St Martin's Residential Homes Ltd

The Leys

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 unannounced inspection took place on 24 August 2015. The Leys provides accommodation for up to 18 older people who require residential and personal care. There were 15 people in residence during this inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 manager had put in place all the relevant training, guidance and supervision of staff to enable them to gain the skills to meet people's needs, but staff had not translated their training into practice which revealed that their learning had not been embedded.

Although there were enough staff on duty, peoples experience of care differed. When staff did not receive close managerial supervision their actions affected people's quality of care. People were not always observed by staff to help prevent them from falling as staff had not been deployed to appropriate areas of the home.

Summary of findings

People's needs were assessed and care plans developed however when the registered manager was not on duty staff did not always provide care or support in a way which reduced risks and people were not always supported to make choices about their care. People were supported to have sufficient food to eat to maintain a balanced diet, however people were at the risk of not having enough to drink, as they did not have free access to drinks at all times.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse. The registered manager knew and acted upon their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS).

The provider had not ensured there was adequate managerial cover during the registered manager's planned leave, as some systems and processes to monitor the quality and safety of the home had not been carried out. Action had not always been taken to drive the required improvements and we continued to identify areas where practice needed to improve i.e. medicines management, staff responsiveness and in the overall level of health and safety within the environment. Since the manager's return these systems and processes were being re-implemented and there were early signs of improvement.

We identified that the provider was in breach of one of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and you can see at the end of this report the action we have asked them to take.

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?

Requires improvement

The service was not consistently safe.

People did not always receive their care and support from sufficient numbers of staff as staff were not always deployed to communal areas.

People's medicines were appropriately administered although improvements are required to ensure that all procedures are followed at all times.

Risks were regularly reviewed but not consistently acted upon.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse.

People received their care and support from staff that had been appropriately recruited.

Is the service effective?

Requires improvement

The service was not always effective.

People were not assured that they were supported by staff that could carry out their roles properly without prompting and close managerial supervision.

People were at the risk of not having enough to drink, as they did not have free access to drinks at all times.

People were supported to have sufficient food to eat to maintain a balanced diet.

The manager knew and acted upon their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were met.

Is the service caring?

Requires improvement

The service was not always caring.

People's care and support did not always take into account their individuality and their diverse needs.

People were not always supported to make choices about their care and staff did not always respect people's preferences.

People's privacy and dignity were respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

People's needs were not always met as staff did not carry out the care that would minimise potential risks such as the development of pressure related conditions.

People's individual interests and hobbies were not taken into account when planning their day.

Procedures to make a complaint did not contain all the relevant information.

Is the service well-led?

Requires improvement 

The service was not always well-led.

The provider had not ensured adequate managerial cover during the registered manager's absence.

The provider did not have effective monitoring in place to enable them to identify and respond where quality or safety were being compromised.

People were not protected from any emergency that may affect the running of the home as staff did not have access to sufficient guidance or information to take action.

The Leys

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 unannounced inspection was carried out by one inspector and took place on 24 August 2015. Prior to the inspection we reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners who help place and monitor the care of people living in the home that have information about the quality of the service.

We undertook general observations in the communal areas of the home, including interactions between staff and people. We observed a mealtime and medicines being dispensed. We spoke with people who lived at the home and also to their family members. We did this so we could obtain their views about the quality of care provided at the home.

We spoke with two people and observed ten people who used the service. We looked at the care records of seven people. We spoke with the provider, and five care staff including and the cleaner and the cook. We looked at five records in relation to staff recruitment and training.

We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Requires improvement

Is the service safe?

Our findings

People felt confident that they could raise their concerns directly with staff and that these would be appropriately responded to. Staff understood their responsibilities to safeguard people and knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. They had received training and were supported by guidance on how to report concerns and the contact details for relevant authorities. Staff provided examples where they had identified concerns and records showed that staff had made timely referrals to the safeguarding authorities.

