Sanctuary Care Limited

Athlone House Nursing Home

Inspection report

Athlone House
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19 January 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 15 and 19 January 2016. This is the first inspection we have carried out since the service registered with the Care Quality Commission (CQC) under a new provider in August 2015. The first day of our visit was unannounced.

Athlone House Nursing Home is registered to provide accommodation, nursing and personal care for up to 23 older people, some of whom may have dementia and end of life care needs. The home is divided over two floors with lift access. Rooms are wheelchair accessible and have ensuite bathroom facilities. At the time of our inspection 22 people were using the service.

The service had a registered manager. 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.

Safeguarding adults from abuse procedures were available and staff understood how to safeguard the people they supported. Staff had received training on the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). These safeguards are there to make sure that people receiving support are looked after in a way that does not inappropriately restrict their freedom. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way.

Where possible, people were involved in decisions about their care and how their needs would be met. Where appropriate, family members and health and social care professionals contributed to the care planning process. Staff knew what to do if people could not make decisions about their care needs in line with the MCA.

Risk assessments were in place and covered areas such as falls, pressure ulcers and nutritional needs. However, not all risk assessments had been completed in full, or reviewed in line with the provider's policies and procedures.

Staff were not always following policy and procedure in relation to the prevention and control of infection.

Medicines were managed safely. Following a discussion with the registered manager we were informed that systems to better manage people's pain relief would be implemented to ensure that people consistently received their medicines safely, and as prescribed.

Monthly audits were carried out across various aspects of the service; these included the administration of medicines and health and safety checks. However, where these audits identified that improvements were needed action, improvements were not always being implemented in a timely manner.

People were provided with a choice of food and drink, and were supported to eat when this was needed. Staff treated people with kindness, patience and understanding.

People told us they were happy with the care provided. Staff were appropriately trained and skilled to care for people. They understood their roles and responsibilities as well as the values of the service.

People were kept safe from the risk of abuse. Risks to people were identified and staff took action to reduce those risks.

Staff supported people to attend healthcare appointments as required and liaised with people's family members, GPs and other healthcare professionals to ensure people's needs were met appropriately.

Staff received supervision and guidance where required. Staff confirmed they felt supported by the manager who we were told was accessible and approachable.

Sufficient staff were available and they had the necessary training to meet people's needs. Staff responded to people's needs promptly.

There was a complaints policy which the registered manager followed when complaints were made to ensure they were investigated and responded to appropriately. People and their relatives felt confident to express any concerns, so these could be addressed.

We identified one breach of the Regulations in relation to risk management. You can see what action we told the provider to take at the back of the full version 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?

Requires Improvement

Aspects of the service were not safe.

People's care records and risk assessments were not always completed accurately, consistently or effectively.

Staff were not always following policy and procedure in relation to the prevention and control of infection.

Procedures were in place to protect people from abuse.

Is the service effective?

Good

The service was effective.

The registered manager and the staff had a good understanding of the principles of the Mental Capacity Act 2005 (MCA).

People were positive about the staff and felt they had the knowledge and skills necessary to support them properly.

People's healthcare needs were monitored by a GP and other healthcare professionals as required.

People's opinions about meal choices were mixed.

Is the service caring?

Good

The service was caring.

Staff were caring and knowledgeable about the people they supported.

People and their representatives were supported to make informed decisions about their care and support.

Specialist healthcare professionals were involved with people with palliative care needs

Is the service responsive?

Good

The service was responsive.

Care plans contained a good level of detail regarding peoples support needs. However, not all care plans were up to date or completed in full.

People were supported to engage in meaningful activities.

People and their relatives were supported to raise concerns with the provider as there was an effective complaints procedure in place.

Is the service well-led?

Good

The service was well-led.

The service had a registered manager who was a qualified and registered nurse with many years of management experience.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

The provider promoted an open and transparent culture in which good practice was identified and encouraged.

Athlone House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 and 19 January 2016. The first day of the inspection was unannounced and carried out by an inspector and two specialist professional advisors who were nurses with knowledge of older people's needs. An inspector completed the second day of the inspection.

Prior to our visit we reviewed the information we held about the service. During our visit we used a number of different methods to help us understand the experiences of people supported by the service. We spoke with four people who used the service, three family members, four care staff, four nurses, a chef, the registered manager and a regional manager. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Therefore we spent time observing interaction between people and the staff who were supporting them.

We looked at a sample of six care records of people who used the service, six medicine administration records, five staff records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People's care records and risk assessments were not always completed accurately, consistently or effectively meaning we could not be assured that people were being protected against the risks of receiving unsafe or inappropriate care. Risk assessments were in place and covered areas such as falls, pressure ulcers and nutritional needs. However, not all risk assessments had been completed in full, or reviewed in line with the provider's policies and procedures.

