St. Thomas Complex Limited

St Thomas Complex

Inspection report

Belgrave Terrace
South Shields
Tyne And Wear
NE33 2RX

Tel: 01914546662
Website: www.stthomascomplex.com

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 7 December 2015 and was unannounced. A second day of inspection took place on 10 November 2015 and was announced. This is the first time the service has been inspected since it was registered on 17 October 2014.

St Thomas Complex is a three storey home that provides personal care and support for up to 52 people, some of who are living with dementia. At the time of our inspection there were 40 people using the service.

At the time of our inspection the service did not have a registered manager. However, the person managing the service had applied for registration. 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.

Staff had a good understanding of safeguarding and were confident in their role in safeguarding people.

Risk assessments were in place for people when required and there was a clear link to care plans in place. There were also general risk assessments regarding the premises and environment.

Medicines where managed safely, effectively and in a way which reflected people's individual needs. All records were up to date and fully completed, with medicine audits being carried out regularly.

Staff were recruited in a safe and consistent manner with all appropriate checks carried out. Staffing levels had recently been increased, and plans were in place to introduce a more robust system to analyse staffing requirements in line with people's needs. From staffing rotas we saw that staffing levels were consistent and alternative arrangements were available to cover shortages of staff.

Staff had some up to date training but at the time of the inspection this did not include safeguarding, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguarding (DoLS). However, the manager had identified this as was planning to book staff on the next available training courses.

The registered manager and staff we spoke to had a good understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). Best interest assessments were evident within care files and DoLS authorisations were in place for every person who used the service.

Staff received regular supervision and told us they felt supported in their roles and they could approach the manager if they had any issues or concerns. Annual appraisals were out of date for all staff members. The manager had a plan in place to bring appraisals up to date in early 2016.

We observed people and staff during mealtimes. People were enjoying their meals, some independently and

others with support from staff. There were choices available for people and support provided by staff was caring, compassionate and at an appropriate pace to each individual.

Care plans were personalised, detailed and contained people's personal preferences, likes and dislikes. Care plans were up to date and reflective of each person's individual needs.

The manager and staff carried out regular audits. These related to people's specific needs and the environment.

There was a range of activities available for people in the service. Activities ranged from a church service every month, chair exercises, singers, pantomimes, animal therapy, cookery, cards, arts and crafts, dolls and soft toy therapy. Staff had a good understanding of activities each individual enjoyed doing. People who used the service discussed activities at residents' meetings and with the activities co-ordinator individually.

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.

People told us they felt safe living at St Thomas Complex.

The manager and staff had a good understanding of safeguarding.

Medicines were managed safely.

People's needs were assessed prior to admission to ensure the service was suitable and could meet their needs.

People had appropriate risk assessments in place when required.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had some up to date training but this did not include safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguard. Plans were in place to bring these up to date and staff demonstrated knowledge and understanding in these areas.

Staff supervisions were carried out regularly. Staff appraisals were out of date for all staff.

People told us they felt supported and cared for by staff who were skilled and experienced to do so.

Staff had a clear understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguard. We saw there were Mental Capacity Act Assessments in place and Deprivation of Liberty Safeguard applications that had been authorised.

People had access to healthcare professionals as they needed them.

Is the service caring?

Good

The service was caring.

People and their relatives told us they were happy with the care they received at St Thomas Complex.

Throughout the inspection we observed staff treated people with dignity and respect.

Staff interacted with people in a respectful, warm and gentle manner with patience and genuine compassion.

People had access to advocacy support and information.

Is the service responsive?

Good

The service was responsive.

People and their relatives told us there was a good range of activities available in the home and there were always things for people to do.

Care plans were up to date and reflected the individual needs of each person.

The manager had clear procedures for dealing with complaints. People and relatives we spoke to told us they felt comfortable raising any issues or concerns.

Is the service well-led?

Good

The service was well-led.

Staff told us they felt supported by the manager. They attended regular staff meetings and felt they contributed to the improvement of the service.

The manager operated an open door policy. Staff told us they felt that the manager was very approachable.

The manager and supporting staff completed regular audits on the service provided and ensured wherever possible lessons were learnt from any accidents or incidents.

St Thomas Complex

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 comprehensive inspection took place on 7 December 2015 and was unannounced. A second day of inspection took place on 10 December 2015 and was announced.

The inspection team consisted of two adult social care inspectors and a specialist advisor.

Before the inspection took place we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch. Healthwatch England is the national consumer champion in health and care.

During the inspection we used a number of different methods to help us understand the experiences of people who lived at St Thomas Complex. We spoke with five people and five relatives. We also spoke with eight members of staff, including the manager, deputy manager, a senior care worker, three care workers, activities coordinator and the chef.

