Minster Care Management Limited

Attlee Court

Inspection report

Attlee Street
Normanton
Wakefield
West Yorkshire
WF6 1DL

Tel: 01924891144

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Attlee Court is a 'care home' for up to 68 people that was providing personal and nursing care to 37 people aged 65 and over at the time of the inspection. People in care homes receive accommodation and nursing or personal care as a single package. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

People's experience of using this service:
Risks were not managed robustly to ensure people's safely and this was a continuing concern from previous inspections.
People were at risk of not being given their medicines safely or consistently.
Care records were not always up to date and did not always reflect people's current needs. Information was inconsistently recorded.
Staff deployment had improved since the last inspection, although there was little assurance of the skills and abilities of agency staff.
Staff employed by the service were supported through training and supervision.
Wound care management had improved since the last inspection.
Staff were kind and caring and there were sufficient numbers of staff to support people.
People enjoyed the activities and there was positive interaction when engaging with the activities staff.
The management team had changed since the last inspection; there was a new manager and deputy manager in post and staff were clearer about their lines of accountability.
The service was in the process of changing the type of care being provided and had ceased to offer nursing care. Staff were adjusting to the changes and there had been some changes to the staff team and their responsibilities.
Quality audits were more detailed and consistent than at previous inspections. However, they still lacked rigour and did not robustly address some aspects of continued concern from the previous inspection, particularly where people were at risk of receiving unsafe care.

Rating at last inspection: Requires Improvement (last report published 13 March 2019). The service had not improved sufficiently at this inspection and the rating remains Requires Improvement.

Why we inspected: This inspection was based on the previous rating and our ongoing concerns about the quality of the care provided.

Enforcement: The service met the characteristics of Inadequate in the key question of safe, and Requires Improvement in Effective, Responsive and Well Led. We are taking enforcement action and will report on this when it is completed.

Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority.

The service remains in 'Special Measures' by CQC. The purpose of special measures is to:
Ensure that providers found to be providing inadequate care significantly improve
Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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

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. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well led. Details are in our Well led findings below.	**Requires Improvement**

Attlee Court

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 was carried out by three adult social care inspectors.

Service and service type: Attlee Court is a care home which provides nursing and personal care and support to older people and older people living with dementia. At the time of the inspection the service was registered to provide nursing care but they were in the process of changing the service provision to remove the nursing care.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager had left the service and there was a new manager in post who was in the process of registering with CQC.

The inspection was carried out on 8 April 2019 and was unannounced.

We reviewed all information about the service including information sent to us by the provider as well as liaison with stakeholders including the local authority. We had not asked the provider to complete a Provider Information Return (PIR) prior to this inspection. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We looked at premises and equipment and documentation relating to the safety of these.
For example:
Notifications we received from the service

Completed CQC surveys from people who used the service
Four people's care records and seven people's medicine records
Records of accidents, incidents and complaints
Audits and quality assurance reports
We spoke with five people using the service; and four relatives
Seven members of staff

Inadequate

Is the service safe?

Our findings

We have inspected this key question to follow up the continued concerns found during our previous inspection in January 2019. We concluded there was a continued breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely

- At the last inspection in January 2019 there were weaknesses in the management of medicines. Some people were prescribed 'as required' (PRN) medicines and the protocols to guide staff in how to administer these medicines were not all in place. The provider's action plan sent to us after the inspection, stated these had all been reviewed and updated, but we found they had not.
- At the last inspection there were concerns about the administration of covert medicine (hidden in food or drink). The provider's action plan stated issues around the management of covert medicines had been addressed, but we found further concerns at this inspection. For example, staff told us they mixed one person's medicine in a drink. This information was not included in the person's medicine administration record (MAR) or their care records. There was no mental capacity assessment or best interest decision recorded for this decision and no evidence of any pharmacist advice about whether it was safe to give this medicine in this way.
- With another person's MAR there was a recent letter from the GP which stated if the person refused their medicines staff could give these covertly. However, there was no information with or in the MAR about how to administer the medicines covertly and no evidence of any pharmacist advice as to how this could be done safely.
- At the last inspection there were inconsistencies in the safe storage of thickening agents (these thicken food and fluids for people with swallowing difficulties) and guidance available to staff was not easily accessible. The provider's action plan stated thickeners were safely stored and guidance was on the tea trolley for staff. At this inspection, we saw tubs of thickener unsafely stored on the tea trolley without lids. There was a list on the tea trolley showing the prescribed dilution for each person. However, this conflicted with information in care records for one person. Their information sheet which had been recently updated showed they had one scoop of thickener to 200mls of fluid, however, other care documentation showed they required four scoops of thickener to 200mls of fluid.
- Although the majority of medicines were stored safely and securely, nutritional supplements were stored in a cupboard in an unlocked kitchenette next to the dining room.
- The storage and recording of controlled drugs (CDs) had improved since the last inspection. CDs were stored securely, stock we checked was correct and administration records had been completed correctly. However, we found the prescriber's instructions for rotating the site of pain patches was not always followed as patches were being applied to the same site more frequently than recommended.
- There were inconsistencies in some of the information provided. For example, allergies listed on information sheets kept with the MARs did not always match allergies recorded on the MARs.

