Crowley Care Homes Limited

Crowley Care Homes Ltd - St Annes Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection visit took place on 24 May 2017. The visit was unannounced.

The service provides accommodation and care for up to 20 people. At the time of our inspection there were 19 people living at the home.

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.

Medicines were not always managed safely and guidance to staff on the administration of 'as required' (PRN) medicine was not always in place.

There were not always enough skilled and qualified staff to provide for people's needs. Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly. Accidents and incidents were recorded, although the causes of these had not been analysed to allow the provider to identify preventative actions which could be taken to reduce the number of occurrences.

Staff received training to ensure that they had the necessary skills to care for the people who lived at the home, and were supported by way of supervisions and appraisals.

People's needs had been assessed when they moved into the home and they and their relatives had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People were happy and felt safe living at the home but said that they did not always have enough support with activities to keep themselves occupied during the day. They had a choice of food and drink with snacks and fruit available throughout the day.

Staff were caring and friendly. They knew the people they cared for well. They protected people's dignity, treated them with respect and encouraged them to maintain their independence. Staff understood the need for confidentiality.

Information was available to people about how they could make a complaint. People were assisted to access healthcare services to maintain their health and well-being. Staff worked with healthcare professionals and people's relatives to ensure that the care provided to people best met their needs.

The provider had not submitted notifications to the Care Quality Commission (CQC) as required by law. Neither had they displayed the rating of 'requires improvement' given at the last inspection carried out by CQC. The manager completed regular audits of the service to check on quality but there was a lack of evidence of Provider oversight. People were asked for their views but the information provided was not consistently used to make improvements to the service.

We found that the provider was not meeting some legal regulations. 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

The service was not always safe.

There were not always enough skilled and qualified staff to provide for people's needs.

People's medicines were not always managed safely.

Staff were aware of the safeguarding process and how to make appropriate referrals to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink and their health care needs were met.

Staff were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were kind and caring although did not always have time to talk to people.

Staff promoted people's dignity and treated them with respect.

Staff encouraged people to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not supported to follow their interests and hobbies. They reported that there were not enough activities during the day to keep them occupied.

People had care plans in place to meet their individual needs.

There was an effective complaints system in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Notifications to the Care Quality Commission were not always sent as required.

Performance ratings were not displayed as required.

Management oversight at a provider level was not sufficient. The registered manager completed regular audits of the service.

There was a registered manager in post who was approachable and supportive of staff.

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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.

An inspection visit took place on 24 May 2017 and was unannounced. The visit was carried out by one inspector. Before the inspection we reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with five people, three relatives and one advocate of people who lived at the home, three care workers, a cook and the registered manager. We reviewed the care records and risk assessments for three people who lived at the home. We looked at four staff recruitment files and reviewed training and supervision records for all the staff. We also reviewed information on the complaints system and how the quality of the service was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at the service. One person said, "It's safe here, it's like a home." A relative told us "I don't have to worry about going away and I know that [relative] is safe and comfortable."

Although people felt safe, several people told us they felt there were not enough staff and this meant they had to wait for care when they needed it. One person said, "There's not enough staff. I have to wait. I don't use a call bell, I just have to scream and shout." When we arrived to carry out the inspection there was one member of staff downstairs who told us two more colleagues were providing care on the first floor. As we entered the lounge, two people were in distress because they required urgent assistance with personal care. Staff only became aware of this and took action when we brought it to their attention. The manager confirmed that the usual number of staff on shift in the morning was three and so the staffing level on the day of the inspection was a true picture of the usual staffing numbers on shift.

Out of the 19 people who used the service, the manager confirmed that 17 required some degree of assistance with personal care, two of which required the assistance of two staff. We concluded from people's comments and our observations that there were not enough staff on duty to meet people's needs safely and in a timely manner.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. We looked at the medicine administration records (MAR) for three people and found these had been completed with no unexplained gaps although incorrect codes had been used without explanation. For example, the code 'O' indicating 'Other' was used with no annotation to indicate what the circumstances were when someone had not received their medicine. Medicines were stored and accounted for as required and there were regular audits to ensure that stock levels were correct. We checked a random sample of boxed medicines to check that records of stock were correct and found no inconsistencies. However, we found stock of a medicine prescribed to one person that was not entered on their MAR. Therefore it was unclear whether or not the person required this medicine and at what dosage and frequency. Staff we spoke with were unable to confirm whether or not this medicine was currently taken by the person. Most people had their medicines provided in blister packs, but some medicines were held separately. While boxed and liquid medicines were dated to show the date they were opened, this was not the case for inhalers. This could lead to people being given medicine that was out of date or in use for longer than recommended.