We looked at five people's care records and 40 people's medicine records. We reviewed four staff files, including records of the recruitment process. We reviewed supervision and training records as well as records relating to the management of the service. We also completed observations around the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at St Thomas Complex. One person said, "I like living here, it's a nice warm home" and "nothing is too much trouble" for staff. One family member said, "I'm happy [relative] is here, [relative] is very content and well looked after". Another family member told us, "[Relative] is safe and well looked after."

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During our inspection we spent time with senior staff during the medicines round. We noted medicine administration was managed appropriately and people were treated with respect and patience. MARS were fully completed and corresponding records and medicines stored confirmed medicines had been administered appropriately, in line with GP instructions. There was a clear audit trail that showed medicines ordered, received, administered and those returned that were refused or no longer required.

Records showed regular medicine audits were carried out by a local pharmacy. One audit identified a small number of errors in the administering of medicines. The manager arranged for senior carers to have face to face training with a representative from the pharmacy, so their medicines knowledge could be updated. The manager also arranged for the local pharmacy to conduct another full audit of medicines following the training. At the time of the inspection both the training and the audit had been arranged but had not yet taken place.

The manager and staff had a good understanding of safeguarding. Staff we spoke to named several forms of abuse and potential signs people may show if they were being subjected to abuse. Staff told us how they would report any suspected abuse. One member of staff said, "I would report it to [manager] or [deputy manager]" if they had any suspicions or concerns about people.

There was a safeguarding log available that included details of safeguarding concerns, alerts and subsequent action taken. Safeguarding records reflected those notified to CQC.

There was a whistle blowing policy in place and staff told us they knew how to use it. One member of staff told us, "I feel comfortable to raise issues" with the manager. Another member of staff told us, "If you ask for something [manager] would get it done". The whistle blowing policy was readily available and accessible to staff. Information about the policy was displayed on notice boards to ensure staff were aware of it and encouraged to use it if they felt necessary.

Accidents and incidents were recorded in a log. Appropriate records were kept which included details of events that had happened, people involved and subsequent action taken.

People had appropriate risk assessments in place where required. Risk assessments were stored within care files and were updated and reviewed in a timely manner, in line with the changing needs of individuals. All identified risks had appropriate care plans in place which detailed how care was to be provided to prevent those risks. For example, where someone had been assessed as being at risk of falls, a risk assessment was in place which detailed peoples' levels of mobility, any equipment to be used and any support required from staff. Care plans were in place for people who were identified as being at risk of falls.

Risk assessments were reviewed regularly and were relevant and up to date. However, one risk assessment was out of date and no longer relevant to the person, as they no longer required a wheelchair and were able to walk independently. We raised this with the manager who told us the person's care file would be given to the delegated key worker to update.

We saw a range of risk assessments in place relating to the premises and environment. These included preparation and storage of food, ironing press, laundry and fire safety. These risk assessments were reviewed regularly and were up to date. Other risk assessments included profiling beds, working environment and infection control.

The manager told us there was a staff member responsible for maintenance who worked at the service five days a week. We saw a maintenance book which contained jobs that had been recorded when needed and signed off when completed. Records showed weekly flushes were completed on showers and specialist baths.

Fire evacuation procedures were on display throughout the home including on the back of people's bedroom doors. One relative told us, "The manager stopped us and introduced herself, had a chat and then explained the fire procedure". A fire file was in place which contained personal emergency evacuation plans (PEEPs) but these were brief and only set out people's mobility levels.

Records showed the registered provider's recruitment process was followed to ensure staff who were recruited were skilled and experienced. All staff had completed an application form and had an interview. Each staff member had necessary checks prior to them being appointed which included reference checks and disclosure and barring service check (DBS). DBS checks are used as a means to assess someone's suitability to work with vulnerable people.

The manager told us they felt staffing levels were number orientated rather than based on the needs of people using the service. Therefore the manager increased the number of carers during the day from four to six as an interim measure. The manager had a plan in place to introduce a more robust system to help them analyse staffing levels and ensure sufficient levels of staff were in place to meet peoples' needs. This would be based on the skill mix of staff, dependency of people using the service and the layout of the building. However, at the time of the inspection there was no timescale identified for when this plan would be put into action. During our visit we observed people were given support by staff in a timely manner and at a pace comfortable to each person. People were not left unassisted for long periods of time and nurse call bells were answered promptly.

We reviewed staffing rotas for a four week period and found staffing levels to be consistent and in line with the levels the manager explained to us. People told us there were enough staff in the home. One relative told us, "There's always staff around if you need them".

