HC-One Limited

St Augustines Court Care Home

Inspection report

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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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 17 and 18 December 2014.

At the last inspection on 29 September 2014, we asked the provider to take action to make improvements to the areas of supporting workers and records. At this inspection we found that improvements had been made in both those areas.

Accommodation for up to 40 people is provided in the home over two floors. The service is designed to meet the needs of older people.

A registered manager was not in place. The previous manager had left the previous month. A manager had started the week of the inspection and she was available throughout the inspection. A registered manager is a

Summary of findings

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.

People were not protected from avoidable harm and risk of injury at all times. Staff knew what to do if they suspected abuse but they did not complete incident forms when they were needed. This meant they did not realise when action was needed to safeguard people. We found that sufficient staff were on duty to keep people safe and meet their needs. Medicines were managed safely; however, a person did not receive one of their medicines for three days.

Appropriate applications had not been made under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards which meant that people could have been unlawfully restricted. We saw that people were not always well supported at mealtimes. However, we saw that the home involved outside professionals in people's care as appropriate and staff felt well supported.

Staff respected people's dignity but did not always respond appropriately to people in discomfort or distress. People were encouraged to make decisions and relatives were consulted, where possible regarding their family member's care.

We found that people were not supported to follow their own interests or hobbies. Complaints systems were in place and information available to people on how to make a complaint but no complaints had been made.

There were systems in place to monitor and improve the quality of the service provided, however, these were not effective. The provider had not identified the concerns that we found during this inspection. No formal meetings were taking place of people and their relatives where they could be involved in the development of the service. However, questionnaires were completed by relatives and people were asked their views when their care records were being reviewed. A new manager was in place who felt supported by the provider and resources were being made available to improve the quality of the service in response to our inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People were not consistently protected from avoidable harm or the risk of injury.

Safe medicines management procedures were followed.

There were appropriate staffing levels to meet the needs of people who used the service and staff were recruited by safe recruitment procedures.

Requires Improvement

Is the service effective?
The service was not always effective.

The service was not meeting the requirements of the Mental Capacity Act (2005) Deprivation of Liberty Safeguards (DoLS).

People were not always well supported to eat and drink.

Staff were supported to ensure they had up to date information to undertake their roles and responsibilities.

Staff involved other healthcare professionals if they had concerns about a person's health.

Requires Improvement

Is the service caring?
The service was not always caring.

Staff did not respond appropriately to a person in distress and a person receiving end of life care who was in discomfort.

People were encouraged to make decisions where appropriate and their privacy and dignity were respected.

Requires Improvement

Is the service responsive?
The service was not always responsive.

People were not supported to maintain hobbies and interests.

Care plans were in place outlining people's care and support needs. Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

Complaints procedures were in place and staff knew how to respond to complaints, however, no complaints had been received.

Requires Improvement

Is the service well-led?
The service was not always well-led.

Requires Improvement

Summary of findings

Audits carried out by the provider and registered manager had not identified all the shortcomings found during this inspection.

People and relatives were not fully involved in the development of the service.

A new manager was in place and staff felt well supported.

St Augustines Court 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 17 and 18 December 2014 and was unannounced.

The inspection team consisted of two inspectors.

Before our inspection we reviewed all the information we held about the home. This information included notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners of the service and Nottingham Healthwatch.

During our inspection, we spoke with two people who used the service and we also 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 spoke with the manager, the assistant operations director, four care staff, a nurse and a cook. We looked at eight care records, two recruitment files, observed care and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from avoidable harm. We observed a person calling out in the lounge area and becoming increasingly distressed. Other people sitting near the person also became distressed. The person calling out started move around and was subjected to physical abuse by two other people. Staff were sitting next to the person and reassured the person who had been subjected to physical abuse. We informed the manager. When we returned the following day these two incidents had not been recorded and no immediate action had been taken to protect the person. These incidents were referred to safeguarding following our inspection. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person told us that they did not feel safe in the home due to the behaviour of some people that walked around the home. We saw that people appeared to be comfortable with staff and they approached staff to seek reassurance when they were anxious. Staff told us that people were safe at the home and they did not have any concerns about other staff. They told us they had received safeguarding training and were able to describe the signs of abuse and the action they would take if they had a cause for concern.

