CareConcepts (St Helens) Limited

Madison Court

Inspection report

Madison Close
Parr
St Helens
Merseyside
WA9 3RW
Tel: 01744 455150
Website:

Date of inspection visit: 5 & 9 February 2015
Date of publication: 28/05/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We inspected this service on the 5 February 2015. This visit was unannounced, which meant that the provider did not know that we were coming. A further announced visit was made to the service on 9 February 2015.

Madison Court provides accommodation for up to 66 people requiring nursing and personal care and for people who require dementia care and support. The home is located close to shops and a local bus route into the town of St Helens. Set in its own grounds the home has car parking facilities.

There was no registered manager in post at the time of this inspection. 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.

During the first inspection of the service in April 2014 we found that improvements were needed in relation to how

Summary of findings

the provider planned and delivered care to people who used the service, how the provider supported workers and how the provider assessed and monitored the quality of service provision. A further visit was made to the service in October 2014. The purpose of this visit was to see what improvements had been made to the service. During the visit in October 2014 we found that the service still required improvement in relation to the management of care and welfare of people who used the service, supporting workers and assessing and monitoring the quality of service provision.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We found that people were not always safe from harm. Incidents relating to safeguarding people and known risks to individuals had not been reported appropriately to the local authority for investigation and therefore people were exposed to continual risks to their welfare.

We found that people's medicines were not managed in a safe way.

The service was not meeting the requirements of the Mental Capacity Act 2005. This was because people's rights and choices were not always considered in a manner that protected their rights and best interests.

People's care and treatment was not planned or delivered in a person centred way that promoted their physical and mental health.

Management systems in place were not effective as they had failed to identify, address and manage risks to ensure that people received a good standard of care and support.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

We found that certain situations when people had been put at risk staff had been recognised or managed these situations appropriately.

We found that people did not receive their medicines as prescribed and medicines were not managed appropriately.

People told us that they felt safe at the home.

Inadequate

Is the service effective?
The service was not effective.

We found that staff were not always in regular receipt of supervision to support them to carry out their role.

We found that people's rights were not always considered under the Mental Capacity Act 2005 in relation to decision making.

Inadequate

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

We found that people's dignity and privacy was not always maintained.

People who used the service and a number of relatives told us that care staff were sensitive, patient and kind.

We observed staff treating people in a positive manner when supporting them.

Requires Improvement

Is the service responsive?
The service was not responsive.

Care planning documents failed to reflect people's identified needs and people were not involved in planning their care.

People were at risk of not receiving the care and support they required because they were not involved in planning their care and their views and preferences were not taken into account.

There was a lack of physical and mental stimulation available to people to promote their wellbeing.

Inadequate

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

Inadequate

Summary of findings

The provider did not have effective systems in place to monitor the quality of the care and support people received whilst living at the home. This was because the quality monitoring systems in place failed to identify risks to people.

There had been no registered manager in place since April 2014.

Madison Court

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 the 5 February 2015 and was unannounced. A second announced visit took place on the 9 February 2015.

The inspection team on the 5 February 2015 consisted of two social care inspectors and an expert by experience. An expert by experience is a person who has personal or professional experience in using this type of service. In addition, a specialist professional advisor (SPA) with specialist knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards (DoLS) joined the inspection team. The visit on the 9 February was carried out by two adult social care inspectors.

We spent time observing the support and interactions people received whilst in communal areas.

We spoke with and spent time with 15 people living at the home and six visiting relatives. In addition we spoke with the manager, the deputy manager, nine members of staff, the area manager and a director of Care Concepts (St Helens) Ltd.

We looked at areas throughout the building and the immediate outside grounds. We spent time looking at records relating to people's care needs and the records of 4 people in detail. We also looked at the records relating to the management of the home which included duty rotas and policies and procedures in place. We asked the manager of the service to provide us with further information following our inspection.

Before our inspection we reviewed all the information we held about the service. This included notifications received, safeguarding referrals, complaints about the service and any other information from members of the public. We contacted the local authority intelligence and outcomes unit who told us that following concerns raised they were continuing to monitor the service.

Inadequate

Is the service safe?

Our findings

People spoken with told us that they felt safe. One person told us "Yes, very safe, when I was ill they looked in on me all the time, they have been fantastic." A visitor commented in relation to their relative "She was having a lot of falls at home, she has only had one while she has been living here. She was not safe at home."