•□Systems in place for ensuring there were sufficient stocks of medicines were not always safe. On the day of the inspection one person was waiting for a pain relief patch to be delivered which was due to be administered that day. The patch was prescribed to be given every three days and although the last one had been used three days earlier, no action had been taken to ensure further patches were obtained in a timely manner. The staff were still waiting for the patch to be delivered when we left the inspection at 6.30pm.
•□The day before our inspection a relative had been informed by staff that their family member had received an overdose of one medicine. The manager had been informed and was starting to investigate the incident on the day of the inspection. We looked at the records the manager had gathered and it was not clear what dose of medicine the person should have had from the records maintained. The manager arranged a GP review and referred the confusion about the unclear dose to the local authority safeguarding team.
•□Staff who supported people with their medicines did so patiently and took their time to explain what the medicines were for and check whether the person was in pain.

Assessing risk, safety monitoring and management
•□At the last inspection we found some areas of risk management needed to improve and the provider had given assurances and an action plan to show how this was being done. At this inspection we had continued concerns about people's safe care and treatment.
•□Risks to people were not always well managed. For example, one person's care records showed they had swallowing difficulties and were at high risk of choking. The choking risk assessment in the paper care records had not been updated since June 2018, there were no risk assessments completed on the electronic care record system. The person had a suction machine in their room which nursing staff used to clear any secretions as and when needed. However, at the time of our inspection the manager was the only nurse working in the home and none of the other staff had been trained in the use of this equipment. The regional manager told us suction training had been arranged for staff and their competency would be assessed in using this equipment. However, we were concerned that suitable arrangements had not been put in place in the interim period to ensure the safety of this person. Following the inspection we made a safeguarding referral and the manager sent us an updated risk assessment for the person.
•□Where other people were at risk of choking this was not well managed. For example, two people whose care records stated they should have had a modified diet, were not given suitable food or supervised closely when eating. One of these people had a recently recorded choking incident and their care record showed conflicting information about the type of diet they required.
•□Another person's care records showed they were at high risk of choking and required a pureed diet and thickened fluids. In the nutritional care plan on the electronic care system it stated staff were allowed to change the constituency of the food. It was not clear who had made this decision or whether it was safe for the person to have their diet changed by staff.
•□One person's care records showed they were at high risk of developing pressure ulcers and had a pressure relieving mattress in place which should be set according to their weight. Their weight records showed they were 50.9kgs, yet their mattress was set to 95kgs.
•□Risk assessments were not all in place or accurate and some lacked detail. Where one accident record showed a person had fallen from a chair, there was no assessment of the person's safety in relation to using the equipment, or whether the chair had been suitable. Another person had bedrails, but there was no assessment in place for this to show how the risks had been considered. Another person's care record had conflicting information; it stated they were both medium and high falls risk, yet their falls support plan was blank.

Staffing and recruitment

•□At the last inspection there was no evidence agency staff had their identity checked or had any induction to working in the home. At this inspection there were profiles and proof of induction for agency staff and the manager told us they met with agency staff before enabling them to work in the home. However, the manager told us they accepted the information sent by the agencies regarding suitability checks and qualifications/skills, without making any further checks to be sure anyone working in the home was suitable to do so.
•□At the last inspection there were gaps in staff personnel files and information was not complete to show staff had been robustly recruited. At this inspection, recruitment procedures had been improved to ensure employment history details were checked and recorded where staff were employed by the provider.
•□There were sufficient numbers of staff on duty to meet people's needs and people did not have to wait long for staff to support them. Staff were not always deployed effectively and on occasion we asked staff to attend to people. For example, visiting opticians came to do sight tests with some people and staff were not always present to give support or reassurance.
•□There were no longer any qualified nurses employed due to the provider changing the type of care offered to people. A small number of people had been unable to leave the home, but still needed nursing care and the manager told us this was provided in consultation with the CCG and community teams.
We concluded there was a continued breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
•□At the last inspection we saw records of unexplained bruising without further information about what had been done to establish the reason or make appropriate referrals to the safeguarding authority. There had been some incidents which should have been notified to CQC but were not. At this inspection there was improved recording and reporting of any bruises and the manager had kept CQC updated about any matters being monitored or referred to safeguarding.
•□At the last inspection accidents and incidents were recorded but there was no evidence of any scrutiny about the cause of these. At this inspection, the accident forms had been amended to include more detail and a seven day bruising chart and body map where there was no immediate sign of injury. There was evidence staff should increase observations and be vigilant where incidents occurred.
•□The manager reviewed all accidents and incidents and sent these for further review to the area manager. Where lessons were identified for staff to learn from, such as medicines errors, these were discussed in meetings and staff supervision.
•□Investigation reports were completed by the manager where concerns were raised or allegations made. We looked at one investigation report where an allegation of possible abuse had been made, although this lacked detail in relation to steps taken in line with safeguarding procedures.
•□Staff understood safeguarding and whistleblowing procedures. They said they felt supported and confident to raise any concerns or report safeguarding matters.
•□People told us they felt safe. One person said, "I trust the staff to keep me safe" and one relative said, "The lasses are great with my [family member]; I know they're safe."