The safeguarding policy and procedure and contact details for the local authority were easily accessible for staff. We saw safeguarding information displayed in the main reception area so people and their relatives knew who to contact if they had concerns. However, incident forms were not completed where appropriate and as a result, potential safeguarding issues were not identified and action was not taken to prevent a recurrence and protect people from further abuse. The manager and the assistant operations director told us they would be holding an urgent staff meeting to set out their expectations regarding incident reporting to ensure people's safety.

People were not always protected from the risk of harm. We observed that two staff members lifted a person under their arms which put the person at risk of injury as staff did not always use safe methods when assisting people to move. We informed the manager who told us they would address the issue. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had one to one supervision for most of the day as they lacked awareness of their surroundings and actions and had behaviours that may challenge others. Staff did not restrict them but allowed them to walk where they wished in the home whilst supervising them in order to keep them safe.

Risk assessments were reviewed regularly. Care plans and guidance were available to manage and reduce these risks. We observed a fire drill and appropriate actions occurred. A contingency plan was in place in the event of emergency. We saw that a personal evacuation plan had been completed for each person using the service. This gave staff guidance on how to support people safely in the event of an emergency.

We saw that the premises and equipment were maintained and safe. Maintenance certificates were up to date for the premises and equipment. Staff told us they had all the equipment they needed.

We observed that people received care promptly when requesting assistance in the lounge areas and in bedrooms. Staff were easily accessible throughout the day. Sufficient staff were on duty to provide one to one care for the people who needed it and to provide safe levels of care. Staff were allocated one to one care for periods of two hours and were then relieved by another member of staff. A member of staff remained in the main lounge at all times in order to attend to people promptly and maintain their safety.

The agency nurse we talked with said they had worked at the home on a number of occasions previously including night duty and they felt staffing levels were good on each occasion. Staff told us that staffing levels were fine. The manager told us that a tool was used to calculate staffing levels and staffing levels were reviewed at daily meetings.

People were recruited using safe recruitment practices. We looked at two recruitment files for staff recently employed by the service. The files contained all relevant information and the service had carried out all appropriate checks before a staff member started work.

We observed that people received their medicines safely. Medicines were stored safely and medicines administration

Requires Improvement

Is the service safe?

charts were fully completed. However, we found that some liquid medicines and topical creams had not been labelled with the date of opening. We also saw that one person had not received a medicine for three days due to ordering problems. The manager told us they would contact the GP and also make a safeguarding referral. Staff told us and records showed that they had received medicines training though some required this updating. Relevant policies and procedures were in place and monthly medicines audits took place.

Requires Improvement

Is the service effective?

Our findings

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed.

We saw that a DoLS authorisation was in place for one person and staff were acting in accordance with the authorisation. However, a number of people were receiving one to one care and their freedom was limited in order to keep them safe but no DoLS applications had been made. We also saw that another person's care plan stated, 'If and when [person] presents as being very physically aggressive, staff to employ minimum restraint and holding [person's] hands.' No DOLS authorisation had been considered for this person either. The manager and assistant operations director told us that there were five people living in the home who they would be making a DoLS authorisation application for. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the home in September 2014 we found that staff were not receiving appropriate training, supervision and appraisals. At this inspection we found that improvements had been made.

We observed that staff supported people effectively; however, staff were not always confident when supporting people with challenging behaviour. The agency nurse we talked with told us that their agency had checked they had undertaken the required mandatory training. Staff told us they felt supported and had received training, supervision and appraisal. We looked at the home's overview of training and saw training was generally well attended. We looked at records which showed that staff received regular supervision and appraisals.

We observed staff explained to people what they were going to do, before they provided care. Staff told us they checked with people prior to providing care to ensure their consent and gain their cooperation. Wherever possible they offered choices and tailored this to the needs of the individual. Staff had an understanding of the requirements of the Mental Capacity Act (MCA) 2005, an Act introduced to protect people who lack capacity to make certain decisions because of illness or disability.

Assessments of capacity and best interests' documentation were not always in place for people who lacked capacity where appropriate. While we saw assessments of capacity and best interests' documentation in some care records, we did not see any mental capacity assessments for two people who lacked capacity to make some decisions for themselves and where the care records identified the people had advanced dementia.