Records documenting the presence of pressure wounds were often inconsistent with onset dates missing and reviews and care management plans incomplete and/or not in use. For example; photographs taken of people's pressure wounds were not always accompanied by consent to photograph information and measurements of the wound area were missing.

Staff were not always following policy and procedure in relation to the prevention and control of infection. We noted that care staff were not always wearing protective clothing when carrying out complex care duties such as tracheotomy care and not always disposing of fluids collected from this process in the appropriate manner.

The shortfalls outlined in the above paragraphs relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were able to explain the risks that people might experience when care was being provided and told us that annual clinical review meetings in conjunction with monthly multi-disciplinary meetings enabled staff to continually assess and monitor risks to people's health and well-being.

The home lacked suitable storage space. Bathrooms were being used to store hoists, mobility and pressure relieving equipment. Staff were unclear whether arrangements had been made for the collection of unused and/or returnable items. We observed people's incontinence pads were being stored on windowsills and surplus mattresses were being stacked beside cupboards in people's rooms. A number of mattress pumps were on the floor rather than hung on the foot boards of people's beds. However, staff responded quickly to our concerns and most of these issues had been addressed when we returned on the second day of our visit.

People told us they felt safe at the home and with the staff who supported them. People's comments included, "I'm blessed, I couldn't have come to a better place," and "I feel safe." One relative told us, "[My family member] is safe, comfortable and very well looked after."

Appropriate arrangements were in place to protect people from the risk of abuse. Staff understood how to recognise potential abuse and who to report their concerns to both in the service and to authorities such as the local safeguarding team and the Care Quality Commission. Staff told us they received regular safeguarding adults training as well as equality and diversity training.

People told us that enough staff were available to meet their needs. One person said, "Staff are always ready to help." We saw that call bells were responded to in a timely manner and that when people requested support from staff they were responded to promptly. However, we noted that one person who was receiving end of life care was unable to reach their call bell. We discussed this with staff who addressed the situation immediately.

Safe recruitment procedures were in place that helped to ensure staff were suitable to work with people as they had undergone the required checks before starting to work at the service. Staff records contained criminal records checks, two references and confirmation of the staff member's identity. Checks had been completed to confirm that staff who had a nursing qualification were registered with the appropriate professional organisations.

Appropriate arrangements were in place for the safe management of medicines. When the nurse gave medicines to people we saw that they were patient and reassuring. The nurse recorded when the medicines had been taken. Staff told us they asked people if they were in pain and made sure they received pain relieving medicines appropriately. However, pain assessment charts were not always completed in a consistent manner and information as to whether people had been offered pain relief was not always recorded on medicine administration (MAR) sheets. We received additional information from the registered manager following our inspection in relation to the use of a pain assessment tool and its implementation. The registered manager told us that in future this tool would be used to improve and monitor pain relief in line with evidence based best practice.

Good

Is the service effective?

Our findings

Training records showed that staff had completed mandatory training. Some care staff had completed a diploma in health and social care. Staff who were qualified nurses had been supported to complete training that meant they could maintain their nursing registration. A training matrix was used to identify when staff needed training updated. Some staff had completed training in care approaches to dementia and told us this training helped them feel confident about carrying out their role and meeting people's needs.

Staff confirmed that they received supervision and that this was an opportunity to get support from management about any work issues or concerns they might have. We looked at five records of staff supervision that showed this was happening and that staff were offered the chance to reflect on their practice. Records showed that staff had received regular supervision in line with the provider's policy.

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 team leader had a good working knowledge of current legislation and guidance. The registered manager and the staff we spoke with had a good understanding of the principles of the MCA. One staff member told us, "No matter how people are, you have to get consent. If I'm going to do personal care, I ask first and explain what I'm going to do." One person who used the service had a DoLS authorisation in place.

People said they were able to make choices about some aspects of their care. We observed staff asking people what they wanted in terms of their support. Staff told us that if the person could not make certain decisions then they would have to think about what was in that person's "best interests" which would involve asking people close to the person as well as other professionals. Staff understood that people's capacity to make some decisions fluctuated depending on how they were feeling.

A GP visited the service twice weekly and more often if required. Care plans showed that other health care professionals, for example, physiotherapists and chiropodists had been consulted about people's needs. Copies of discharge letters from the hospital were kept in people's care records.

People's nutritional needs were assessed and when they had particular preferences regarding their diet, these were recorded in their care plan. One person said, "We have the best chef ever." Another person we

spoke with told us "the food isn't great." The chef was able to explain the dietary needs of people who had diabetes or were on soft or pureed diets. Different meal choices were available and people were asked what their preferences were. At lunchtime staff were available to assist people to eat and drink when they needed support to do this. We saw staff supporting and assisting people with meals taken in their own rooms. Staff sat next to each person and supported or fed them in an unhurried and respectful way, encouraging people to be as independent as possible and chatting to the person in an appropriate manner. Snacks and fresh fruit were available throughout the day.

Good

Is the service caring?

