St. Anthony's Residential Home Limited

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Inspection report

Station Road
Liskeard
Cornwall
PL14 4BY

Tel: 01579342308

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Anthony's residential home limited is a care home that provides personal care for up to 16 predominantly older people. At the time of the inspection 13 people were living at the service. Some of these people were living with dementia.

People's experience of using this service and what we found
The inspection was prompted following concerns raised to the Care Quality Commission in relation to the governance of the service, risk for the safety and welfare of people using the service, kitchen environment, food portions and lack of choice in meals.

Prior to the inspection we had received concerns that the service was not being governed effectively. At the inspection, there was no evidence of how the registered manager was running the service. There was no evidence of the registered manager making decisions about the future growth and development of the service. There were gaps in audits, people's views were not sought or considered. The registered manager had not identified issues we found during the inspection.

Medicines were not being managed safely. An unsecure box of medicines ready for return to the pharmacist was left outside the locked cupboard, where it should have been stored. This meant there was a potential risk to people. Where people were administered medicines 'when required', staff had not recorded the reason they were administered or whether they were effective.

The service had begun the transition from a paper care planning system to an electronic recording system. Some care records were not complete. One person had been in the service for four months on a respite basis. However, there had been no formal care plan put in place. Staff understood the person's needs and daily records were kept. Falls and incidents were being recorded as well as advice from professionals involved in the person's care. However, not having a detailed care plan meant staff did not have the necessary level of detail to respond to the person's needs.

The service did not have effective systems to monitor equipment and utilities. There was no current gas service certificate and the stair lift had not been serviced. This meant there was potential for risk. The nominated individual took action to arrange the gas system service the same day. Other service certificates were in place.

Not all people had emergency plans in place outlining how to support them should they need to evacuate the building in an emergency.
Recruitment records were generally satisfactory with checks evident. However, one member of staff did not have references in place to support the providers decision to employ them. This meant they may not have been suitable to work with vulnerable adults.

Prior to the inspection we received concerns the kitchen area was not hygienic; portions of food were small and meal choices were limited. We spoke with the cook, observed the kitchen area and looked at portion sizes. These concerns were unsubstantiated. The lunch was observed, portion sizes were good, and consideration was given for people's individual choices and appetites. The service had a 5-star food hygiene rating and the kitchen area was clean.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

There were enough staff to meet people's needs and ensure their safety. Staff told us, "Not been here long but yes, there are enough staff" and "We have time to do our jobs".

People made choices about where and how to spend their time. People told us they were happy with the care they received and believed the service was a safe place to live. Where people were unable to tell us about their experiences, we observed they were relaxed and at ease with staff.

Staff told us that they had received the training they needed to meet people's needs safely and effectively. The deputy manager maintained oversight of training to ensure staff had the necessary training, knowledge and skills to provide consistent care.

People were supported to access healthcare services, staff recognised changes in people's health, and sought professional advice appropriately.

The building was clean, and there were appropriate procedures to ensure infection control risks were minimised. Some parts of the environment were cluttered. A vacant room was being used to store equipment. The nominated individual told us additional storage was being created by erecting an outhouse. Some walls in the lounge and entrance had outdated newspaper articles and dated information leaflets.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good published (19 November 2019).

Why we inspected
The inspection was prompted in part due to concerns received about governance, medicines, staffing and people's choices. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Anthony's Residential Home Limited on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have found breaches in relation to the management of risk, management oversight and incomplete

records at this inspection.

Please see the action we have told the provider to take at the end of this report.

Notice of inspection
This inspection was unannounced.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our safe findings below.

St Anthony's Residential Home Limited

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of one inspector.

Service and service type
St Anthony's residential home limited is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at on this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We also reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about. This information helps support our inspections. We used all of this information to plan our inspection.

The provider was asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with the registered manager, nominated individual and deputy manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with 3 people 3 care staff, the cook and a visiting professional.

We reviewed a range of records. This included 3 people's care records. We checked 3 people's medicines records and looked at arrangements for administering, storing and managing medicines. We looked at records in relation to staff training and supervision. A variety of records relating to the management of the service, including audits, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks to people were not always managed effectively. Not all equipment and utilities were being checked regularly. The gas safety service had not been checked for 2 years. The nominated individual arranged for this to be carried out the following day. The stair lift did not have a service certificate. This meant there was potential for risk to people using the service.
- Not all people had emergency plans in place outlining how to support them should they need to evacuate the building in an emergency.
- Window restrictors were in place for some first-floor windows but not all. This meant there was potential for people to be at risk of falls from those windows. Following the inspection, we were assured action was being taken to apply restrictors to the remaining windows.

