent the spread of infection. We found the home to be clean and staff had easy access to Personal Protective Equipment (PPE) to use when supporting people. Staff we spoke with displayed a good understanding of how to ensure the prevention of infection.

Requires Improvement

Is the service effective?

Our findings

People gave us mixed feedback regarding the food available at the home. One person told us, "Sometimes the meals are ok, sometimes not". Another person said, "The food is alright here, it's good". People felt that although they were provided with choices at mealtimes, these did not reflect their preferences with regards to food. One person told us, "They [staff] do offer a choice, but the way they cook it is not to my liking". Another person added, "There is choices but sometimes it's still not what you want". We saw at mealtime that one person refused their meal once presented with it. We spoke to the person and found that this was because they did not like how the meal looked on the plate. We saw that staff did offer the person an alternative which they also declined. We spoke with the provider and found that meals were provided by an outside company who would prepare the food and deliver this for staff to then warm up. This meant that there was little opportunity for meals to be altered to suit people's preferences as they were pre-prepared. This was further confirmed by a person who informed us that he felt some meals had too much pepper but could not do anything about this as the meals were delivered this way. This meant that although choices of meals were available, people were not able to adjust the meals to suit their individual tastes. Following the inspection, the provider informed us that they have contacted the catering company and that meals are available that have less pepper content. We saw that people had their specific dietary needs met and staff responsible for providing people with their meals had access to this information where needed. We saw that where support or encourage to eat and drink was needed, this was given by staff who were aware of people's dietary needs.

We found that the decoration of the service did not always support people's individual needs. For example, noticeboards in the dining area that gave people information about meal options were in small text only, no information on these boards had been provided in an accessible format. In addition, there was a lack of signage around the home to support people to move around freely and promote their independence. Where signs were available, these did not take into account people's individual needs; such as being provided in pictorial format or in other languages to aid people's understanding of the information in place.

People told us that they felt that staff had the skills required to support them effectively. One person told us, "There are some very good care workers here" and a relative added, "[Person's name] does get good care here". Staff told us that before they started work they were given an induction to the home that included completing training and shadowing a more experienced member of staff. The staff member said, "I was shown around the home, introduced to everyone and read all of the care plans. I then shadowed for two days". However, a newer member of staff told us they had not yet received their induction. The staff member told us that they had been introduced to people and observed for a day but had not yet been on any training with this provider. This meant that although there was an induction system in place, this was not consistently applied before staff commenced their role. The provider had systems in place to enrol new staff on the Care Certificate. The Care Certificate is an identified set of standards the care workers must adhere too.

Staff told us they had access to ongoing training and supervision and that this enabled them to support people effectively. One member of staff told us, "The training is useful and the trainers are so friendly. It

makes sense to me and I have been asked if I want any extra training". The staff member went on to explain that they had requested training in behaviour that may challenge to support them with some people living at the home and that this training was then provided. Records we viewed showed that staff had attended training and that this included training that covered people's individual care needs.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 that people were asked for their consent prior to receiving support and staff we spoke with displayed a good understanding of how to gain consent. One member of staff told us, "I gain consent by asking. If a person can't verbally say yes or no, I will look for other signals such as thumbs up or shaking of the head". We saw staff ask people for their consent throughout the inspection and respected the decisions people made.

Where people had DoLS authorisations in place, we saw that these had been applied for appropriately and that staff knew who had these in place and understood the basis for which the authorisations had been granted. However, we found that records held in relation to best interests decisions where people lacked capacity were not always detailed and it was not clear who had been involved in the best interests discussions. We also could not find evidence that where there had been a delay in receiving an outcome of a DoLS application, that the provider had taken action to chase this with the managing authority and keep a record of the restrictions being put into place while the DoLS decision was being made. This meant that although staff were aware of who had a DoLS in place and we did not see any evidence to suggest that people were being unlawfully restricted, further work was required around the recording of decisions where people lacked capacity.

People's care needs were assessed before they moved into the home. These assessments took in account people's medical and health needs and assessed the level of support required. The assessments also considered any protected characteristics under the Equality Act including religious or cultural needs.

People told us they had access to healthcare services where required. One person told us they saw their GP and district nurses regularly. Records we viewed showed that people were referred to healthcare services where this was required and we saw that people had been seen by Speech and Language Therapy and Nurses where needed. We saw that people received regular checks from their dentist and opticians.