Protocols to instruct staff on the administration of 'as required' (PRN) medicines were not in place to inform staff about why a person may need the particular medicine, and what signs to look for in the event the person was unable to state their need verbally. Only the most basic information was provided. For example, one person's record stated, "Please do not give [name of drug] unless [name] really needs it." This did not give staff adequate information to be able to judge what symptoms the person would experience to indicate when this medicine was required. The records for one person who was prescribed Alendronic Acid did not

include any details of the correct procedure to ensure this medicine was administered safely and as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staff were able to describe some of the ways in which they kept people safe, and the process they would follow if they were concerned that a person might be at risk. One member of staff said, "I would always report anything wrong to my manager." Another member of staff said, "I would go to the manager and they would take action."

We saw the provider had up to date safeguarding and whistleblowing policies. Whistle blowing is a process by which staff can raise concerns without the fear of any consequences for doing so. We saw from records that the manager reported safeguarding concerns to the local authority appropriately.

There were personalised risk assessments for each person who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the action staff should take should an incident occur. Examples of risk assessments carried out included the risks associated with developing pressure ulcers, the risk of malnutrition, mobility, and falls.

There were general risk assessments completed which identified any risks to the environment. Regular maintenance checks were being carried out including portable appliance testing (PAT), gas safety checks and fire equipment checks. Equipment, including hoists, was serviced regularly. We noted that, where incidents or accidents took place in the home these were appropriately recorded although the manager did not have a formal process for analysing the records to establish patterns and trends. This would be of benefit because it would enable action to be identified to reduce the risk of further occurrences.

The provider had effective recruitment processes and systems to complete all the relevant pre-employment checks, including requesting references from previous employers, proof of the applicants' identity, confirmation of their right to work in this country, and Disclosure and Barring Service (DBS) reports for all the staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

Good

Is the service effective?

Our findings

People and their relatives thought that the staff were well trained. One person told us, "The staff are good. They know what they are doing." A relative said, "The staff know people's needs and I would say they've had training."

Staff told us they were supported to complete regular training and were pleased with the quality of the training on offer. New members of staff completed an induction into the service when they first took up their role. One member of staff said, "I've worked here a while, but yes I had an induction and I get enough training; all the usual ones but also things like diabetic care and pressure care. Things that are relevant to people's needs." Induction included an opportunity to work alongside experienced members of staff, observe practice and read through relevant records. We noted that the service tested the knowledge of staff to determine whether training had been effective in enhancing their overall understanding of each subject. The manager told us that staff received supervision every three months and an appraisal of their performance annually. Staff confirmed that they received regular supervision and appraisal.

People told us that staff always asked for permission before care was provided. One person told us, "They always ask me if it's okay and always tell me what they are doing." The staff we spoke with understood the need for consent and the ways in which people provided consent for them to deliver care. One member of staff said, "It's all about the person. They come first and they must make the choices that are right for them. We have to respect their wishes."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had completed training in MCA and we found that staff worked within the principles of this legislation. However, we found that some areas of their knowledge and understanding needed to be developed further particularly in relation to how capacity was assessed. However, care records showed that capacity assessments were completed by the registered manager and where applicable requests were made in accordance with the DoLS procedures.

People were complimentary about the food and said they had enough to eat and drink. One person said, "Oh yes you can't complain about the food. It's very good." A relative said, "The food is lovely and they get lots of choices to drink." We observed people eating at lunchtime and saw that they had a choice of balanced, nutritious and wholesome food which took into account their individual preferences and dietary needs. People were shown the meals available to them before they were asked to choose which they wanted. We noted that people who required a different diet for health or ethical reasons were provided for

well with food of the same quality as everyone else.