Staff told us there were enough staff to meet people's needs and people were safe. One member of staff told us there were "plenty of staff with time to chat to residents".

The registered provider had a robust disciplinary procedure that was followed in practice. Records showed incidents had been investigated, appropriate bodies or professionals had been referred to, for example, DBS and local safeguarding team, and appropriate action had been taken and recorded.

Requires Improvement

Is the service effective?

Our findings

People told us they felt supported and cared for by staff who were skilled and experienced to do so. One person said, "I cannot grumble, the girls are great." A relative said "Staff are really good with [relative's] diabetes."

Staff had completed up to date training in some areas such as falls, risk management, fire safety, infection control and health and safety. However, training for safeguarding, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguarding (DoLS) was out of date for all staff. The manager had identified this and informed us that she was planning to book staff on the next available training courses for MCA, DoLS and safeguarding.

Staff we spoke with said they received an induction when they started and had to shadow experienced staff as part of the process. Staff also told us they received regular training. One member of staff we spoke to said, "I couldn't carry out moving and handling until I was trained." Records showed new staff completed a comprehensive induction which covered areas such as care provision, practical skills, wellbeing, routines and work roles.

Staff told us they received regular supervisions, where they discussed their performance at work, any issues or concerns either they or the manager had and any areas for further development. Records showed staff supervisions were being carried out regularly and contained details of discussions had as well as actions agreed. Actions were followed up in following supervision meetings.

The provider had a policy and commitment for each staff member to receive an annual appraisal. Appraisal discussions covered tasks, work programmes, objectives, health and safety, care issues, learning and development and planning ahead. The manager acknowledged that appraisals were out of date and none had been completed for 2015. A planner was produced by the manager which committed for all appraisals would be brought up to date by the end of January 2016.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DOLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager explained when they would use best interest decision forms and demonstrated knowledge of MCA and DOLS. People's care records contained best interest decisions which corresponded to the information contained in the DOLS authorisations.

Staff understood what MCA assessments were and when they should be completed. Staff also had an understanding of DoLS including what they were, when they were used and understood that a number of people living at St Thomas Complex had a DoLS in place.

People told us they enjoyed the food at St Thomas Complex and there was always enough to eat. One relative said the home has "good food," and another relative told us, "The food is lovely." During our inspection we observed a meal time experience in both dining rooms. The atmosphere was relaxed and people were served their food in a polite, respectful manner. We saw staff encouraged people to eat independently where possible. People who required support to eat their meals were patiently supported and at a pace comfortable to each individual. Although people chose their meals in advance, staff asked again at the dinner table if that was what they still wanted. Staff later told us this was due to people sometimes changing their mind or not remembering what they had chosen.

The chef told us people were asked what meals they would like for lunch and dinner on a morning. They were given two options for each meal time and their choices were recorded. The chef told us they made alternative dishes for people who didn't want either of the two options available. The chef told us they held information in the kitchen about everyone's dietary requirements such as those who were diabetic or required fortified drinks. The chef also had details of people's preferences, likes and dislikes which was updated as people's tastes changed or new people arrived at the service.

During our inspection we observed a refreshments trolley being taken around the home to people in between meal times. People were offered hot and cold beverages as well as finger sandwiches, scones, biscuits, cakes, yoghurts and fruit. This meant there was always a variety of food and drinks available for people throughout the day.

During meal times we observed the table was set nicely with place mats, napkins, cutlery, condiments, cups and milk jugs. The dining rooms were decorated in a homely way with curtains, pictures and appropriate furniture. Jugs of juice were readily available and food was well presented and looked appetising.

People had access to dieticians, speech and language therapists, district nurses, doctors, occupational therapists, community psychiatric nurses and chiropodists. Care files contained clear records of contact with all professionals. For example, one person attended the fracture clinic after a fall, and was then referred to the falls team. An occupational therapist then assessed a person for mobility aids while they were recovering from a fracture and made a referral to wheelchair services for the provision of a wheelchair.

Communal areas were clean and tidy with the décor giving a homely feel. There were pictures, ornaments, flowers and photographs around the home. There were clearly identifiable signs around the home containing pictures as well as words to help people locate areas in the home such as the lounges, dining rooms, conservatory and bathrooms. We also observed a dementia friendly clock in the home which was on display in the ground floor lounge.

Information and photographs about staff members' qualifications and experience were displayed in the reception area. However this needed updating to include details of the new senior care worker.

Good

Is the service caring?