The provider had not ensured systems to mitigate risk were effective. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff supported people to move around and transfer safely.

Using medicines safely

- The management of medicines was not always safe. Medicines were stored in a locked cabinet at the rear of the main lounge next to a locked storage cupboard. We found an unsecure box of medicines on the floor by the side of the locked cupboard. They were medicines ready to return to the pharmacist and usually stored in the locked cupboard. Staff could not confirm why they were outside the cupboard and posing a potential risk to people. They were immediately put back into the locked facility.
- Some people required medicines 'as required', [PRN]. Staff had not recorded reasons for these medicines being administered and whether they had been effective.

Medicine storage and medicines records were not safe or effective. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff recorded on Medicines Administration Charts (MARs) when medicines were given. At a recent audit the deputy manager had found gaps in medicine records. Action had been taken by reminding staff at handovers. The deputy manager had also recently made changes to the auditing of medicines. This had improved the omissions. There were some gaps in the topical medicines [creams] for some people. Staff told us they had to apply the topical medicines and then go to complete the records. They said this could be later in the day and could be missed. We discussed this with the deputy manager who agreed to look at the

current system. We judged there had been no impact on people and immediate action was taken to address this.
● Staff were trained in safe handling of medicines and had checks to make sure they administered medicines safely.

Staffing and recruitment
● Staff were generally recruited safely. Staff files showed a range of checks including references, an application form with any gaps in employment explored, proof of identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults. However, one person had been employed without any evidence of references being taken. This meant the provider did not have the information to judge the staff member's character in previous employment.

We recommend the provider ensures there is evidence they have assured themselves, that applicants have satisfactory references in place prior to commencing a role at the service.

● There were sufficient numbers of staff employed and on duty to meet people's assessed needs. People's needs were responded to. Staff told us there were enough staff to support people. Staff told us, "Staffing is OK. We work well together and cover any gaps," "Every day is different, but we don't have issues with the levels of staff." We observed staff responding to calls promptly and time to carry out their duties.

Systems and processes to safeguard people from the risk of abuse
● The provider had effective safeguarding systems in place and staff knew what actions to take to help ensure people were protected from harm or abuse.
●Staff received training and were able to tell us what safeguarding, and whistleblowing meant.
● The provider had worked with multi agency safeguarding procedures when there had been safeguarding concerns.

Preventing and controlling infection including the cleanliness of premises
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

The service was supporting visits from families and friends. Protocols were in place should there be any disruption due to Covid-19 outbreaks.

Learning lessons when things go wrong
● Appropriate action was taken following any accidents and incidents to minimise the risk of adverse events reoccurring. For example, seeking advice from external healthcare professionals such as occupational therapists or physiotherapists, after incidents where people had fallen.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Records were not always complete or in place for people. One person had been admitted to the service for respite care. This person did not have a completed care plan in place after 4 months. Information in place for this person included daily notes, professional visits and accidents and incidents. There was no other detail about what this person's needs were. It was clear staff understood the persons needs and we observed them responding to them as well as discussing them with us. However, by not having a completed care plan meant staff did not have all the detailed information they needed to deliver consistent care and support. This was addressed with immediate effect.
- The service was in the process of transferring care plans from a paper system to an electronic system. Some of the records we looked at did not have information detailing changes. For example, one person had recently had a change in a medical condition. While it was recorded there was no detail as to the impact of this. Another person's weight had significantly increased. This was recorded but there was no information for staff about suggesting a change in diet or healthy eating plan.

The provider had failed to ensure people's needs were effectively assessed and recorded. This was a breach of This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Assessments of people's needs were reviewed. However, we identified some gaps in timescales. This had been identified by the deputy manager and action was being taken to address this. We judged this did not have an impact on people.
- Management and staff worked with external healthcare professionals to deliver care in line with best practice.

Adapting service, design, decoration to meet people's needs

- The environment was cluttered in some areas. Action had been taken to temporarily store equipment in a vacant room until a new outbuilding could be used for storage. Paintwork throughout the home was chipped and damaged in places.
- Some walls in the lounge and entrance displayed? outdated newspaper articles and dated information leaflets. This showed a lack of attention to the environment.

We recommend the provider ensures the premises used by people maintained to a satisfactory standard.