People spoken with told us that they thought that there were enough staff to deal with their needs. None of the people spoken with said they had to wait long for assistance. One person told us "When I need the toilet in the night I ring and they come very quickly."

Most of the people spoken with thought that the home was clean. One person told us "My bed is lovely and clean and nice and soft."

We saw that a policy and procedure was in place within the manager's office in relation to safeguarding people. Training information demonstrated that all but two of the 67 nursing and care staff had completed training in the safeguarding of vulnerable adults as part to their induction training. In addition, records demonstrated that almost 50% of the nursing and care staff had received refresher training in relation to safeguarding people. However, we found that not all staff had recognised safeguarding concerns. For example, we asked a member of staff why a particular serious incident had not been referred to the local authority under their safeguarding procedures and they told us that they didn't feel it was a safeguarding matter. Another member of staff told us that they had discussed this as a group but no staff had reported it as it had been going on for some time. We found that not all safeguarding concerns had been reported appropriately. For example, we saw that on six occasions concerns and incidents had been recorded but no further action had been taken to report the concerns and therefore people had not been protected from further incidents occurring.

We observed two incidents in which one person approached and became aggressive towards another person and walked away into another part of the room, the other person followed them however, no staff were seen to intervene. This was a concern as the lack of staff action could have resulted in a person being put at unnecessary risk from harm.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 (Regulated Activities 2014) because people using the service were not safeguarded against the risk of abuse.

We saw that a policy and procedure was in place in relation to medicines management. Training records demonstrated that all but two staff had undertaken training in medication as part of their induction into their role. Almost 50% of staff had also completed refresher training which included medication. Staff spoken with during our visit confirmed that they had received up to date training in relation to medicines. Each floor of the building had a locked designated room for the safe storage of medicines. However, we saw that medicines were not always stored safely as the keys to the medicines room on one floor were kept in an unlocked drawer in the kitchen area that was accessible to anyone who entered that room.

We looked at the management of controlled drugs (CDs). We saw on one floor that three people had been administered their prescribed medicines on the day of our visit. However, the records relating to this administration had only been signed by one member of staff and not two.

A number of people were prescribed medicines to be taken "as required" (PRN). Some of these medicines were prescribed to control agitation or anxiety. We saw that people's PRN medicines were not always managed appropriately. For example, one person's records demonstrated that their medicine was to be administered when anxious and agitated. On some of the days in which the person had been administered PRN medicines their records failed to demonstrate the reasons for the administration of the medicine. The person's dosage for the medicine had been reduced, however their care planning records had not been updated with this information. This demonstrated that the provider was not following guidance from the National Institute for Health and Care Excellence (NICE) for Managing Medicines In Care Homes 2014.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities)

Inadequate

Is the service safe?

Regulations 2010, which corresponds to Regulation 12 (Regulated Activities2014) because the provider had failed to protect people who use the service from the unsafe use and management of medicines.

We saw that care planning information contained risk assessment in relation to falls, moving and handling and skin pressure areas. However, we found that potential risks to people were not always appropriately assessed and planned for. For example, one person's care planning documentation stated that they could be resistive to care and support, however the associated risk assessment in relation to violence and aggression stated that the person was not resistant. Another person's risk assessment in relation to the support they required for moving and handling had failed to consider a period of time in which they had required the use of a wheelchair.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (Regulated Activities 2014) as people using the service were not protected against the risks of receiving care or treatment that is inappropriate or unsafe.

People spoken with told us that they felt safe. For example, one person told us "Yes, very safe, when I was ill in bed they looked in on me all the time they have been fantastic." A visitor told us about their relative "She was having a lot of falls at home and she has only had one while she has been living here. She was not safe at home."

At the time of our visit there were sufficient numbers of care and nursing staff on duty in addition to catering and domestic staff. However, we did see on one occasion see that people had to wait for attention. For example, a person waited for 15 minutes whilst staff located a wheelchair to enable them to their bedroom from the lounge. This demonstrated that equipment was not always readily available to allow staff to support people in a timely manner,

We saw that appropriate recruitment procedures were in place. We saw that these procedures included obtaining appropriate references and Disclosure and Barring Service (DBS) checks prior to a new member of staff commencing employment. We looked at the recruitment records of four recently recruited staff and saw that they contained evidence that the appropriate recruitment checks had been carried out. This showed that systems were in place to help ensure that only staff suitable to work with vulnerable people were employed at the home.

