Crowley Care Homes Limited

Crowley Care Homes Ltd - St Annes Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 24 January 2016 and was unannounced. During our last inspection in December 2013 the service was found to be compliant with our standards.

Crowley Care Homes Ltd- St Annes Care Home is a residential service providing care and support to older people in central Luton. They provide long-term care and short-term respite care to up to 20 people. At the time of our inspection there were 18 people using the service.

The service had a manager who was not registered by the Care Quality Commission (CQC) yet, although our records confirmed that their application had been received. 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 & Social Care Act and associated regulations about how the service is run.

People were kept safe from risk of harm and supported by staff who understood their needs and maintained their health and well-being. They had enough to eat and drink and were provided with a varied and balanced diet which took into account their individual preferences and choices. The service worked closely with healthcare professionals to ensure that people's healthcare needs were assessed and met. People were provided opportunities to provide feedback on their care and were supported to maintain relationships with friends and family. The service provided some activities to people, but there was no activity co-ordinator in post at the time of our inspection and people were not always stimulated with a full programme of activities throughout the day.

Staff received training which was relevant to their role and enabled them to provide person-centred and effective care. People were cared for by staff who were knowledgeable, caring and compassionate. There were enough staff on duty to keep people safe and people were positive about the consistency of support they received and the attitude of those who supported them. Staff were provided with supervisions and performance reviews, and attended regular team meetings to enable them to contribute to the planning and development of the service. Staff understood the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs) and how they applied to the people using the service.

People, their relatives and staff were complimentary about the management of the service. There was a robust quality assurance system in place which identified any improvements needed in the service and took action to resolve them. Medicines were administered safely, and risk assessments were detailed and supported staff to keep people safe from any risk of harm.

Details of people's support needs, likes and dislikes and social histories were included in their care plans, and daily notes showed that people's daily routines and tasks were carried out efficiently. However, care plans did not always contain consistent and relevant information, and the review process did not always lead to appropriate changes being made. The provider had not submitted notifications when there had

been a death in the service.

During our inspection we found that the provider was in breach of two regulations of the Health and Social Act (2008). You can see what action we've asked the provider to take at the end of the report.

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 was safe.

There were enough staff available to keep people safe.

People's medicines were stored and administered safely.

People had robust risk assessments in place to protect them from any risk of harm.

There were robust recruitment systems in place to employ new staff safely.

Is the service effective?

Good

The service was effective.

Staff were provided training which enabled them to offer effective support to people.

People were supported to maintain a healthy and balanced diet.

People's healthcare needs were established and the service worked with healthcare professionals to ensure people's well-being was maintained.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, compassionate and dedicated.

People's dignity and respect was observed at all times.

People and their relatives had the opportunity to provide feedback on their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always contain consistent, relevant and up to date information.

People were not always kept stimulated by activities in the service.

The service had an effective system for handling complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not submitted notifications to the Care Quality Commission as required by law.

People were complimentary about the manager of the service.

There was a robust quality assurance system in place for identifying improvements and areas for development in the service.

Crowley Care Homes Ltd - St Annes 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 took place on 22 February 2015 and was unannounced. The inspection was undertaken by one inspector.

Before the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We reviewed local authority inspection records and spoke to four professionals involved with the service to gain their feedback.

During the inspection we spoke with two people using the service, three of their relatives, the registered manager and four members of staff. We observed interactions between people and staff around the service by using 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 looked at care records for four people using the service, five staff files containing training records, inductions and recruitment information and looked at risk assessments and emergency plans. We also reviewed records for medicine administration, audits, minutes of meetings, satisfaction surveys and healthcare plans.

Good

Is the service safe?

Our findings

People said they felt safe living at the service and were protected from risk of harm. One person told us, "Yes, it's safe living here." Another person said, "I've been better looked after here than anywhere else- I'm safe and the home is safe, they wouldn't let anything bad happen to us." People's relatives had no concerns regarding their family member's safety. One relative said, "[They] are kept safe, no doubt about that."