People's needs were regularly reviewed so that risks were identified and acted upon as their needs changed. People's risk assessments were included in their care plan and were updated to reflect changes and the resulting actions that needed to be taken by staff to ensure people's continued safety. These contained actions for minimising potential risks such as risks associated with falls. However there were inconsistencies in the way that the care was implemented in practice. When the manager was present the planned care was carried out, but when the manager was not present we observed that care was not always provided in line with people's care plans and assessments.

Although the duty rota demonstrated that there were enough staff on duty to provide for people's needs, the care and support offered to people was inconsistent. When the registered manager was on duty we saw that staff were deployed in a way which enabled them to respond swiftly to people's care and support needs. However when the registered manager was not on duty staff did not always spend time with or caring for people in the communal area of the home, where most people spent their day. We observed one person become unwell when there was no staff in the lounge area, and we saw that the other people in the lounge had to shout for help to get the staff's attention. One person continuously complained of feeling cold, but staff were not in the lounge to hear or respond to them. This meant that at times people had to wait before receiving the care or support they needed.

There was an appropriate recruitment process in place. Staff were only employed at the home after all essential pre-employment checks and evidence of their good character had been satisfactorily established.

We observed staff administering medicines to people and heard them explain what the medicines were for. Staff followed guidelines for medicines that were only given at times when they were needed for example Paracetamol for when people were in pain. However, not all of the arrangements for the management of medicines were carried out in line with their own policies, as there was a lack of recording people's allergies and staff did not always record when creams had been given.

There was a system in place for ensuring that the front door was secure to minimise the likelihood of uninvited visitors entering the premises without staff knowledge or people's agreement. However, staff needed to be more vigilant as they were not always mindful of the need to ensure that the premises were kept appropriately secure to keep people safe, we found that on two occasions during our inspection that the door had been left open.

Requires improvement

Is the service effective?

Our findings

People were not assured that they would always receive care that was focussed on their individual needs. The consistency of care depended upon the presence of the manager. The manager had ensured that staff that had undergone an induction which helped them to get to know the people who lived at the home and how to meet their needs. Staff received regular supervision which they told us that they found 'helpful' to support them to carry out their roles. Staff had undergone training to enable them to gain the skills required to meet people's needs and we observed that they were able to communicate effectively with people living at the home. Staff spoke to us about the individual needs of people and demonstrated good knowledge of people's routines, likes and dislikes. However when staff were not being guided and directed by the manager they did not always use their acquired knowledge and skills to provide care for people that met their needs. We observed people who had been identified as at risk of acquiring pressure ulcers did not always receive care to relieve their pressure areas.

The registered manager had an awareness of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and we saw that people who required mental capacity assessments, best interest decisions or required a DoLS authorisation had these carried out. Staff had received training and understood their responsibilities in how people wanted their support needs met. However, there was a need for staff to implement this in practice, as there was a lack of consistency in the way they supported people. We observed that people were not empowered to be involved in day to day decisions when the manager was not present. For example we saw two people asking to go back to their rooms in the afternoon, and staff declined their wishes.

Staff were aware of people's nutritional needs including their likes and dislikes. Staff assessed people's risks of not eating enough by using a Malnutrition Universal Screening Tool (MUST). Staff referred people to their GP and dietitian when they had been assessed as being at risk. People were provided with enough food to help protect them from the potential adverse effects of poor nutrition. The cook had a good knowledge of people's dietary needs and had access to information at a glance which showed people's needs, likes and dislikes and were able to adjust meals accordingly. We observed a lunch time and saw that people who were not able to eat independently were supported to eat by staff. We noted that there was a choice of food available at lunchtime, but not all of the people we observed had been offered a choice of the meals. Care should be taken to ensure that all people were aware of the choices and other options that were available.