Preventing and controlling infection
•□At the last inspection we found there was a broken washing machine which caused a backlog of laundry and posed a risk to infection control. At this inspection the provider had addressed the concern and had a contingency in place should this happen again.
•□Staff used appropriate protective clothing to reduce the risk of infection and there was a regular cleaning regime in place. The home was clean and well maintained.

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

- Staff employed by the provider had supervision and training. The manager showed us a 10 day training programme to upskill senior care staff in specialist areas, such as advanced medication, tissue viability and stroke awareness. The training matrix showed where all staff had completed training and where this was due to expire. Competency checks of staff performance were carried out as well as night checks.
- Agency staff received basic moving and handling training in the home, but no other areas of training or competency checks were delivered for this group of staff. The manager told us they relied on the agencies who supplied the staff to ensure staff skills were correct as per their profile. Agency staff we spoke with told us they had induction when they started at the service and they were clear about what was expected of them. The manager told us they tried to use the same members of agency staff to provide consistent care for people.
- Staff we spoke with said they felt well supported and confirmed their training and development needs were discussed with the manager, for example, at supervision.
- Some staff demonstrated a lack of skills and experience when interacting with people who were living with dementia. For example, staff did not always engage with people at face level or speak clearly and complex sentences were sometimes used. We discussed this at feedback and the manager said they would consider this.
- Staff handover information was more detailed than at previous inspections and there were regular staff meetings held which were minuted.

Supporting people to eat and drink enough to maintain a balanced diet

- People had a nutritional plan in their care record. People were offered a choice of food, although for people living with dementia this was not a visual choice to help them consider what they would like.
- People were supported to eat and drink and staff gave one to one assistance where this was required. However, the mealtime experience was varied, with some people waiting a long time to be served and people served at different times whilst seated together. The lunch time meal in the residential unit was disorganised with care staff not present in the dining room for periods of time.
- Some people said they enjoyed the meals. One person said, "It's the best part of the day. The food's not bad" and another person said, "I do like the meals." Other people were not as happy. One person said, "I never know what it is, I just wait and see. It's alright, not always what I like" and another person said, "I just eat it, it's not the best."
- People's weight was monitored with evidence of action taken, such as referral to the GP where there was weight loss.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support

•□The manager worked closely with other professionals involved in people's care and knew who to contact should there need to be any referrals to support people's health.
•□Wound care records had improved. The manager told us two people had pressure ulcers and these were now being treated and managed by community nurses.
•□Where people had moved to alternative homes to receive nursing care, the manager told us they had worked with other professionals to ensure reviews and assessments were carried out.

Adapting service, design, decoration to meet people's needs
•□Individual bedrooms were well maintained and people were able to identify their own bedroom door. People who remained in bed looked comfortable and staff made frequent checks.
•□The communal spaces for people living with dementia had been extended and adapted in response to increased numbers of people living in the home. There were more areas for people to choose where to sit or spend time with visitors.
•□There was a planned programme of improvements to the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Ensuring consent to care and treatment in line with law and guidance
•□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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
•□We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

•□Staff we spoke with had an understanding of the legislation in support of people's rights and decision making processes. Staff respected people's rights to make their own choices and decisions, and these were promoted in practice.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Supporting people to express their views and be involved in making decisions about their care
- Care records we looked at showed communication plans were sometimes blank.
- Staff supported people with appropriate explanations and choices, although support for people living with dementia was not always fully in place for them to understand and make decisions.

- Staff involved people in expressing their preferences where they were able to. Where people had difficulty doing so, staff said they observed facial expressions and non-verbal cues to help them understand what people were feeling.

Ensuring people are well treated and supported; respecting equality and diversity
- People were respectfully acknowledged and treated with kindness by staff on the whole.
- Staff told us they enjoyed caring for people and tried to offer them the same standard of care as they would for their own relatives.
- Staff knew people's individual needs, social histories and their personal preferences. One relative said staff understood their family member's needs. They told us, "They [staff] know how to care just right for my [family member] and they've known them a long time."
- Staff understood people's equality and diversity needs and said any particular preferences would be recorded on individual care plans. Although the training matrix showed staff had completed equality and diversity training, staff we spoke with could not confirm whether they had done this.