We saw a Do Not Attempt Cardio-Pulmonary Resuscitation (DNAR) decision was in place for one person. This had been reviewed every six months by the person's GP and recorded and discussed with the person's relative. The person had been noted as lacking the capacity for the decision. Another DNACPR had not been fully completed and had been discussed with a relative, not the person concerned. There was no reason noted for why it had not been discussed with them. The reason given for the decisions was 'Dementia.' The manager agreed to contact the GP to review the DNACPR documentation as soon as possible.

We observed that staff did not always respond promptly and confidently to people with behaviours that may challenge. We observed a staff member providing one to one care for a resident. When the person reacted unexpectedly, the staff member moved back quickly and did not respond appropriately resulting in a negative response from the person. Another staff member intervened quickly and the person immediately calmed. One staff member, who was providing one to one care for a person with challenging behaviour, said they had not been given any guidance on the best way of managing the person when they were aggressive or when they resisted personal care.

We checked to see whether people received effective nutrition and hydration. People gave us mixed views about the food they received. A person said, "It's the same food all of the time." However, they also said, "I've just had a nice pudding." Another person said, "I don't like the food so I eat biscuits." However, they also said, "The egg and chips are ok."

Requires Improvement

Is the service effective?

Drinks were available in the dining areas at all times and we saw people being encouraged to drink. Snacks, such as crisps, were also provided and we saw people who were walking along the corridors stopping to eat these at intervals throughout the day.

We observed the lunchtime meal in the dining area and lounge. Some people sat in the dining room whilst others had their meal while sitting on their chairs in the lounge. Tables were covered with a tablecloth but there were no condiments on the table. Cutlery was brought to the table by staff immediately before providing the food. Each person's food was plated in the kitchen but we did not see any consultation with the person about which of the two choices on the menu they would prefer or any individual preferences regarding vegetables. However, we were told one person would only eat cheese on toast for lunch and we saw this was provided for them.

Several people needed to be supported to eat and most others required considerable encouragement and support to eat. There were adequate numbers of staff to provide support at lunchtime and staff sat at people's level and supported them at the person's pace. However, there was very little interaction between some staff and the people they were supporting. Several people forgot their meal was there or wandered off during the meal, eating very little. Staff encouraged them to return to their meal and if they did not appear to want to eat their main course offered them a dessert. We noticed some staff kept going back to people to check on their progress and provide active encouragement when they were eating little, but others only provided token encouragement. We noticed two people remove meat from their mouths which they had attempted to chew, and then appeared reluctant to eat more. Staff did not notice and offer any alternative which meant that people were not always effectively supported to eat enough.

The chef told us that the provider devised the menu with the aim of providing a nutritiously balanced diet. They said there were no people with cultural requirements or on special diets. People's nutritional risks were regularly reviewed and care plans were in place to address any identified risks. We saw that people's weights were regularly monitored in order to identify when people were losing or gaining weight. Where it had been identified that there were concerns about a person's fluid intake, a chart had been put into place to record their fluid intake and output.

A person told us they could see their GP when they wanted. Staff told us that the GP for most of the people at the home visited on a weekly basis. A request for a GP visit was made for one person on the day of the inspection and staff ensured the GP understood a visit was required that day. The care records showed that other professionals were involved in people's care where appropriate to ensure that people were supported to maintain good health.

Requires Improvement

Is the service caring?

Our findings

Staff were not consistently caring. We saw some caring interactions, however we observed a person become distressed. Staff did not respond promptly to the person's distress and when they did respond, they offered very limited reassurance to them.

We discussed the preferences of people who used the service with care staff. Staff had a good knowledge of people's likes and dislikes. Care records we looked at were detailed regarding people's preferences and life histories.

On admission to the home the provider took into account and explored people's individual needs and preferences such as their cultural and religious requirements. For example where one person's religious requirements had been identified, they had been supported to meet these needs. This meant that people's diverse needs were being assessed and respected.

We observed that people were encouraged to make decisions where appropriate. The manager told us that one person's care was reviewed each day and the person and their relatives were consulted with regarding their care. Most care records did not show that people were involved in their care; however, we saw some involvement of relatives in people's care. The guide for people using the service contained details of advocacy schemes available for people if they required support. We also saw advocacy information and Healthwatch leaflets in the main reception area.

Staff respected people's dignity. We observed staff wiping people's faces following their meal and taking them to change their clothes when they became stained with food. Staff described giving people choice in relation to their everyday care and ensuring privacy by knocking on bedroom doors before entering and protecting their modesty by covering them as much as possible when supporting them in their personal hygiene. Staff told us that they encouraged people to be independent where appropriate.