The service had a safeguarding policy in place which detailed how people could be kept safe from any risk of harm. Information about the different agencies which could be contacted in case of any safeguarding concerns were clearly visible through the service, and staff understood their responsibility to report if they believed people were at risk. Safeguarding referrals had been made to the local authority and the manager carried out a weekly audit of these to ensure that they had been investigated and that outcomes were recorded.

Risks to people's safety had been identified for each person. This included identifying any risk of behaviour which may have had an impact on the person or others, including triggers and any signs that the person may be anxious or experiencing difficulties. Details were included of how to support the person through this safely. Risk assessments were completed in each specific area of the person's care and included ways in which each risk could be minimised by staff. For example where people with visual impairments might have been at risk of burning themselves on any hot equipment, we saw that radiator covers had been fitted in each room. Moving and handling assessments were in place and provided a score based on factors such as the person's weight, ability to move independently and any supervision required from staff. A falls risk assessment had been completed for each person and established how any risk of falling in the service could be prevented. For example we saw in one person's care plan that they would require supervision from one carer when moving around the home. We observed during our inspection that carers understood this need for additional support and were always attending to the person when they moved.

People and their relatives told us they felt there were enough staff to keep people safe. One person said, "Sometimes they're a bit short and they're always busy, but they're always there when I need them for anything." A relative said, "Yes, there's enough staff, there always seems to be plenty." Staffing dependency tools had been completed which looked at the needs of each resident, how many carers were required for each task and how the home needed to be staffed accordingly. This included a breakdown of each task, the support required and the level of people's needs. This helped the manager to assess how many staff would be required at key times of day. We reviewed rotas from October 2015 to February 2016 and found that there were always enough staff available on shift as required. Three staff worked during the day and two were available at night. The service had a number of bank staff who covered any shortfalls or absences, and the provider operated an on-call system to ensure that somebody was always available to support staff.

People's medicines were stored and administered safely. Staff received training in medicines administration and were subject to observations and competency assessments before they were permitted to provide people their medicines. Each person had information sheets available which detailed the medicines they took, the reason they were prescribed and information relating to any PRN (when required) medicines.

When people required PRN, this was signed off by two of the care staff to ensure that these were being administered safely and in line with their prescribed guidelines. Medicines administration record (MAR) charts were filled out correctly with no unexplained gaps. Audits of medicines took place weekly, stock was regularly checked and temperature was taken in the storage cabinet to ensure that no medicines were being stored inappropriately.

Good

Is the service effective?

Our findings

People told us that staff received the correct training to care for them effectively. One person said, "The staff are good, they're very good at understanding my needs." We spoke with a relative who felt that the staff were knowledgeable and able to meet their family member's needs. They told us, "[Relative] never seems to want for anything, they know how to take care of them and the [staff] are very competent in my experience, I have no concerns about that at all."

Staff received training in moving and handling, fire safety, administration of medicines and safeguarding. In addition, they also received specialised training in subjects that were relevant to the needs of the people who used the service, such as dementia care, end of life and palliative care, diabetes awareness and pressure care. Staff told us this training enabled them to understand people's specific needs better. One member of staff said, "You already know about a lot of it from your day to day work, but it just confirms your understanding and helps you to realise how important these things are. The courses are quite intensive and help us to reflect upon what we're doing and why. They definitely help us to become better carers for people." Records confirmed that staff training was up to date.

Staff received a full induction into the service which gave them an opportunity to work alongside experienced members of the team to observe practice and get to know people and their needs. Induction checklists were completed for new starters which involved reading through care plans, understanding the provider's policies and procedures and undertaking all of the mandatory training relevant to their role. One member of staff told us, "I had a good induction- they make sure you're confident and know what you're doing before you start working alone, they support you through it all the way."

Staff were regularly supervised. One member of staff we spoke to said, "Supervisions are good, we usually talk about individual residents, training and any changes around the home. I find them helpful most of the time, I'm definitely supervised enough to help me to keep up with what's happening here." Staff files we looked at confirmed that staff usually received supervision once every two months and the manager had a system for identifying when these supervisions were due. Performance management reviews took place annually which assessed the staff member's overall competence and identified areas for development. In addition, staff were given specific supervisions to test their knowledge in key areas such as safeguarding and the Mental Capacity Act.