Inadequate

Is the service effective?

Our findings

At out last inspection of the service in October 2014 we were concerned that people were being cared for by staff who were not always supported to deliver care and treatment safely. This was because we found that staff had not always received regular supervision for their role. We asked the provider to make improvements on how staff were supported. Staff supervision gives staff the opportunity to spend time with the line manager to discuss their role and identify any support they may need in order to support people who use the service with their needs and wishes.

During this inspection we found that little improvement had been made as to how staff were supported to carry out their role. We looked at the records in relation to staff supervision and saw that not all staff had received supervision for their role in line with the service's procedures that stated staff were to have a minimum of six formal supervisions a year. We saw that more than eight staff employed at the service had two or less opportunities to have supervision for their role. In addition, records demonstrated that under 55% of staff who had been employed for over 12 months had received an annual appraisal for their role.

This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (Regulated Activities 2014) because people using the service were being cared for by staff who were not always supported to deliver care and treatment safely.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 is in place to ensure decisions for people who are not able to verbally give consent or are unable to make specific decisions are protected from harm or discrimination and that any decisions made on their behalf are done so in their best interest. We saw that policies in relation to consent, best interest, MCA and DoLS were well written and offered guidance to the reader. However, the information was not readily available to staff supporting people with their day to day needs. This staff on duty were unable to locate the procedures easily and the documents were found in a file by a member of the inspection team. We saw practices around the home that demonstrated that the policies and guidance in place had not been followed. For example, there were proformas in place for three people who used the service authorising the use of covert medication. The documents were out of date as they were valid only until November 2014. The information did contain reference to the four stage assessment process needed in these situations, however this was just a tick box process and there was no information detailing that the decision to use covert medication was in the person's best interests. This demonstrated that best practice guidance had not been followed.

We saw little evidence that people who lacked capacity to make decisions for themselves were being supported in accordance with the MCA within the home. For example, we saw that best interest decisions had been in place for three people in relation to the use of covert medication there were no best interest decisions recorded. Any decision made in a person best interest should be fully recorded. Staff spoken with told us that they had not received any training in relation to MCA or DoLS. Staff were unable to explain the purpose of the MCA, best interests or DoLS. One unit manager told us they thought the MCA was "About giving", "Social Services do it if they do not have capacity." Another member of staff told us that they thought the MCA was a mental illness.

People were not supported to move around the home independently. We saw that people's bedroom doors were locked and the dining room on one floor. Staff told us that doors were locked due to health and safety. We saw a senior member of staff telling one person that they were in a queue to use the communal toilet. The locking of people's bedroom doors failed to give individuals access to their room and private space when they wished and also prevented them from using their en-suite toilet facility in their room.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 (Regulated Activities 2014) because the provider had failed to protect the rights of people who lacked capacity to make their own decisions.

We saw that when new staff were recruited to their role they undertook an induction. We looked at the content of

Inadequate

Is the service effective?

the induction and saw that, over a five day period, staff attended training in relation to their role. After being employed for 12 months staff then received a three day refresher course. Information gained during the inspection demonstrated that staff training was scheduled to change from April 2015 so that it included all of the 15 standards of the Care Certificate being implemented nationally by Skills for Care. Training records demonstrated that staff had received an induction into their role.

Staff told us that they had recently received training for their role. For example, staff had recently attended a training course on dementia.

We spent time with people during lunch. We saw that improvements could be made to people's mealtime experience. For example, we saw that dining tables were set with cutlery and plastic drinking tumblers. There were no condiments or napkins available. We saw a number of people being given blue plastic aprons to wear to protect their clothing. None of the people spoken with had seen a menu. However, one person told us that a member of staff "Comes round every morning and tells what is on the menu to choose from." People told us and we saw that drinks and snacks were served throughout the day to people and fruit was available in the dining rooms. Water jugs were available in people's bedrooms.

People had access to a local GP service. In addition, the services of a consultant geriatrician and clinical support team were available to staff for advice. We spoke with a member of the team who told us that they visited the service on a weekly basis to deliver care and treatment to people.

Requires Improvement

Is the service caring?

Our findings

People who used the service and a number of relatives told us that care staff were sensitive, patient and kind.