Our findings

People told us that staff treated them with compassion and kindness. People and relatives were positive about the staff. Staff were observed to be kind, friendly and respectful in their interactions with people. One person said, "The staff are so friendly."

People were treated in a caring and respectful manner by staff who involved them in making decisions about their care. One person told us, "Staff are brilliant." Staff knocked on bedroom doors before entering although we observed that doors were not always closed when staff were supporting and assisting people with their care needs.

Care records set out people's preferences such as the clothes they preferred to wear, whether they preferred showers or baths, a male or female carer and information about their interests and hobbies. A brief outline of people's histories were recorded in their care records. Staff demonstrated a good understanding of people's likes and dislikes and their life histories.

Staff knew how to support people to express their views and be actively involved in making decisions about their care as far as possible. Care plans showed that people and their relatives had been consulted about how they wished to be supported. Relatives had been involved in decisions and received feedback about changes to people's care where appropriate.

Staff treated people with respect and as individuals with different needs and preferences. Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender and supported them in a caring way. Relatives had been asked about people's cultural and religious needs. Care records showed that staff supported people to practice their religion.

We found that people's relatives and those that mattered to them could visit them when they wanted to. One relative told us they visited every day and always had tea with their family member. Another relative told us they were always made to feel welcome by staff.

We saw evidence that specialist healthcare professionals were involved with people with palliative care needs and that the home had gained accreditation in the Gold Standards Framework (GSF). GSF is a systematic, evidence based approach to optimising care for people approaching the end of their lives. GSF meetings were held on a regular basis and the home worked closely with specialist palliative care nurses.

Good

Is the service responsive?

Our findings

People and their relatives had been involved with planning and reviewing their care. Any changes to people's care was discussed with them and their relatives where appropriate. One relative said, "They make sure that we are involved in deciding what will happen." Staff explained how they met people's needs in line with their care plans. Care plans were in place to address people's identified needs, however, these were not always up to date or completed in full.

There was a key worker system in place in the service. A key worker is a staff member who monitors the support needs and progress of a person they have been assigned to support. People were also allocated two named nurses. People with complex care needs who required 24 hour continuing care were assigned one to one care staff trained to monitor and manage percutaneous endoscopic gastrostomy (PEG) feeding (a medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate), tracheostomy and catheter care. Care staff completed specific care records relating to each person receiving continuing care which were monitored regularly by nursing staff.

People could choose to be engaged in activities that reflected their interests and supported their wellbeing. A range of activities were available for people which included occasional shopping trips, board games and grooming sessions. We saw that a number of activities took place throughout the day, including a music activity, nail and hand massage sessions and dominoes. Activities took place in communal lounge areas and in people's rooms.

Meetings were held with people and their relatives on a monthly basis at which issues regarding future activities and the general running of the service were discussed.

People were confident that if they made a complaint this would be listened to and the provider would take action to make sure that their concerns were addressed. One person said, "I have no complaints, but if I did they would sort it out." Copies of the complaints procedure were on display in the service.

Good

Is the service well-led?

Our findings

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager was a qualified registered nurse with many years of clinical practice and business management experience.

People using the service, their relatives and friends were positive about the registered manager and the way the service was managed. People and their relatives knew who the registered manager was and said he was approachable and friendly. One relative said, "The manager always listens to what you have to say."

Staff were also positive about the management and told us the registered manager was open to any suggestions they made. One member of staff told us, "[The registered manager] is the perfect manager; he's very supportive and a good listener. If we have any concerns, he's ready to listen to you and solve the problem."

The service had recently introduced a new daily 'stand up' meeting where the Registered Manager and Heads of Department meet to discuss priorities for the day, work load and new admissions. The meetings were aimed at improving communication between staff members. One member of staff told us the new meetings were a positive thing whilst another member of staff said the meetings were too brief and that clearer communication was still required between nursing and care staff.

The service had a number of quality monitoring systems including regular meetings and monthly quality audits. People confirmed that they were asked about the quality of the service and had made comments about this. They felt the service took their views into account in order to improve service delivery.
Regular auditing and monitoring of the quality of care was taking place. Audits were carried out across various aspects of the service, these included the care planning, medicines and training and development. Where these audits identified that improvements needed to be made records showed that an action plan had been put in place. However, these issues were not always being rectified in a timely manner particularly in relation to the accuracy and consistency of care record documentation. Following the inspection the registered manager provided us with further information as to how these issues were being managed. We were told that 80% of named nurses had recently completed training in care planning in order to raise the standard of documentation and improve service delivery.

Incident and accident records identified any actions taken and learning for the service. Incidents and accidents had been reviewed by the registered manager and action was taken to make sure that any risks identified were addressed. The provider's procedure was available for staff to refer to when necessary, and records showed this had been followed for all incidents and accidents recorded.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not always assessing the risks to the health and safety of service users. Regulation 12 (1) (2) a, b, h.