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). Staff we spoke with were able to tell us what was meant by these and how they impacted upon the people using the service. This had been raised as an area of concern during the service's last local authority inspection. The manager told us they had used

supervisions and meetings to refresh staff knowledge and ensure they were knowledgeable about current practice.

DoLs authorisations were in place for people who were deprived of their liberty and were subject to regular review with the involvement of their relatives and professionals involved with their care. The service had assessed whether each person might be subject to deprivation in different areas, for example where bed rails were required to be used or where people didn't have the capacity to consent to care or treatment.

People's care plans were signed to indicate that they had given consent to receiving care and support from the service. Where people were unable to provide consent, for example for receiving care and treatment from the service, there had been capacity assessments and best interest decisions made which determined whether the person was able to provide consent. Where people's relatives were involved in their care we saw that they had signed care plans on their behalf. Reasons for the person's inability to provide consent were listed to explain why this was necessary.

People told us they had enough to eat and drink and enjoyed the food provided by the service. One person said, "Whatever I like, the cook makes sure I get it." Another person told us they'd been provided with food from their native country upon request which they'd enjoyed. The service employed a full-time chef who was provided with a list of people's specific dietary needs. The chef had undertaken training relevant to care roles to support their understanding of the people using the service and how their nutritional needs were to be met through appropriate diet. We observed lunch being served and saw that people were provided with a choice of healthy foods and support to eat where required. People's individual dietary needs and preferences had been taken into account, for example where meat was on the menu there was a vegetarian alternative provided each time, as well as pureed food for people who were unable to consume solids.

Malnutrition Universal Screening Tools (MUST) tools were completed for each person and detailed any risk of malnutrition, the person's food and drink choices and preferences and any special support required with diet or eating. People's weight was routinely recorded and any changes in the person's physical health or dietary intake were identified.

Information relating to people's health conditions was included within care plans and staff were issued with information sheets which provided more detail about each condition. Staff were still encouraged to contact district nursing or GPs in case of any concerns, but this information enabled them to have some knowledge of how the condition affected the person, what signs to look out for and how they might identify a change or deterioration in their health. Visits and telephone calls with healthcare professionals were recorded each time they took place, and these included details of any changes to medicines, outcomes for the person and medical advice that needed to be implemented into care plans. We spoke with a visiting healthcare professional during the inspection who told us, "They take good care of them here. When I've had to ask them to monitor something or offer a specific type of care, they're always responsive and they always want to speak to me to understand the person's condition better. They take an interest in the person's healthcare, which doesn't happen everywhere."

Good

Is the service caring?

Our findings

People told us they were cared for by staff who were kind, compassionate and respectful. One person said, "It's a very nice home. Everyone has been lovely ever since I came here and they're always checking I'm okay and taking the time to laugh and joke with us. I really like it here." Another person said, "The [staff] are so friendly, they're great." Relatives we spoke with were equally complimentary about the attitude and commitment of the staff team and felt their relative was well cared-for. One relative told us, "They take really good care of [relative]."

When people arrived at the care home they were provided with a residents guide and given information on who they could speak to or contact if they had any concerns. This included details of advocacy services and who was who within the wider organisation. A 'resident's experience' assessment was completed for each person which checked upon the welfare and happiness of new admissions to the service, either on a permanent or respite basis. Details of family involvement were included within care plans and established how people could be supported to maintain and develop relationships with family and friends. People told us that their friends and loved ones were free to visit any time and made to feel welcome when they came.

Monthly residents meetings took place which gave people the opportunity to have their say on issues affecting the home. The manager issued people with agendas for these meetings and provided them with an opportunity to provide feedback on key areas of the service, including whether they felt safe, whether staff treated them with respect and whether they were satisfied with the care and support they received. Actions were identified at these meetings for staff based on people's feedback- for example one person had asked for some specific food to be prepared from their native country. When we spoke to the person they told us they'd been provided with the meal as requested by the cook and were happy with the outcome.