Requires Improvement

Is the service caring?

Our findings

People told us that they felt staff were mostly kind and caring. One person told us, "I get on with the staff" and another person added, "They [staff] treat you so nice". However, not all people living at the home felt they trusted staff. There had been previous safeguarding incidents occur at the home that had caused people to feel this way. We found that although action was taken to keep people safe when the concerns were identified, the provider had not considered the impact these incidents would have on people's emotional well-being. As a result of this, the safeguarding incidents were clearly still on some people's minds and impacted their relationships with staff. We raised this with the deputy manager and senior care staff. They informed us that other than the initial action ensuring people were safe, no thoughts had been given to ensuring people's ongoing emotional well-being was discussed and supported following the incidents. This meant that although some people got on well with staff, the lack of action following incidents at the home had meant other people felt they could not enjoy caring relationships with the staff team.

We found that some people had specific communication needs. There were people who were living at the home who did not speak English as their primary language. We spoke with staff about how they met these communication needs. Staff gave detailed explanations of how they supported effective communication including, using hand gestures and showing people their options. Staff explained that if this was not effective, then they would find a member of staff who spoke the person's language to support with translation. Staff told us and records showed that there was always a member of staff in the home who spoke the person's first language. We found that although staff could provide good examples of how they communicated with people, this was not reflected in the care records and the information held was vague and did not reflect the wealth of information given to us by staff about how they communicated with people?. This meant that further work was required on records to ensure that all staff had the information they needed to communicate with people effectively.

People told us they felt treated with dignity and had privacy when they requested this. Staff spoken with were able to provide examples of how they ensured dignity was promoted. One member of staff told us, "I will do things like making sure curtains are closed when I support with personal care and always explain what I am doing and ask for permission before doing anything". We saw that staff acknowledged people's rights to privacy and knocked bedroom doors before entering people's rooms. People were also supported to maintain their independence where able. Staff told us they encouraged people to complete personal care tasks independently and only provided this support where it was requested or needed. This showed that staff understood the importance of encouraging people's independence.

People told us they were given choices and were able to make their own decision with regards to their daily care. We saw that people were provided with choices such as where they would like to sit and what drinks they would like.

Where people required the support of an advocate, systems were in place to access these services. An advocate can be used when people have difficulty making decisions and require this support to voice their views and wishes.

Requires Improvement

Is the service responsive?

Our findings

People were not satisfied with the activities on offer at the home. One person told us, "Most people here are old, all they do is sit and go to sleep". Another person said, "All we do is sit, I get fed up. They [staff] do my nails, we should go for a walk". Others told us that activities were limited to listening to the radio and watching television. Our conversations with people indicated that there were a number of opportunities to do activities within the home that would meet people's interests and hobbies but that these had not been identified or acted upon. For example, two people expressed an interest in football and told us they would like to watch this when it is on television but that staff do not support them to pursue this interest. The person told us, "I don't even get to see the results these days". Another person told us they would like to go fishing but had not done this for some time. This meant that people were not being supported to engage in activities that interest them and reflect their preferences. Following the inspection, the provider informed us that it would be unsafe for one person to be taken fishing. However, the provider had not considered alternative activities for this person that would incorporate his interest in fishing. We saw some activities on going throughout the inspection. This included a game of dominoes and a ball game. There was also a film being shown on the television. However, the level of interaction in these activities were low. We spoke with staff who told us that participation in activities had been low but consideration had not been given as to why this was the case and whether activities that better reflected people's interests would result in higher number of participants.

People told us they knew how to make a complaint. One relative we spoke with said, "If [person's name] has had an issue, I have been to [provider's name] and they have sorted it out as best they can". Another relative added, "They [the provider] is quick off the mark, if there is anything they will get on the phone". We saw that there was a complaints procedure in place but found that records were not always kept in relation to complaints made. We found records for one complaint and saw this had been investigated and responded too by the provider. However one relative informed us of an ongoing issue they had with laundry. They had raised these with the provider but did not feel the issue was resolved. We could not see a record of this complaint within the provider's systems to view how this complaint had been investigated. This meant that although there was a system in place for responding to and recording complaints, this was not being applied consistently.