People's dignity and independence were not always promoted around the home. For example, we observed one person walking around with torn shoes. Staff spoken with told us that they were aware of the person's shoes and that they would be taken out the following week to purchase another pair. We observed a person sitting at a dining room table who was in need of personal care. We raised this with staff who told us they were aware of the person's needs, however they initially said they were having a meeting and support would be given after the meeting.

We saw during lunchtime that sunlight was streaming through the windows in one dining room onto people's faces. We saw no effort being made to check with people to see if they were being made uncomfortable by this.

This is a breach of Regulation 17 of the Heath and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 (Regulated Activities 2014) because the provider had failed to promote and respect people's independence or treat them with respect.

We saw that people were not always supported to maintain their privacy and dignity. For example, we observed one person sleeping heavily with their mouth open in a communal area. The person's dignity could have been facilitated if they had been offered support to go to their bedroom.

We saw examples of caring practice. For example, we saw one person being supported to independently mobilise from one room to another by two members of staff. They offered encouragement and support to the individual who saw what they had done as an achievement. On another floor we saw a member of staff spend time brushing and fixing a person's shoulder length hair so that it was not falling onto their face. This action made the person more comfortable and helped maintain their dignity.

We observed a number of staff responding to people in caring manner that showed they were interested in what the person wanted to say and do. In addition we saw another member of staff walking around the corridors with a person as this is what they enjoyed doing.

We spoke to a senior member of staff about the availability of advocacy services for people who used the service. They told us that they would contact the local authority if they thought a person would benefit from the use of an advocate. We saw one example of staff contacting an advocate on behalf of a person who had no family to support them in making decisions. An advocate is a person who represents and works with a person or group of people who may need support and encouragement to exercise their rights.

People spoken with told us that they were able to make choices for themselves, like where to take their meals or what time they wished to get up in the morning or go to bed in the evening.

Staff told us they had recognised that a number of people may become anxious in a group situation. They told us that they had begun to take these people into a downstairs conservatory so that they had a more quiet and spacious environment to spend time in.

We saw that people's bedrooms were personalised with ornaments, photographs and personal treasures that they had brought with them when they moved into the home.

Inadequate

Is the service responsive?

Our findings

People spoken with and visiting relatives told us that they had not had any input into the care plans. They told us that staff never talked to them about what was important to them. We asked a member of staff if people able to do so signed their care plans. They told us that it was not common practice to involve people when care was planned.

At out last inspection of the service in October 2014 we were concerned that people's care and support was not being appropriately planned for. This was because we found that people's care and treatment was not always delivered in a way that met their needs. We asked the provider to make improvements.

We found during this visit that little improvement had been made as to how people's care was planned and delivered. We saw that the information contained in people's care planning documents failed to identify and offer guidance as to how a person should be supported. For example, one person's care plan stated "Can display challenging behaviour at times, cognitive impairment caused by dementia." In order to support the person with these needs the instructions were to "administer pxd medication monitor effects." We saw no personal preferences, information about life history or personalised information about the person recorded. This meant that individual likes and dislikes may not be taken into account when planning the person's care and treatment. The care plans were not person centred and failed to consider people's autonomy and liberty, neither did they encourage staff to maximise people's capacity to be involved and to make decisions.

We saw that care planning documents in place failed to ensure people's welfare and safety. For example, we saw that one person had a risk assessment for 'safety in the environment' which stated that they should be subject to "continuous observation", however, this information was not considered in the person's care plans.

We saw little evidence of activities available for people to promote physical and mental stimulation. People spoken with were unable to recall any recent activities. Staff told us that activities were often personalised such as painting nails, hairdressing and massage. Several staff commented about the lack of stimulation and activities for people. For example, one staff member told us they thought people were under stimulated and lacked exercise. Other comments from staff included "I would like them [people] to go out more; they never go out. I have never seen anyone on [one unit] doing activities. [They] say there is not much they can do with them because they have dementia". "Activities very limited on this floor", "The dining room is an unused resource, there could be so much more. We have ideas but nobody listens, ideas are shrugged off."

We saw that assessments carried out prior to and when a person moved into the home were not always signed by the person carrying out the assessment or dated. In addition, we found that assessments were not always accurate. For example, one person's Malnutrition Universal Screening Tool (MUST) stated that the person had experienced weight loss, however, this had not been reflected in the review of the assessment. The risk factor to the person was documented as low, however, once the weight loss was considered the person was at medium risk.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (Regulated Activities 2014) because the provider had not taken proper steps to ensure that people were protected against the risks of receiving inappropriate or unsafe care and treatment.

