Deal Old Peoples Housing Society Limited

St Albans House

Inspection report

12 The Grove
Deal
Kent
CT14 9TL

Tel: 01304374243

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on the 20 April 2017 and was unannounced.

St Albans House provides accommodation for up to 19 older people who need support with their personal care. The service is converted house. Accommodation is arranged over three floors. A stair lift and a passenger lift are available to assist people to access the upper floors. The service has 19 single rooms including two with en-suite facilities. There were 14 people living at the service at the time of our inspection.

The registered provider, Deal Old People's Housing Society Limited is a registered charity and a committee oversees the running of the service. A registered manager was working at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People told us that they felt safe living at St Alban's. However, detailed information was not available for staff to refer to about how to manage risks to people. This did not impact on people as staff knew how to keep people as safe as possible. Accidents and incidents had been recorded, these had not been analysed to identify any patterns or trends to prevent them happening again.

People received their medicines when they needed them, but medicines were not always recorded and managed safely.

There was not always sufficient staff on duty to provide care and support to people when they needed it. Care plans did not contain detailed information about people's choices and preferences. Staff knew people well and supported them in a person centred way.

The provider had a recruitment process in place to make sure that staff employed were of good character. This process had not been followed consistently and shortfalls were identified at the inspection. Staff had completed training to be able to provide safe and effective care, however, this training needed to be updated.

Staff received one to one supervision and yearly appraisals to identify their development and training needs. Staff told us that they did not always feel supported or listened to by the registered manager, and some of their concerns had not been addressed. The culture within the service was not open, inclusive and empowering. The registered manager and the staff were not working together as a team. Staff felt that the service had lost its vision about the care provided.

Checks on the environment and appliances such as the lift and boiler had been completed to keep people safe. There were systems in place to monitor the quality of the service. Surveys had been sent to relatives, staff and other stakeholders such as district nurses but not to people. Audits had been completed but not

identified the shortfalls found within the service.

The registered manager had not formally assessed people's capacity to make specific decisions. When speaking with people they had capacity and staff supported them to make decisions. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). People were not restricted and there were no authorisations in place.

People's health was monitored and staff worked with health and social care professionals to make sure people's health care needs were met. People were offered a balanced diet and were offered food they liked. People had the opportunity to join in activities; people told us that staff supported them to continue their hobbies and interests.

Staff were kind and caring to people and treated them with dignity and respect. Relatives and friends were encouraged to visit people. Staff knew visitors and people well; there was a warm and friendly relationship. Staff knew the signs of abuse and were confident to raise any concerns they had with the registered manager.

There were procedures in place to record and investigate complaints, there had been no complaints recorded. The provider had submitted notifications to the Care Quality Commission in a timely manner and in line with guidelines.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and made recommendations. You can see what actions we have asked the provider to take at the end of this 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

The service was not always safe.

Potential risks to people had not been assessed and guidance had not been given to staff to mitigate risks.

Recruitment processes were not consistently followed.

Medicines were not always managed safely. People received their medicines when they needed them.

People were protected from the risks of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received one to one supervision but did not feel they were listened to.
Staff had received training to carry out their role but this had not been updated.

Staff worked within the principles of the Mental Capacity Act, however, there had been no formal assessment of people's capacity to make specific decisions.

People were offered a choice of food to keep them as healthy as possible.

People were supported to have regular health checks and to attend healthcare appointments.

Is the service caring?

Good

The service was caring.

Staff were kind and caring to people.

People were given privacy and treated with dignity and respect.

People were supported to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Detailed guidance was not available for staff to refer to about people's care preferences. Care plans were not reviewed regularly to reflect changes in people's health care needs.

People had access to a range of activities.

Systems were in place to resolve any concerns people may have.

Is the service well-led?

Requires Improvement

The service was not well led.

Staff did not feel they were supported.

Audits of the service had not been consistently completed and shortfalls found at the inspection had not been identified.

The provider had not used feedback from people, staff and relatives to make improvements to the service.

Notifications had been submitted to CQC in line with guidance.

St Albans House

Detailed findings

Background to this inspection

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

The inspection took place on 20 April 2017 and was unannounced. It was carried out by two inspectors.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service. We looked at notifications received by CQC. A notification is information about important events which the provider is required to tell us about by law, like a death or serious injury.

We looked around areas of the service, and talked to five people who live at the service. Conversations with people took place in people's rooms and the main communal areas. We did not use the Short Observational Framework for Inspection (SOFI) as people were able to talk with us. SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We reviewed records including four care plans and risk assessments. We looked at a range of other records, staff rotas, medicine records and quality assurance surveys and audits.