Peoples care needs had been assessed prior to the moving into the home and informed the information that was included in people's care plans. We saw that records included information about people's medical history and care needs. People had also been given opportunity to express their preferences with regards to their care. We found that people had been asked about how they wished to have their room decorated, if they had any preferences with regards to the gender of staff supporting them and what activities they enjoyed. We saw that where people's care needs changed, care plans were reviewed. We found that staff knew people well. Staff could provide details on people's needs, likes, dislikes and how they preferred to be supported.

There was no one living at the home that was in receipt of end of life care. However, care plans were in place that identified people's wishes with regards to resuscitation and who people would like to be involved in

their care if they were to be at the end of their life.

People told us they were supported to maintain relationships with their loved ones. One person told us, "[Relative's name] comes to see me". We were told that there were no restrictions on people having visitors in the home and saw that where people had guests, they were given privacy to spend time alone if requested.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in November 2017, we found significant shortfalls in the provider's systems to monitor and improve the quality of the service. This resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found that although improvements were being made, there continued to be concerns around the provider's ability to make and sustain improvements at the service and so the breach of Regulation 17 was not met.

Following the departure of the home manager in November 2017, the provider had recruited a deputy manager to support them in the daily running of the service. However, shortly after our inspection visit, we received information that the deputy manager had left and recruitment was starting to identify a new deputy manager. This raises concerns about the stability of the management structure at the service as there has been a high turnover of management staff in the previous six months.

The provider with the support of their consultants had implemented a new auditing system. We saw that these new audits had been in place for one month. We saw that these audits had identified some areas for improvement and that these areas had been acted upon. However, the new auditing system had not been effective in identifying the issues we found at inspection. For example, the audits had failed to identify where people were not being supported in line with their care records. We found that where support to re-position was required, this was not provided in a consistent way. We also found that people did not consistently receive the one to one supervision they required and that people did not have access to the walking aids they had been assessed as needing. The provider later told us that this person had not required the use of walking sticks and they had checked this with family prior to removing the walking aids, however, the provider could not provide evidence to suggest that the decision to remove the walking aids had been discussed or agreed with others. These areas of concern had not been picked up in any of the audits completed in the previous months. This evidenced that although work had been done to improve the auditing systems in place; these remained ineffective in identifying and acting on risks to ensure people were safe.

The providers governance systems had also not ensured that records held about people and their care needs were complete and accurate. For example, we found that staff had been completing re-positioning charts incorrectly. Staff were not consistently recording what position they had supported the person into. This meant we were unable to evidence that the correct pressure area care had been provided as records had not been completed accurately. We also found that where people's needs in relation to their choking risk had changed, the records did not accurately reflect this change. We found that the change was recorded in a handwritten entry on the update page of the care records but the care plan and risk assessment remained unchanged, meaning that these documents no longer accurately reflected the person's needs.

We saw that people and their relatives had been provided with opportunity to feedback on their experience of the service. This was done via questionnaires and residents meetings. Although the provider's analysis of the questionnaires indicated that no actions were required, we saw that suggestions regarding the lack of activities had not yet been acted upon. This had a completed action date of the end of April 2018 but the

provider could not evidence what work was being done to address this feedback. Following the inspection, the provider provided evidence that they were keeping records in relation to the activities being completed by staff to monitor the activities taking place. However, the records did not show that the number of activities available had increased as a result of the feedback provided.

Following the last inspection, the provider employed the services of a care consultant to support them in making improvements at the service. The consultants had devised an action plan for the provider to work on to improve the service provided to people and was providing weekly visits to monitor the progress made. The provider informed us that the consultants had also supported them to make a decision on whether they were able to meet the needs of a potential new person at the home. This raised concerns about the provider's ability to identify, make and then sustain improvements at the service as they were heavily reliant on the consultants support in this area. Following the inspection, the provider informed us that a new manager had been recruited and would be responsible for driving improvements moving forward.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff told us they felt supported by the provider and felt the culture of the service was open and transparent. One member of staff told us, "If I have any worries or concerns, I know I could ask the question. If I did say something, it would be acted upon". We found that staff had been informed on the whistle blowing procedure and felt able to use this if needed.

The provider is required by law to submit notifications to us about incidents that occurred at the service. We found that the provider continued to submit these notifications as required and so was meeting this regulation.

It is a requirement that providers ensure that their most recent rating is displayed within the home and on any websites ran by the provider in relation to this home. We saw that although the provider did not have a website, they had displayed their rating in the reception area of the home and so had met this requirement.