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

People were supported to have their health care needs met. A visiting professional said, "The staff are good here. They are supportive and responsive to advice we give. They have a good approach and know people well. They keep us informed, which is always good." Visits and telephone calls with healthcare professionals were recorded on people's care plans with details of any advice given such as changes in medicines or further referrals that should be made. We saw evidence of input from a wide range of healthcare professionals such as doctors, district or community nurses, chiropodists, and dietitians.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring. One person told us, "I've been quite happy here. The staff are good. They are nice to me and speak kindly." A relative said, "They have a nice approach." Another relative said, "They are really great. They respond to suggestions and clearly really care. They've made a real difference to my [relative]." We noted that staff spoke kindly to people and appeared to know their needs well. Despite this, we found that much of the conversation was related to the tasks being carried out and there were times during the day when little else was said to people because staff were very busy. When staff did have opportunities to speak to people they were positive, cheerful and respectful.

Staff treated people with dignity and respect and told us how they maintained people's privacy by knocking on doors before entering and covering them up as much as possible during personal care. The manager told us about the approach used to provide care to one person who felt very uncomfortable during personal care. The person required the support of two staff to mobilise using the hoist. To reduce the person's discomfort, the second member of staff only entered the room when moving was required and remained outside during the rest of the task to respect the person's privacy. This had resulted in the person feeling much less anxious about the support and therefore they felt able to accept it. The person's relative confirmed that this had significantly reduced their distress during care.

A relative told us that the service had supported their family member to regain their independence. The person had previously stayed most of the time in bed but since moving to the service was gradually mobilising and spending more time up in the lounge. This had a significantly positive impact on their wellbeing and we saw them laughing and making jokes with their relative during our visit.

People told us that their relatives could visit them whenever they wanted to. One relative said, "We can come any time we like and stay as long as we like." People were given information on who they could speak to or contact if they had any concerns. This included details of advocacy services and who was who within the wider organisation. We saw that one person had the support of an advocate to enable them to make decisions about their care independently.

We saw that there was information available to people and their relatives on areas such as safeguarding and complaints on noticeboards around the house.

Requires Improvement

Is the service responsive?

Our findings

Although care plans contained good information about people's interests and hobbies, people did not think that there was enough to occupy them during the day. The information about people's preferences had not been used effectively to ensure people had meaningful and interesting pastimes to participate in during the day. One person told us, "I do get bored. I used to play cards at the day centre but there's nothing like that here." Another person said, "I would like to be at [previous residence]. I had my own telly there. I just sit here all day long until it's time for bed. Sometimes a musician comes but normal days, nothing." A relative said "They have music periodically. We don't see activities but we are only here [twice a week]. They do dominoes occasionally but not with [relative]." However another relative said, "There's events and activities often going on, like sing songs and parties, sometimes people do jigsaws."

The manager and staff told us that some activities took place during the week and showed us some photographs of staff playing dominoes and games with people. The manager showed us an activities time table which showed a planned activities session scheduled every afternoon for two hours. However, on further exploration it emerged that these sessions did not always take place and records showed activities took place on one afternoon a week only. The manager maintained the frequency was greater than this but was unable to provide evidence of this. On the day of the inspection no activities were taking place throughout the day and many people spent a lot of the day sleeping in their chair in the lounge. Before lunch we observed 11 people in the lounge with 2 staff. Eight of the people were sleeping and three were withdrawn and disengaged. The television was on but no one was watching it and the two staff were silent.

The manager told us that on warm days people made good use of the garden. However, despite it being a warm and sunny day, the only people who made use of the garden were those who chose to go out there to smoke.

Furthermore in the afternoon of the day of the inspection, we observed that a training session for staff was taking place in the communal lounge. Whilst this was going on, people were sitting around the edge of the same room with nothing to do. Even if they had wanted to watch the television, they would not have been able to watch uninterrupted as the training was taking place around the table which was positioned in front of the television.