Staff were not always mindful in ensuring that people had enough to drink. People were only supplied with drinks at set times, or when they asked, however, not everyone had a drink available to them at all times. We observed that people did not have a supply of drinks, such as a jug of water available to them in their rooms. Staff recorded what people drank on fluid charts, which demonstrated that people were offered drinks only between 7am and 5pm daily. Staff were unable to tell us, and there was no record of, what people drank in the evening or at night. People were at risk of not receiving enough to drink to maintain their health and wellbeing.

People were referred to the GP promptly when they experienced health problems, and staff followed the advice given by the GP. Relatives spoke with appreciation of the staff, one described staff as "brilliant", they went on to explain that staff always kept them informed and said their relative was very happy living there. People were referred to appropriate community based professionals such as the occupational therapist when they required equipment to help them to mobilise.

Requires improvement

Is the service caring?

Our findings

People's experiences of caring staff were dependent upon who was on duty at the time. We observed long periods of time where people were sat in a circle in the lounge area in silence. Staff missed opportunities to interact and engage with people as they remained in the corridor area away from the communal area where people sat. This was in stark contrast to when the manager was present where we observed a two way interaction with people and staff, in particular the manager who involved people in conversations. The manager had a good relationship with people and staff did know people well; in the presence of the manager staff spoke with people in a sociable and inclusive way. When the manager was not on duty, we observed that the only interaction people had with staff was made when staff were carrying out tasks.

People did not always receive care that was personalised or met their individual needs as staff did not always show consideration for people's individual needs; for example one person with poor eyesight was unable to choose their meal, or know what they were about to eat. They described what happened when they received their meals: "They [staff] just bring it, they don't tell me what it is, but I can't see."

People's ability to make choices about their day to day living was inconsistent. We saw good examples of people making choices, such as, people choosing the time they woke up and went to bed, one person said "there is no particular time to get up; I like to have my breakfast in my room at about 8am." However, we also saw examples where people were not always listened to and their wishes were not always respected. We observed two people asking staff if they could go back to their rooms in the afternoon, we heard staff discouraging both people stating that they should stay in the lounge. There was no activity or interaction in the lounge and the people remained in their chairs in silence the lounge.

People's privacy and dignity were respected, particularly when people were being supported with their personal care. Bedroom doors were kept closed whilst people received personal care and people told us that staff did not enter their bedrooms uninvited. People described staff as 'caring', one person said "they [staff] come into my room twice in the night to check that I am alright".

People were encouraged to bring items into their accommodation which enabled them to personalise their own private space and feel 'at home'. We saw evidence of this in some people's accommodation, with items of personal value on display, such as photographs and other personal belongings that were important to them and reflected their interests. However some people had responded to the manager's questionnaire to say that they would like more involvement in how they wanted their room to look. This feedback was recent and the provider had not responded to this yet.

Requires improvement

Is the service responsive?

Our findings

Although there were systems in place to assess people's needs they did not always receive the care that was planned.

People had been assessed for their risk of acquiring pressure ulcers, and care plans were in place to reduce these risks. Some people had air mattresses on their beds that were designed to relieve their pressure areas whilst they were in bed. However, there were no records to demonstrate that staff had checked, and our observations showed that the mattresses were not kept on the correct settings which meant that they were ineffective and people were at risk of acquiring pressure ulcers.

The manager had identified development needs of staff in pressure area care. They had directed staff in the practice they expected to see and highlighted on-going issues in the way care was provided. Care plans were in place for staff to refer to, however, we saw that staff continued to provide care that was not effective, for example, people remained in wheelchairs for long periods without adequate pressure relieving care.

People were assessed before they went to live at the home; a range of information was gathered and focused assessments were carried to consider people's physical and emotional needs and compatibility with the people already living in the home. This enabled the manager to make a judgement whether their needs could be met. Although this information was available to staff they did not recognise the significance of the information in building relationships with people and some staff lacked insight into how this could have been used to interact with people effectively.