Our findings

People and their relatives told us they were happy with the care they received at St Thomas Complex. One person said, "The staff are very sweet," and another person said, "There is a lot of nice people who work here." One family member we spoke to said "[Relative] has been unwell, the home keep me up to date" and "staff are approachable." Another family member we spoke to said their relative had a "nice room, lovely and clean" and "staff always say hello."

The atmosphere at the service was calm, friendly and warm. One relative said there's "always a nice atmosphere" in the home and "everyone is friendly." During our inspection we saw people smiling, laughing and responding positively to staff which told us they were happy with the support they received.

Throughout the inspection we observed staff treated people with dignity and respect. Staff spoke to people in a respectful and polite manner, and referred to them by their preferred name. Staff explained support they were offering to people and gained permission before providing it, for example, supporting a person to transfer from an armchair to a wheelchair and supporting them to the dining room for lunch. We observed staff knocking on people's doors and waiting for a response before entering.

We observed positive interactions between people and staff members, such as encouraging people to join in activities or supporting them with daily tasks. We saw people received verbal support of encouragement and prompts from staff in relation to their care, which promoted their independence in doing things for themselves. For example, prompting and encouraging people to eat their meals.

People also received physical support from staff with eating and drinking as well as when moving around the home. We observed physical support being provided in line with individual care plans and in a caring and compassionate way. Support was gentle, patient and at a pace comfortable to each individual.

During the inspection we observed staff interacting with people in a respectful, warm and gentle manner with patience and genuine compassion. Staff used appropriate touching as reassurance which people responded to positively. For example, a member of staff spoke to a person and stroked their hand and the person smiled, spoke back to the member of staff and grabbed hold of their hand.

At the time of the inspection one person was receiving support from an independent mental capacity advocate (IMCA) in relation to their DoLS authorisation. Advocacy services were advertised and promoted throughout the home. The manager told us that should anyone require the use of an advocate this would be arranged for them as soon as possible.

The conservatory had a newly installed water feature which created a relaxing atmosphere which people seemed to like and enjoy. The manager told us the conservatory was also another room people could use when family members visited, rather than in their rooms or other communal areas that were busier.

Both dining rooms had drinks and snacks readily available for people to have during the day. During a lunch

time we observed vegetables placed in the middle of each table for people to help themselves to and put on their plate. This meant they had control over their own portion sizes as well as promoting their independence.

Good

Is the service responsive?

Our findings

People told us they enjoyed a number of activities in the home. One person said, "There's always something going on" and the home was "a busy place". They also said they were "always asked by [activities co-ordinator]" if they wanted to join in activities.

The home employed an activities co-ordinator who organised daily and weekly things for people to do either on their own or as part of a group. The activities co-ordinator also organised raffles and other fund raising events to raise money for activities within the home and events external to the home. All money raised was recorded and displayed on the noticeboard in the main corridor of the home.

During our visit we observed people making decisions in relation to activities as well as food and drinks. It was clear people were in control of their care and walked freely around the home, to and from their rooms, the lounge, conservatory and dining room. Staff responded appropriately to decisions made by people. For example, some people chose not to watch the pantomime that was taking place in the dining room. Instead they stayed in the lounge watching television, playing sudoku and chatting with others. Staff were respectful of people's choices and continued to revisit the lounge to chat to people and ask if they needed anything.

People's care plans included information about their individual social needs and recorded what activities people had taken part in. Community activities varied for each individual for example, trips out to the park or out for coffee. The manager told us the activities co-ordinator was focussing on tailoring outings to people's individual needs, likes and interests to encourage people to go out into the community. The activities co-ordinator met with people in groups and on a one to one basis to chat about current activities both inside and outside of the home. Discussions included what people had enjoyed, hadn't enjoyed and what they would like to do in future. The activities co-ordinator then considered this information when organising future events and activities for people. The manager also told us they were looking to introduce 'singing for the brain' in conjunction with the Alzheimer's Society specifically for people living with dementia in the home.

One person we spoke with told us they enjoyed playing cards. Other activities in the home included a church service every month, chair exercises, singers, pantomimes, animal therapy, cookery, cards, arts and crafts, dolls and soft toy therapy and games such as scrabble.

Records showed thorough pre-admission assessments were completed in relation to people's needs. For example, medicines, medical history, sleep pattern, skin assessment, dietary needs, personal care and wellbeing. Pre-admission assessments showed people's needs were identified. This meant the service were able to put care plans in place that were reflective of peoples support needs.

People had a range of care plans in place to meet their needs including personal care, medicines, nutrition, skin integrity and mobility as well as more specific care plans for things such as anxiety. We reviewed people's care records and noted they were personalised, regularly reviewed and reflected the needs of the person. We saw personal preferences and choices included in care plans. For example, on person's personal

care and wellbeing care plan specifically stated that the person's support was to be provided by female care staff only.