Interactions between staff and people were caring and we observed staff speaking to people in an upbeat, positive and jovial manner, using their preferred names to refer to them. The staff we spoke with had been working for the service for many years and demonstrated a supportive and committed attitude to the people they cared for. One person told us, "They don't change much, I know all of them and they know me. It's nice seeing the same faces every day." Staff were able to tell us about people's histories and preferences and spoke passionately about their work and the care they provided. One member of staff said, "I love this job, I love having contact with the people and helping them." Another member of staff said, "The people and the staff here keep us going- we're a nice team and as far as the residents are concerned- we know they're happy and want to make sure we keep it that way."

People told us they felt their dignity and privacy were respected by staff. One person said, "I'm treated with so much respect, that's a given here." A healthcare professional we spoke with told us, "Most of my clients are very complex- they meet their dignity and respect every single time." Each section of people's care plans included ways in which people's dignity and privacy could be observed and respected and these were specific to each person. For example we saw that in one care plan where the person required some of their personal care in their bedroom, the care plan included clear instructions on how staff were to respect the person's privacy and dignity by closing the curtains, closing the door and softening the lights.

The home had received a number of compliments from relatives grateful for the standard of care their loved one received. One compliment said 'Whenever we visit the staff are always very welcoming and we're able to see first-hand how well you look after the residents.' A card received said 'So caring and polite. Nothing is ever too much.' Several people were complimentary about the standard of care their relative had received and all felt they'd been made to feel at home and comfortable during their time at the service. One relative had written to their local newspaper to praise the standard of care they'd received as 'nothing short of amazing'.

Requires Improvement

Is the service responsive?

Our findings

People told us they didn't always know what was in their care plans or whether they had one in place. One person said, "I think they're working on it, but no, I don't have one at the moment." Another person said, "They haven't spoken to me about it (my care plan), no."

Care plans were in place for each person but we found that these contained a lot of outdated and sometimes conflicting information which did not always provide an accessible and current overview of the person's support needs. For example, one person who received all of their care in bed still had risk assessments and guidance in place for using a wheelchair and references to their use of this equipment were made throughout their care plan. Similarly, the same person had been assessed as being at risk of refusing medicines and therefore written up as needing liquid and crushed medicines, but an audit of the person's medicine administration needs in January 2016 stated "usually compliant, sometimes refuses and may hide tablets."

Care plans were subject to regular review and these reviews included an assessment of each area of their support. For example we saw that where one person had recently had a visit from the GP, the review identified the on-going treatment and what this meant for their care plan. We saw that where somebody had been identified as being at risk of loss of skin integrity, that they'd been provided with specialist pressure care equipment. However, we found that these reviews did not always appear to capture the most up to date information. For example in February 2016 a review had taken place but the notes were almost identical to the review that had taken place the previous month. Where the person or their relatives were asked to provide their feedback, this information had been duplicated for four months in a row. Neither the person or their relative had signed to indicate that they agreed with the review. While changes were detailed in review notes, many assessments, guidelines and support plans were years old and hadn't been updated following these reviews.

This was a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us that they referred to people's care plans prior to delivering care to enable them to understand the person's needs. One member of staff said, "We are involved in helping to create the care plans. We read through them during our induction, and then discuss changes later on if needed. If we weren't sure on anything, we'd consult the plan."

If people had been admitted to hospital then the service completed a body mapping form and undertook a physical assessment which looked at skin integrity, any marks or bruises and any other changes that needed to be taken into account when considering the person's on-going physical support needs. 'Additional Progress Report Notes' were completed following any major incident or anything significant that was important to include in the person's care plan.

Social skills, hobbies and cultural/spiritual needs were included and listed ways in which staff could support

people to maintain their interests. For example where one person enjoyed watching football matches we saw that staff were asked to engage him in this topic and encourage his participation when there were sporting programs on the television. However, we found that people weren't always engaged or offered activities throughout the day. One person told us, "We do want activities put on- there aren't really any at the moment." The service had employed an activities co-ordinator who had left in November 2015. The registered manager told us they were actively recruiting a suitable replacement, and told us about the ways in which they'd tried to keep people active and stimulated in the meantime. One member of staff told us, "We've had musicians coming in, people who dress up, singers and they have a hairdresser who comes often. We hold parties on special occasions for them too. Sometimes it's not always easy to spend as much time with them as we'd like because we're busy, but we always try and keep them engaged." The manager showed us the activity schedule that the co-ordinator had run before they left and we saw that people had a good variety of different activities on offer. However, during our inspection we observed that there wasn't much activity to keep people stimulated during the morning. There were periods where staff were required to attend to other duties around the service and couldn't always engage people in activity. People were observed spending most of their time asleep or having their routine needs attended to. Although we did observe staff singing, joking and engaging with people positively this lack of a structured activity program throughout the day could have meant were not always adequately stimulated.