People's personal information was stored in secure lockable offices in order to keep their information safe. We saw that not all of the records maintained were done so in an appropriate manner that promoted person centred care. For example, one person's records described them as "Wandersome" and having "Stubborn behaviour". People's daily care records which were in place to document the care and support people had received or been offered throughout the day were not always clear or easy to understand. For example, one entry into a person's care planning records stated "Following GP NV is now px'd diazepam 5mg" and other abbreviations seen to be used included "HX" and "RV". This is contrary to the Nursing and Midwifery Council guidance on record-keeping.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17

Inadequate

Is the service responsive?

(Regulated Activities 2014) as the provider had failed to ensure that people are protected from inappropriate care and treatment by maintaining accurate records.

We saw that a complaints procedure was available around the building. During our visit we asked for a summary of the complaints that had been made directly to the service since we last visited. The information demonstrated that nine complaints had been made since October 2014. We saw that a representative of the provider was in the process of ensuring that all complaints had been responded to appropriately. Relatives raised concerns with us prior and during the visit in relation to the quality of food, missing personal effects and clothing from people's bedrooms and the quality of the laundry service within the home.

Inadequate

Is the service well-led?

Our findings

At out last inspection of the service in October 2014 we were concerned that systems in place to regularly assess and monitor the service that people received were not effective. We asked the provider to make improvements.

During this visit we saw that little improvement had been made as to how the service that people received was monitored. We saw that a number of quality assurance documents had been developed to monitor the quality of the service people received. For example, a quality assurance framework document was available that had last been updated in February 2015. The document failed to recognise the areas of non compliance and poor practice within the service. For example, we saw that improvements were needed in relation to people's care plans and individual assessments, however the document stated that this standard had been met.

An action plan to improve quality outcomes 2015 was made available to us. This document listed the action required in order to improve the service. We saw that this action plan failed to consider areas identified as needing improvement in relation to people's care and support. For example, areas of care and support in relation to decision making; the implementation of the Mental Capacity Act 2005; medicines management; mental and physical stimulation and person-centred care delivery were not listed in the improvement plan. This demonstrated that the current systems in place to evaluate and monitor the quality of the service people received were not effective.

We saw that the provider had developed a monthly quality visit form to monitor the service being delivered. The most recent quality visit had taken place on 10 December 2014. We saw that the visit form recorded several areas of concern. For example, people's fluid intake monitoring charts had been completed however, there did not appear to be any corrective action taken when a person's fluid intake was below the expected amount. Further information recorded demonstrated that people's care planning and recording documents had not been completed in full. For, example, records for one person stated that they were to be weighed on a weekly basis, however, there were no weights recorded for the previous five weeks.

We saw that monthly reviews of care planning documents and medicines were carried out by the staff team. We found that these reviews were not effective as they had failed to identify shortfalls in the care and treatment of people living with dementia.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, which corresponds to Regulation 17 (Regulated Activities 2014) because the provider had failed to ensure that effective systems were in place to regularly assess and monitor the quality of service provision or identify and minimise risks to people.

There was no registered manager in post at the time of this inspection. 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. There had been no registered manager in post since April 2014.

On the first day of this inspection we spoke with a manager who had been in post for approximately three months. On the second day of our inspection these management arrangements had changed and a recently recruited deputy manager had taken up the role of manager as the manager we met one the first day of our visit had ceased their employment. We saw on occasion that new staff in post were impeded by not being fully acquainted with the processes and procedures that had been put in place by their predecessors. Staff spoke positively about the impact this manager had had on the service in the short time they had been employed as deputy. Staff described her as "amazing", that she had brought energy to the unit and that they were viewing the future positively.

The new manager in post demonstrated a clear understanding of what changes were needed to improve the service and was able to explain what good care looked like.

Records were stored appropriately to ensure that people's personal information was protected, Lockable facilities were available throughout the building to keep people's information safe. During the inspection process the provider demonstrated a good understanding of the Data Protection Act.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People who use services were not protected from inappropriate care as suitable arrangements were not in place for acting in accordance with, the consent of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People who use services were not protected from inappropriate care and treatment as accurate and effective records were not maintained.**

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 **People who use services were not protected from inappropriate care and treatment as accurate and effective records were not maintained.**