The manager said they tried to ensure birthdays and other significant dates were celebrated but also commented that it could be difficult to find suitable activities because, "People with dementia often just walk away." We concluded from this that people did not have enough to stimulate or engage them and that activity provision required improvement to meet the individual needs of people using the service, particularly those people living with dementia.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An initial assessment was carried out when people first came to the service to determine their level of need

and from this a care plan was developed. People we spoke with were unsure about whether or not they had a care plan but did confirm they were asked for their views about their care. Relatives we spoke with confirmed they were involved in planning appropriate support on their family member's behalf where this was appropriate. One relative said, "They always involve me and keep me informed."

There was evidence that people and their relatives had been involved in this process. The Care plans covered areas such as eating and drinking, personal care, sleeping, skincare, mobility, and communication. Where people had a specific medical condition, a care plan had been developed to guide staff on how to meet the person's needs in relation to this. Care plans contained personalised details to guide staff on how to deliver care that suited people's individual needs or preferences. Care plans were regularly reviewed to ensure the contents was up to date and relevant to the person's current needs.

The provider had an up to date complaints policy and procedure. People and relatives told us that they were aware of the complaints system and that they would feel comfortable to raise any concerns with the staff or the manager depending on how serious the issue was. We saw that complaints were recorded, investigated and responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post.

At our previous inspection in February 2016 we found that the provider had not submitted notifications to the Care Quality Commission (CQC) in relation to people who had died whilst living at the service. This was a breach of regulation 16 of the Care Quality Commission (registration) Regulations 2009. We issued the provider with a fixed penalty notice for this breach. At this inspection we found that notifications of deaths had been sent to the CQC as required.

Before this inspection we checked our records to see whether other notifications required by law had been sent to the CQC by the service. We identified that, although the local authority had made us aware of two safeguarding allegations in the past twelve months, notifications of these events had not been sent to us by the service. We discussed this with the manager who did not appear to be aware of this requirement and said they thought the local authority informed the CQC.

This is a breach of Regulation 18 of the Care Quality Commission (registration) regulations 2009.

It is a regulatory requirement that service provider's display any performance rating given by the CQC on their website if they have one, and in a prominent position at the service. Before the inspection, we checked the provider's website and found that the rating of 'requires improvement' given at our last inspection was not displayed. At the inspection we looked at the website again in the presence of the manager, who confirmed it was not displayed. We also asked the manager to show us where the rating was displayed in the home. Although the manager was able to show us a copy of the last inspection report in a stack of documents in the entrance hall, the rating was not prominently displayed. The manager confirmed they were not aware of this requirement.

This was a breach of regulation 20a of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The manager completed audits of the service including checks on care plans, medicines, infection control and health and safety, although actions were not always recorded or signed off when completed. The manager told us that the provider visited the service regularly but did not complete formal provider quality monitoring visits. When they came, the manager said they might randomly check a record such as the complaints log, although no written record of this was kept. This meant that no audits were carried out by anyone other than those involved directly with the service in order to corroborate the home manager's audits and ensure that they were used to drive improvements. This lack of provider oversight meant that issues such as insufficient staffing, lack of stimulation and unsafe medicine management were not addressed.

We saw that people, relatives and visiting professionals were asked for their views about the service through surveys and through meetings but it was not evident how this information was consistently used to make

improvements to the service.

The lack of provider oversight and the failure to use information to make continuous improvements to the service were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People and their relatives knew who the manager was and told us they were approachable and visible throughout the service. During the day we observed that the manager had positive relationships with people and their relatives and knew their needs well.

Staff told us that they felt listened to and valued by the registered manager. One member of staff said, "[Registered Manager] is great. Really supportive. I can talk to her if I have any concerns and know she will do something." They felt the manager encouraged a person centred culture and provided a positive role model to them. One member of staff said, "I think it is a positive culture here. We do what we can for people and provide a home from home." Comments from relatives were very positive about the culture the service, describing it as "Comfortable", "Personal and not clinical" and like, "family".

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 18 Registration Regulations 2009 Notifications of other incidents Safeguarding notifications not sent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's interests, although identified, were not addressed and there was a lack of meaningful activities provided to stimulate people and offer them enough to do.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Management oversight at provider level was insufficient and people's views were not used to consistently improve

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments failure to display rating

The enforcement action we took:

Fixed Penalty Notices were served for failure to display on the company website and failure to display at the premises