● Access to the building was suitable for people with reduced mobility and wheelchairs. There was a stair lift to access the first floor.
● The service had toilets and bathrooms with equipment to support people's independence.
● People's rooms were personalised to their individual requirements.

Supporting people to eat and drink enough to maintain a balanced diet
●Prior to the inspection we received a concern that people did not have a choice in meals, portions were small, and the kitchen area was not hygienic. We spoke with the cook, observed the kitchen area and looked at portion sizes. These concerns were unsubstantiated. Portion sizes were good, and consideration was given for people's individual choices and appetites. The service had a 5-star food hygiene rating and the kitchen area was clean.
●People had access to a varied diet. The cook and care staff were aware of any dietary requirements and preferences.
● Care plans included information about people's dietary needs and their likes and dislikes. This included any information about specific aids people needed to support them to eat and drink independently. Some people had plate guards which supported them to eat independently.
● Hot and cold drinks were served regularly to help prevent dehydration.

Staff support: induction, training, skills and experience
● People received effective care and treatment from competent and skilled staff who had the relevant qualifications and skills to meet their needs.
● Staff confirmed they had an induction when they started work which included a period of shadowing experienced members of staff and learning about people's needs and how to support them. One member of staff told us, "I had a good induction and have completed the Care Certificate. The manager checks me to make sure I'm doing things right".
● The deputy manager supported staff in their roles through regular meetings, observations of their practice and informal support. Staff had the opportunity to discuss their individual work and development needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's health conditions were being managed, and the staff engaged with other organisations to help provide consistent care. Health professionals visited daily and provided staff with guidance when necessary to support people's health and social care needs.
● Staff communicated well with external professionals and any guidance and advice was followed. A visiting professional confirmed staff respond to any guidance.
● The service worked closely with the local GP practice and they visited when necessary.
● Staff supported people to have regular health checks including opticians, hearing, and dental checks. Staff supported people to continue to mobilise independently.

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

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

principles of the MCA.

●People were supported in accordance with the requirements of the MCA. Staff consistently took the least restrictive option when supporting people to stay safe and independent. They sought people's consent before they delivered care and support to them.
● Staff supported people to be as independent as possible with making decisions about their care and support. Systems within the service helped ensure decisions made on people's behalf would be in a person's best interest.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The quality assurance and auditing systems were not effective in driving improvements in the service. Audits were not always completed. For example, environmental audits were not in place to review the condition of the service.
- The provider had not identified the issues we identified at this inspection.

The provider had failed to establish satisfactory governance arrangements and to maintain an effective overview of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager worked alongside the deputy manager and nominated individual for the day-to-day running of the service.
- Important information about changes in people's care needs was communicated at staff handover meetings each day.
- The provider had notified CQC of any incidents in line with the regulations.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The provider had not ensured the service had an effective system to engage with stakeholders and gain their views and comments to review the quality of the service and take action where needed. While staff meetings occurred, resident meetings were not held on a regular basis. People's views were not sought. For example, no surveys were being undertaken.

The provider had failed to gain the views of stakeholders to measure the service's effectiveness. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had received one-to-one supervision with the deputy manager. This provided opportunities for staff and managers to discuss any issues or proposed changes within the service. There were also regular updates through shift handovers.
- Managers and staff understood equality issues and valued and respected people's diversity.
- The service worked in partnership with health and social care professionals to ensure people received

support to meet their needs.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The management team's aim was to maintain a positive culture within the staff team. Staff told us they felt supported. One staff member told us, "I feel really supported".

● The service had a commitment to meeting people's individual needs and providing person-centred care.

● Management and staff were committed to their roles and had built positive relationships with people. Staff understood people's individual care and communication needs and this helped to ensure people received care and support that promoted their well-being.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider understood their responsibilities under the duty of candour. Relatives were kept informed of any changes in people's needs or incidents that occurred.

● The ethos of the service was to be open, transparent and honest. Staff were encouraged to raise any concerns in confidence through a whistleblowing policy. Staff said they were confident any concerns would be listened to and acted on promptly.

Continuous learning and improving care

● The deputy manager recognised the importance of ensuring staff had access to learning and development programme. They told us, "It is really important to have a trained staff team. I have reviewed the training and it's all up to date now". This was confirmed when we looked at training records.

● The management team worked closely together in order to support improvements to the service.

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 had not ensured systems to mitigate risk were effective. Medicine storage and medicines records were not safe or effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure people's needs were effectively assessed and recorded. The provider had failed to establish satisfactory governance arrangements and to maintain an effective overview of the service.