Checks were carried out routinely on people to ensure they were comfortable, changed position and had their personal care needs attended to regularly. Each check was recorded in the person's daily notes and we saw that people had checks in line with the information stated in their care plan. We reviewed these charts and found that the appropriate checks were being carried out as specified by people's care plans. Daily notes were detailed and included information regarding the person's daily routines, how their needs were met and activities. During the inspection we observed that staff were regularly ensuring that they were responding to people by following their daily task lists. When people activated their call bells there was a quick response from staff to attend to their needs.

There was a complaints policy in place which provided details of who people could complain to if necessary and how their complaint would be handled. People told us they would feel comfortable raising concerns if necessary and knew who to complain to. One person said, "I'd talk to the manager, she'd get it sorted out, or if not then I have my social worker to help me with things." The service had received three complaints from relatives and taken appropriate action to resolve these. For example where one relative had made a complaint about a maintenance issue in one person's room, this had been quickly resolved and the outcome provided to the relative.

Requires Improvement

Is the service well-led?

Our findings

Before the inspection we reviewed information submitted to us by the provider which indicated that there had been no deaths in the service during 2015. However the manager told us that there had been four deaths in this time, notifications of which were not submitted to us at the time. Providers are required to notify the Care Quality Commission of any death to people using the service. Additionally, we hadn't received any information regarding authorisations for people who were deprived of their liberty by the service. While the appropriate authorisations were in place, providers are also required to notify us of these by law.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

At the time of this inspection, the manager was not registered with the Care Quality Commission, but she was in the process of doing so.

People we spoke with were complimentary about the manager. One person said, "I can speak to the manager about anything- she's lovely." Another person told us, "She's one of the best, I can go to her with anything." Staff felt well supported and told us that the manager was approachable and had an open door policy when they needed anything. One member of staff said, "She's a good manager, she's there when we need her." Another said, "The manager is good, we communicate well together."

There was a robust quality assurance system in place to identify improvements and areas for development in the service. The manager carried out monthly audits on the home, including weekly random checks on people's personal finances, on-going safeguarding, medicines, admissions, care plans and complaints. Actions identified by these audits were resolved promptly. For example we saw that where some parts of the service required redecoration, the work had been commissioned and completed as specified. The provider had developed a business improvement plan which established the visions and values of the service as 'St Annes strives to offer excellent and affordable health care with the support of community based services in the local area'.

A local monitoring visit had taken place recently which had rated the service overall as 'good'. Where some issues had been highlighted, the manager had devised an action plan and met with staff to discuss ways in which they intended to improve in the areas identified. We read through the minutes from this meeting and saw the ways in which the manager had addressed these concerns. For example the report had highlighted a lack of complaints being recorded, and during our inspection we saw that efforts had been made to be more proactive in recording and resolving complaints.

People and their relatives were sent questionnaires which asked them to provide feedback on the quality of their care and suggest any improvements that needed to be made. The feedback was positive and praised the attitude and commitment of the staff. Another survey was sent out called 'professional visitors to the home', which recorded all visits from professionals and sought their feedback upon each occasion. This enabled the manager to ensure that everybody associated with the service had a chance to contribute to its

development.

Staff meetings took place every few months and provided an opportunity for staff to meet together and discuss issues affecting the home. Staff told us these meetings were useful. One member of staff said, "We have staff meetings every few months, they're useful for keeping up with things." Items discussed included training, supervision, activities and the needs of individual residents. We saw that any issues highlighted in these meetings were followed up by the manager who provided a memo to staff listing the key points that had been raised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans did not always contain up to date or consistent information.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The CQC were not notified of deaths of people using the service.

The enforcement action we took:

A fixed penality notice was issued against the provider on 20 April 2016.