We talked with relatives who were visiting people, the registered manager, care staff, the cooks, domestic staff and the finance assistance. We spoke with health care professionals before the inspection.

The previous inspection was carried out in September 2015, no breaches of regulations were identified at this inspection.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said "I feel safe as I know the staff will come when I call." A relative told us, "I know (my relative) is safe and well looked after."

Risks to people had not been assessed and guidance had not been provided to staff about how to support people to remain as safe as possible. Some people required support with their mobility. There was no detailed guidance for staff about how to move people safely. For example, one care plan stated, 'Stand aid with two staff', there was no information on how the person's health condition affected the support they needed when using the stand aid. Another person was prescribed blood thinning medicine; there was no guidance for staff to recognise or manage the risks to the person when taking this kind of medicine.

One person was prescribed oxygen therapy; there was a risk assessment in place and details about how long the person should have the oxygen in place each day. There was no record of the rate the oxygen should be set at; staff were not able to check that the rate was correct. Records showed that the person had not been receiving oxygen as prescribed; they had made the decision themselves. There was no guidance for staff about what to do if the person became unwell or what signs and symptoms to look for if they were becoming distressed from not having the oxygen as prescribed.

Some people were at risk of developing skin damage, pressure relieving mattresses had been put in place to mitigate the risk. There were no checks in place to ensure the mattress was working as required and the mattress was set to correctly to be effective. There was a risk people would not receive safe and appropriate care and support.

The provider failed to assess risks to people and provide guidance to mitigate these risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We observed staff supporting people with their mobility safely and appropriately for the person. Staff were able to explain how they supported people who used equipment to move, and the actions they took to ensure the person remained safe.

People told us they received their medicines when they needed them. However, medicines were not always recorded and managed safely. Some instructions on the medicine administration records (MAR) had been handwritten by staff. These instructions should have been signed by two staff to confirm the instruction was correct, this had not been completed.

Some people were prescribed medicines 'when required', such as pain relief. Guidance had not been provided to staff about the 'when required' medicines each person was prescribed, such as when it should be offered and the minimum time needed between doses.

Some MAR charts had not been signed to indicate staff had given medicines as prescribed. When checked the number of tablets in stock confirmed that the medicines had been given. The direction of how much

medicine should be given on one person's MAR sheet had been changed by staff. The label on the box of medicines had not been changed and there were no written instructions from the GP in the medicines record to confirm that the prescription had been changed. There was a risk that people would not receive their medicines as prescribed.

The registered persons failed to record and manage medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were procedures in place to recruit staff safely; however, this had not been followed consistently. There were not always photographs in staff files to confirm the identity of staff. Some staff did not have a full employment history recorded and this had not been discussed with them. Disclosure and Barring Services (DBS) criminal records checks had not always been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. One person had a letter from the DBS to confirm that they were not on the barred list for working with vulnerable people but a full DBS had not been completed. The registered persons had obtained two written references for each person and had verified these by telephone.

The registered persons failed to recruit staff safely. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always sufficient care staff on duty to meet people's needs. The registered manager worked as part of the care team each morning with two carers. There were some people that required two staff to support them; people told us that they had to wait for support during the morning. There were sufficient staff on duty during the evening and at night. The registered manager told us that agency staff were being used in the evenings. The registered manager requested the same agency staff so they knew people. We recommend that the provider assess staffing levels.

Checks had been completed on the environment and equipment for example the lift and boiler to make sure they were safe. There was a current fire risk assessment in place. Fire drills had been completed, to ensure staff and people know what to do in the event of a fire. Each person had a personal emergency evacuation plan (PEEP) in place. A PEEP sets out the specific physical and communication requirements that each person had to ensure that people could be safely evacuated from the service. There were not specific details on how to evacuate people during the day and night, this was an area for improvement.

Staff knew how to keep people safe. Staff were trained and understood how to recognise signs of abuse and what to do if they suspected incidents of abuse. Staff told us they were confident that the registered manager would take any action that was needed. Staff were aware of the whistle blowing policy and the ability to take concerns to outside agencies, if they felt that any situations were not being dealt with properly.

Requires Improvement

Is the service effective?

Our findings

People told us that they were supported to make decisions and choices about their lives. One person told us, "I like to be independent, but can be unsteady, the staff worry but let me carry on and help when I ask."

Staff told us that they received the training they needed to complete their roles. When people began working at the service they completed an induction, including core training such as moving and handling and safeguarding. The induction included shadow shifts with more experienced staff to get to know people's choices, preferences and routines. Staff had either completed or were working towards recognised adult social care vocational qualifications. Vocational qualifications are work based awards that are achieved through assessment and training. To achieve vocational qualifications staff must prove they are competent to carry out their role to the required standard.