Respecting and promoting people's privacy, dignity and independence
- Staff encouraged people with their mobility, ensuring they necessary equipment to hand if they needed this.
- People were supported to mobilise at their own pace and staff were patient when carrying out care and support.
- People had private space to use to spend time with their visitors and maintain relationships with people outside the home. Relatives we spoke with said they were made to feel welcome at any time.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- At the last inspection care records contained inaccurate, conflicting information and were still in the process of being uploaded to electronic records, something which had been ongoing for some time. At this inspection care records were still not always up to date and did not always reflect people's current needs.
- We looked at one person's paper and electronic care records. The paper records contained detailed care plans and risk assessments however many of these had not been reviewed or updated since February 2019. Some of the care plans were also on the electronic system however these did not always contain the detailed information provided in the paper records. There were no risk assessments completed on the electronic system and the medical history section, care summary and communication sections were blank.
- Recommendations made by a visiting healthcare professional in March 2019 about the use of equipment for one person was not reflected in the person's paper or electronic care plans. The deputy manager told us they were in the process of updating these and transferring all the information onto the electronic care system.
- Staff we spoke with said they tried to update the electronic care system as they completed each task and where they were late doing so, the management team would get an electronic alert.
- Agency staff were not able to access the care plan system and so relied on regular staff to keep them informed of people's needs and update records on their behalf, for example, if they had completed a care task.
- One person who came to stay at the home on the day of the inspection had conflicting information in their care record about the support they needed with their mobility.
- Relatives we spoke with did not always know their family members had care records.
- Staff knew people's preferences and activities staff chatted with people about the things which mattered to them, such as who was coming to visit and what they would like to do.
- People joined in with organised activities and enjoyed individual conversations with activities staff, who knew what they were interested in.
- Some staff told us some agency staff lacked understanding of the English language and as such they did not always comprehend what people needed. We saw one person struggled to understand a member of staff and the member of staff was then assisted by a colleague.
- Staff responded to people with minimal delay when they used their call bells, although on one occasion we heard a member of staff was less patient and told a person they were busy completing care tasks.

Improving care quality in response to complaints or concerns

- People and relatives said they knew how to raise a complaint and would approach the staff or see the person in charge. One relative said they had discussed issues of concern with staff and things had improved.

•□Complaints were recorded and responses detailed.

End of life care and support
•□Staff had a compassionate approach to providing end of life care where this was necessary.
•□Care records had details of people's expressed preferences for their care at the end of their life.
•□Training had been identified to support staff in providing end of life care.

Requires Improvement

Is the service well-led?

Our findings

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- At the last inspection we found there had not been enough action to address continued breaches in regulations and make sufficient improvements to the quality of care. At this inspection, although some progress was being made, there were continued breaches in regulations and areas of concern remained. We concluded there was a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.
- Not enough improvements had been made to ensure risks to people's care were identified, mitigated and managed properly. The last inspection identified some risks were not being monitored safely, but this inspection highlighted further risks, particularly around the area of choking. Where matters of safety were discussed at the last inspection, some of these remained unaddressed.
- The provider had made changes to the management of the home which were still being adapted to within the service. A new manager, deputy manager and more clearly defined roles were being established and embedded at the time of this inspection.
- The provider was in the process of changing the service offered and had stopped providing nursing care since the last inspection. This had meant a period of transition for people in the home as well as staff and there had been staff team changes as part of this.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There were more consistent and systematic audits being carried out, although these lacked rigour and did not identify areas of concern highlighted by the inspection process, or sufficiently address continued breaches in regulations.
- Roles within the home were more clearly defined and staff said they understood their responsibilities and who they were accountable to.
- The manager was supported by provider and senior managers from the organisation and there were regular quality assurance visits.
- The provider produced an improvement plan following the last inspection which showed some areas had been addressed, and some areas were still in progress. This was not completely accurate as we found some aspects had not been addressed as stated. They had also produced a health and safety action plan with timescales for completion of maintenance and improvements to the premises and outdoor areas. The timescales were beyond the inspection date and there was evidence of this being work in progress.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Changes within the service had been communicated to people, relatives and staff through face to face meetings and discussions.
- Relatives we spoke with said they were aware of the changes to the home manager and the staff team. One relative said, "It's ridiculous, they've had five managers in seven years." Other relatives said the manager was approachable and regularly visible within the home. One relative said, "They keep us up to date with what's going on."
- One person told us they had been involved in discussions about which home to move to, in order to receive nursing care and they felt they had been consulted and informed.
- Information about events in the home was communicated through the noticeboard and discussions with activities staff as well as relatives and residents meetings.

Working in partnership with others

- The manager told us they were working closely with the local authority contracts team, the CCG and safeguarding teams to ensure people's care was suitable.