Families helped to provide information about peoples' past lives and what types of activities they enjoyed. Some staff were aware of people's interests but these did not form an integral part of their care planning and were not incorporated into their daily living. People told us that there was "not much to do" in the home, we saw that the same activities were planned every week such as singing with staff. We observed that staff did not readily engage or interact with people unless they were providing care. There were set times of the day when staff would enable people to join in with activities such as karaoke. The provider had received feedback which included requests to try different activities, but as the feedback was recent the provider had not yet responded to this.

Relatives found the manager was approachable to talk to and a complaints procedure was available to people, it explained how they could make a complaint, however, the complaints procedure did not explain that they could appeal to an ombudsman if their complaint was not dealt with to their satisfaction. The provider needs to develop sufficient systems to record and monitor peoples' verbal and written complaints and demonstrate how they have responded and learnt from the complaints to improve their service.

Requires improvement

Is the service well-led?

Our findings

People were not assured of receiving care in a home that was competently managed on a daily as well as long-term basis. There was a registered manager in post, however, the provider had not ensured that there was adequate managerial cover whilst the registered manager had been on planned leave or on part-time return. During the time of the manager's absence the systems and processes designed to ensure safe care had broken down and there was a lack of adequate leadership from senior staff. This had been evident as staff lacked direction when the manager was not around which had led to people experiencing different levels of care depending on if manager was present. The manager had now returned to their role full time, they were beginning to re-establish systems and processes that provided a framework for the manager and staff to provide safe care.

The provider did not have systems and processes in place to monitor the quality and safety of the service. For example the provider had not identified that there were issues with the effectiveness of their management of medicines, fire safety procedures, water temperatures and Control of Substances Hazardous to Health (COSSH). We brought these issues to the attention of the provider who immediately carried out appropriate monitoring.

There were no adequate systems in place to enable the provider to identify and respond where quality or safety were being compromised. They had devised a business continuity plan for any event that may disrupt their ability to provide care. However, the business plan was not complete as emergency contact details for vital services such as water, sewage, electric, gas were not available. There had been episodes where there had been a lack of hot water, staff had not contacted the provider and did not have details of who to contact to get the water system reinstated. This meant that staff did not have access to sufficient details to act in the event of an emergency that affected the running of the home.

The manager held staff meetings regularly to discuss areas for improvement and update staff on training issues. The minutes of the meetings demonstrated that there was clear communication of any issues that need to be addressed and these minutes were distributed to staff that were not able to attend the meetings. The information shared at these meetings was not always implemented, for example staff did not ensure that people were transferred to armchairs from their wheelchairs. The manager requires the support of staff in implementing changes in the way that care is carried out in order that they meet people's needs.

We observed a very different atmosphere and levels of interaction when the manager was not present; staff took the opportunity to disengage and respond on a task level only and they did not empower people to make decisions. Staff had not translated their training into practice which revealed that their learning had not been embedded. These issues had not been detected by the provider as they had not assessed the quality of the interaction and engagement between staff and people using the service. Close attention is required to the competency of the staff to work independently of the manager to meet people's needs.

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

The manager had carried out residents meetings to discuss the impact of the building work and introduce a new system of a key worker for each person. People had been involved during the meeting in March 2015 in the choosing the meals that appeared on the menus snacks throughout the day.

People's care records had been reviewed on a regular basis and records relating to staff recruitment and training were fit for purpose. Individual care records we looked at accurately reflected the care each person received. Records were securely stored to ensure confidentiality of information.

Policies and procedures to guide staff were in place and had been updated when required. We spoke with staff that were able to demonstrate a good understanding of policies such as safeguarding people and confidentiality which underpinned their job role however, further understanding of their roles in ensuring that people are protected by policies such as health and safety are required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured adequate managerial cover during the registered manager's absence. Regulation 17 (2b) The provider did not have effective monitoring in place to enable them to identify and respond where quality or safety were being compromised. Regulation 17 (2b) People were not protected from any emergency that may affect the running of the home as staff did not have access to sufficient guidance or information to take action. Regulation 17 (2b)