The training records showed that staff had received training but some training needed to be up dated. The registered manager had identified this and up dates were being arranged. Staff understood their roles and responsibilities; they were able to explain how they put their training into practice. Staff explained how they supported people with their mobility and personal care. We observed staff ensuring people were safe and supporting them to maintain their safety. Staff received one to one supervisions and appraisals to discuss their development and training needs. However, staff did not feel they were listened to when they brought up concerns.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under MCA. The application procedure 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.

People we spoke with had capacity to make their own decisions and were not being restricted. Staff were observed asking people's consent before providing support. Staff ensured people made decisions about how they spent their time and what they had to eat and drink. People's decisions about using bed rails had been recorded in the person's care plan. People or their relatives had signed to confirm they had read the care plan and agreed to the support to be provided. People's ability to make specific decisions had not been formally assessed by staff and recorded. This was an area for improvement.

People were supported to eat a balanced diet to maintain good health. Staff knew what people liked to eat and the size of portions they preferred. We observed the lunchtime meal; people were able to choose if they wanted to eat in their room or dining room. People were given a choice of meals and desserts. The meal was

a social occasion; people were chatting with staff and said how much they enjoyed the meal. Staff supported people with their meals when needed. People who had problems with swallowing had a pureed diet prepared for them.

People told us that they enjoyed the food. One person told us, "I am happy with the food it is very nice." A relative told us, "The food is good, we had Christmas dinner here and it was lovely." People were encouraged to use their favourite crockery from home that brought back memories and made them feel at home.

Staff supported people to maintain good health and were supported to see health professionals when they needed to. People had access to health such as opticians, dentists and district nurses when needed. Staff took prompt action when changes in people's health occurred. For example, one person had lost weight, they were referred to the dietician for advice. Staff were following the advice given and the person had started to gain weight.

Good

Is the service caring?

Our findings

People appeared happy and relaxed in each other's company. One person told us, "We come into the lounge and have a chat or read, whatever we want to do."

Staff spoke with people, and each other with kindness, respect and patience. Staff showed a genuine interest in people and what people had to say. A relative had brought in a cup and saucer from a person's home. The cook spent time asking about the history of the cup and saucer and why it was special to the person. The person explained that it had been a wedding present to her parents, the cook promised, "I'll take good care of it and make sure that you can use it every day." At lunch, the cup and saucer started a conversation between people and staff, about their special wedding presents.

People were encouraged to maintain friendships and relationships. People told us their loved ones could visit at any time and there were no restrictions. During the inspection, visitors spent time in the lounge, they knew people well and everyone enjoyed a conversation about the changes in village life. People's privacy and dignity was respected. People were supported to go back to their room, if they wanted, when their visitors arrived.

Staff told us how they promoted people's dignity, such as, making sure doors were closed and people were covered up during personal care. When people choose to spend time in their room staff respected their request for privacy. Staff checked on people to make sure they had everything they needed. Staff referred to people by their preferred names and were relaxed in their company.

People were encouraged to be involved in making decisions about their care. When changes in their needs arose, people were informed of the advice that had been given by professionals. The person and the staff agreed a plan that incorporated the guidance.

People were supported to be as independent as possible. Staff encouraged people to be independent when transferring and mobilising. Staff knew people well, they knew how to encourage people to do small actions to keep themselves independent, for example, having the wheelchair close by so that the person felt safe when mobilising and transferring.

People's rooms had been personalised with photos and small pieces of furniture to help them feel at home. Staff knew people and their individual preferences well, including their life histories and spoke with them about things that were familiar and important to them.

People's religious and cultural needs were recorded and respected. Arrangements were made for visiting clergy from different denominations so people could follow their beliefs. People's choices and preferences for their end of life were recorded to make sure their care and support was provided in the way they had chosen.

Personal and confidential information about people and their needs were kept safe and secure. Meetings

with people or when people's needs were discussed were carried out in private. There was good communication between staff members with handover meetings held between shifts and a communication book that noted any changes or professional contact that staff needed to be aware of.

Requires Improvement

Is the service responsive?

Our findings

People told us they received the care and support they needed and that staff were responsive to their needs. People said, "Staff come to me when I call them", "They call the doctor when I am not well", "The staff are very good and help me when I need them". A relative told us, "They keep me informed of any changes to (my relative)."

People and their relatives met with the registered manager to talk about their needs and wishes, before they moved into the service. A relative told us that their loved one had spent days at St Albans to see if they liked it before moving to the service. An assessment was completed with people and their relatives to agree their support needs.