The guide for people who used the service included information on relatives visiting the home, although we did not see any relatives visiting during our inspection. We saw that there were areas in the home where people could have privacy if they wanted it.

We observed the care of a person who was receiving end of life care. Staff behaved in a compassionate manner when checking on the person and providing care. However, they did not appear to identify interventions which could help to make the person more comfortable until prompted. We saw that the person looked uncomfortable and in pain and when it was suggested that the person might benefit from a change of position and required additional pain relief, they initially said the person had received paracetamol and the doctor was due to visit the following day. However, when prompted further, they asked the nurse to review the person and a call was made asking the GP to visit the person that day.

Requires Improvement

Is the service responsive?

Our findings

A person said, “It’s absolutely rubbish. There’s nothing to do here. I’m sick to death of the TV.” We didn’t see people being supported to follow their preferred hobbies or interests during our inspection. Staff made little attempt to engage people in any activity unless they needed to distract them when they were displaying behaviour that may challenge. Staff told us there were normally activities in the afternoons and people had the opportunity to go into town occasionally and there was a minibus for trips into the community. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the home in September 2014 we found care records did not always contain accurate information. At this inspection we found that improvements had been made.

People received care and treatment when they needed it and in line with their personalised needs. We saw that staff responded promptly to any requests for assistance from people. The nurse told us they received a comprehensive handover and were given a handover sheet with essential information about the people they were providing care for. Staff had understanding of people’s individual needs.

The care records we reviewed contained an individual profile for the person identifying their likes and dislikes, things that were important to them and things they enjoyed doing. Care plans were reviewed regularly and care plans were generally in place for recorded needs. People’s diverse needs were identified. We saw that a person’s religious needs had been identified and met.

Staff told us that if a person had a complaint they would try to resolve it there and then if possible. They would report any complaints to the manager and document them. There were no complaints recorded. Information on how to raise a concern was in the guide for people using the service. The complaints policy and procedure were easily accessible for staff and provided clear guidance to follow.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were not fully effective. We saw that checks on the quality of care were completed by the registered manager and also representatives of the provider not directly working at the home. We were told by a representative of the provider that it was acknowledged that these checks had not been accurate and had not been carried out frequently enough. They told us that the audits would be carried out by different representatives of the provider and would be completed more regularly. We saw that previous audits were incomplete or had identified issues but not put actions in place to address issues. We saw that an infection control audit carried out by a commissioner of care identified issues but these had not all been responded to.

We identified a number of shortcomings during this inspection which had not been identified or addressed following audits carried out by the provider. These included the areas of safeguarding, safe moving and handling and activities. These shortcomings constituted a breach of the regulations. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff appeared to work together well as a team and had good relationships with each other. However, there was variability in their efforts to engage with people with advanced dementia. No meetings were taking place for people and their relatives to discuss the development of the service. We saw that there was a comments book in the main reception for relatives and the comments had been reviewed by the previous manager. Surveys had been completed by relatives and an action plan was in place to address issues raised. Information for people on expressing their views and opinions was in the guide for people who used the service.

We saw that the provider's set of values were displayed in the main reception area. These values referred to kindness, respect, integrity, listening, privacy, dignity and choice, complaints, feedback and zero tolerance to abuse. These values were also in the guide for people who used the service which we saw in each bedroom. A staff meeting had been held with the previous manager who had set out their expectations of staff. The new manager told us that they would be holding a staff meeting to set out their expectations of staff. A Whistleblowing policy was in place and contained appropriate details.

Staff said they felt well supported and they were listened to when they raised issues. An agency nurse said, "I like coming to work here because it is a good home and everything is really well organised." The registered manager was no longer working at the home. A new manager was in post and she clearly explained her responsibilities and how she worked with the staff to deliver good care in the home. The manager felt well supported by the provider. We saw that all conditions of registration with the CQC were being met and the registered manager had sent notifications to us where required. During our inspection and since our inspection the assistant operations director has ensured resources were available to improve the quality of service provided. Specialists within the provider have visited the service to provide advice and guidance on improvements that could be made to the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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 service users must be appropriate, meet their needs and reflect their preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Service users must be protected from abuse and improper treatment in accordance with this regulation.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.**