Staff we spoke with were able to tell us about people's individual needs and how best to support them. They were also able to explain people's routines, preferences, likes and dislikes in relation to daily routines. For example, what time people tend to get up, how they like their tea and what their day usually entailed. This meant staff had a good level of knowledge about people.

Care records showed some people had hospital passports in place, to be used in the event of someone being admitted to hospital. However, these were not evident in every care file we looked at. Passports contained all relevant and necessary information regarding an individual that would then be shared with medical professionals should people go to hospital. Passports seen were partially completed with all relevant personal information, personal preferences, likes and dislikes. Appropriate places were left blank that would need to be completed prior to a transition to ensure information was relevant, up to date and reflective of the person.

The service had a complaints procedure that detailed each stage of a complaint and how it would be managed. The complaints procedure was displayed on noticeboards around the home and was discussed with people and relatives during resident and relative meetings. People and relatives we spoke to told us they knew who to complain to and would feel comfortable complaining if they had any issues.

A complaints file held a copy of the complaints policy and procedure, a log of all complaints received and detailed investigations that had been carried out. Outcomes of investigations were communicated to complainants and others concerned including staff during staff meetings.

Regular resident and relative meetings were held in the home and various topics were discussed regarding the premises and the service. For example, activities, the link GP, new staff and redecoration plans for the home. This meant that people and their relatives were involved in the future planning of the service.

Good

Is the service well-led?

Our findings

Staff told us they felt the service was well-led. They spoke highly of the manager and told us they felt comfortable raising any concerns with her or going to her for support. One staff member said, "I love it here and things have got so much better with the new manager". Another staff member told us communication was good and said, "The manager is responsive to all suggestions and needs".
We received similar feedback from people using the service and relatives we spoke to. One person said, "[Manager] is very nice" and a relative said the "manager is good".

The home did not have a registered manager at the time of our inspection. However, the person managing the service had been in post since September 2015 and had placed an application with CQC to become registered. The manager had submitted statutory notifications and stored a copy in an allocated file.

The manager told us she operated an open door policy to ensure staff could raise any issues or concerns and could approach her with any requests for support. One staff member said the manager is "very nice, she's friendly, appreciative and approachable," another member of staff told us the manager was "making lots of changes for the better."

Throughout the inspection visits there was a management presence in the home with either the manager or the deputy manager readily available for staff, people who use the service, relatives and other professionals to speak to. During out of hours, the manager told us that a senior was the lead but staff could contact her if they needed to speak to her.

The manager and supporting staff members completed a number of audits in the home which varied in frequency. Audits included fire alarm system checks and drills. Other audits regularly carried out related to areas such as health and safety and care plans internally and medication audits externally which were effective in identifying issues and required improvements. For example, medicine audits completed identified issues with missed medicines. Appropriate action was taken and training was scheduled with a local pharmacy.

Family and friend surveys were sent out on 2 November 2015 of which 12 were returned completed. At the time of our inspection the information hadn't been collated and analysed by the manager. We noted from the returned surveys that all feedback was positive with relatives stating they were happy with the service, they felt involved in care plan reviews for the relatives and they knew how to make a complaint.

During our inspection we noted that there were relatives' questionnaires available in the main reception for relatives to complete at any time. This meant that relatives' views and comments both good and bad were encouraged by the home.

The manager had introduced the residents' experience quality check that she carried out monthly. This involved the manager entering the home on an evening, unannounced and spending the evening and night in the home. The manager recorded and evaluated their experience and shared her observations and any

issues with staff during staff meetings for example, that the dining room was noisy and how the noise could be reduced.

Staff told us they had regular staff meetings where they discuss changes to the home and any issues of concern. Staff told us they could raise issues and ideas during staff meetings. The meetings were also used to provide updates to people's care plans. Staff meetings were advertised on the noticeboard in the staff room as well as the main notice board in the home. Minutes of staff meetings were stored in a file, were accessible to staff and included actions or decisions agreed.

The home had a system in place for the daily handover of information. Written handovers were completed three times per day to correspond with the end of each shift. Handovers included information relating to each person's day in general including mood, diet, activities and appointments.

Staff recorded appointments, day trips and outings for people in the communication file which was accessible to all staff. The deputy manager explained that all staff read the communication file when they started work. The communication file held details of appointments, repairs and visits from professionals that were scheduled for people as well as planned outings. Actions required such as booking appointments or transport for appointments and follow ups of appointments or tests. Staff signed each action when carried out to confirm it had been completed.