Each person had a care plan. The care plans contained information about people's lives before coming to live at St Albans, health conditions and basic support needs. The care plans did not contain details about people's choices and preferences. However, staff knew people and their preferences. Staff were able to tell us how they supported people; this included when people liked to get up and go to bed. People told us that they were supported in the way they preferred. One person told us, "I have my lunch in my chair. Staff help me back to bed and then get me up for my tea. This is what I like to do." This information was not recorded in the person's care plan.

Care plans were not reviewed regularly. For example, a health professional advised that a person should have bed rest while they had a wound on their leg to promote healing. This had been put in the care plan and agreed with the person. During the inspection, the person was sitting in the lounge. Staff confirmed that the wound had healed and the person was able to get up and about. This had not been updated in the care plan.

The registered manager had started working with health care professionals to complete detailed care plans for each person.

Staff supported people to be as independent as possible. People told us that staff worried about them being independent but supported them to do as much as they could for themselves.

People told us that staff came when they called but they sometimes had to wait in the morning as staff were very busy. One person said, "They are very good but busy in the morning with no time to chat."

People told us that they had enough to do during the day and were supported to follow their interests. People spent their time reading, chatting and knitting when in the lounge. Some people wanted to spend their time in their rooms watching television or listening to the radio. There was a conservatory that people could use, with a phone for private calls.

There was a programme of activities that included a PAT dog, bands and chair exercises. During the inspection people went to the hairdresser and attended an exercise class. People said they enjoyed these.

The provider had a complaints policy and procedure in place. The policy was displayed in the corridor. The policy was not in a prominent place and in a format that was easy to read. This was an area for improvement.

There had been no complaints recorded and people told us that they had no complaints. The registered manager understood that complaints needed to be recorded and used as a learning experience to improve the service.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us that they saw the registered manager regularly and they felt they could speak to them about any concerns they may have.

The registered manager had been in post since October 2016 and had worked at the service before taking this role. Before this inspection there had been concerns raised about the leadership and management of the service from health care professionals. Concerns had been raised that the registered manager had contacted other professionals such as the GP or district nurse when it was not necessary. Also, that the registered manager did not have information available about people when required and this put people at risk.

Staff told us, "The registered manager is excellent with people and is very kind and caring." However, they felt the registered manager was not confident in her role. Staff told us there was a lack of communication, they were not listened to and that the service had lost its vision.

Staff received one to one supervision with the registered manager but did not feel supported. They felt that their concerns about staffing and the changes within the service had been ignored. Staff felt that the registered manager did not have enough time to complete their managerial duties as they were providing care in the mornings and working long hours.

The staff promoted a positive, person centred culture with people and there was a warm and friendly relationship. The culture within the service was not open, inclusive and empowering. The registered manager and the staff were not working together as a team. Staff told us that the registered manager did not provide them with the support and guidance when they asked for it. The registered manager felt they supported staff and this had not been appreciated.
There were systems in place to monitor the quality of the service provided. Checks and audits were completed by the registered manager, these audits had not identified the shortfalls in risk assessments, medicines and care plans that we found.

Accurate and complete records in respect of each person were not maintained. Risks relating to people's care and support had not been consistently assessed and documented. Clear guidance had not always been provided to staff about how to mitigate risks to people. Care plans had not consistently been reviewed and updated to reflect people's changing needs. Medicines had not been recorded and managed safely. These issues had not been identified by the registered manager's audits.

Accidents and incidents had been recorded but had not been analysed to identify trends and patterns, to help reduce the risk of them happening again.

There was a quality assurance system in place. Surveys had been sent to relatives, staff and other health professionals. The views and opinions of the people living at St Albans had not been sought. The registered manager had organised staff meetings but there had been no resident meetings for people to give their

views.

The results of the survey had not been summarised and people had not been informed of the outcome. There was no evidence to confirm how people's views and opinions had been used to continuously improve the service. The registered manager told us that everyone would be sent quality assurance surveys in the future.

The registered persons had not ensured that the systems in place to quality assure and check the care being provided was effective. The provider had not actively sought the views of people living at the service to ensure the continuous improvement of the service. The provider had failed to ensure that records were accurate or fully completed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service like a death or serious injury. This is so we can check that appropriate action had been taken. Notifications had been sent to CQC when required.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess risks to people and provide guidance to mitigate these risks. The provider failed to record and manage medicines safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the systems in place to quality assure and check the care being provided were effective. The provider had not actively sought the views of people living at the service to ensure the continuous improvement of the service. The provider had failed to ensure that records were accurate or fully completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to recruit staff safely.