The Augustinian Nursing Sisters

The Augustinian Nursing Sisters Ince Blundell Hall

Inspection report

Ince Blundell Hall
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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

About the service
The Augustinian Nursing Sisters Ince Blundell Hall is a residential care home providing personal care to 8 people aged 65 and over at the time of the inspection, including people living with dementia. The service can support up to 22 people. The service is a domestic style property and accommodation is over three floors.

People's experience of using this service and what we found
Risks to people were not always appropriately assessed or managed. Care plans did not contain enough information to support people safely. Plans were not updated when people's needs changed which put them at risk of not receiving appropriate care that kept them safe from harm.

There were no systems in place to effectively and consistently analyse incidents to ensure learning could be implemented at the earliest opportunity to prevent reoccurrence.

People were at risk of being supported by staff that had not been recruited safely. There were enough staff to meet people's basic needs. However, there were ineffective systems to determine staffing levels and not all staff had completed training necessary for their role.

There was a lack of leadership, oversight and governance in the home. There had been a high turnover of managers at the service. There was no current manger in place. A senior member of staff had assumed some management responsibilities, but this was not clearly defined. There was confusion amongst all staff about roles and responsibilities.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There were some concerns with fire doors and fire safety. Some fire doors did not close fully or had smoke seals missing. Fire evacuation drills had not taken place regularly and not all staff were aware of the fire evacuation procedure. A fire evacuation plan was in place but was not effective. The local fire service had recommended the evacuation plan was changed but this was not completed. We raised concerns with the local fire service and the provider responded immediately to address these.

Safeguarding procedures were in place and appropriate, but the safeguarding policy was out of date. Staff knew how to recognise, and report concerns of a safeguarding nature, however they had not all been trained in safeguarding. We made a recommendation about the providers safeguarding procedures.

Medicines were safely managed. However, not all staff had appropriate competency checks in place to ensure their practice remained safe. This was addressed during the inspection.

People were at risk of not having their nutritional needs met. Records showed that when people required their food and fluid intake to be monitored, this was not always recorded effectively. Care records did not always accurately reflect people's nutritional needs and staff did not always know what people's nutritional needs were.

People were supported by staff who were kind and caring in their interactions. A relative told us staff were "too caring" and sometimes did too much for people restricting their independence. One person told us, although staff were kind and caring, they were sometimes demeaning in the way they spoke to people.

People were supported at the end of their lives in a respectful and dignified way.

People were supported with their religious needs and to maintain social contact with loved ones.

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

Rating at last inspection
The last rating for this service was good (published 28th January 2020).

Why we inspected
The inspection was prompted in part due to concerns received about standards of care, staffing and records. A decision was made for us to inspect and examine those risks under the key questions of safe and well-led.

We inspected and found there were further concerns, so we widened the scope of the inspection to become a comprehensive inspection which looked at all five key questions.

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.

You can see what action we have asked the provider to take at the end of this full report.

The registered provider has been responsive to concerns noted during the inspection and has started to take action to make improvements and promote safety within the home.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Augustinian Nursing Sisters Ince Blundell Hall on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the assessment, management and mitigation of risk, recruitment processes, compliance with Mental Capacity Act 2005 and governance and oversight of the service.

We have made a recommendation about the providers safeguarding procedures and policy.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress with improvements and the closure of the service. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 well-led. Details are in our well-led findings below.	**Inadequate**

The Augustinian Nursing Sisters Ince Blundell Hall

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
On day one and three the inspection was carried out by two inspectors. On the second day it was carried out by one inspector.

Service and service type
The Augustinian Nursing Sisters Ince Blundell Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who use the service and one relative about their experience of the care provided. We spoke with nine members of staff including the provider, senior care workers and care workers.

We reviewed a range of records. This included seven people's care records, and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

We made a referral to the local fire service to raise concerns with fire safety at the home. We also referred concerns to the local safeguarding team.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were exposed to risk of harm due to a lack of person-centred risk assessment. Risk assessments were either not completed, not accurate or reflective of people's current needs, or not detailed enough to guide staff on safely supporting people.
- Where people were supported with bedrails, there were no risk assessments in place to ensure risks to people had been assessed and managed. Bed rails checks were not always completed to make sure they were safe.
- Analysis of incidents was not completed which meant opportunities for learning and reducing the risk of recurrence were missed.
- A room containing high risk materials and hazardous substances was left unsecured throughout the inspection. There was no lock on this door to enable the safe storage of these items.
- Fire evacuation drills had not always taken place as required and some staff were not aware of the evacuation process. A fire risk assessment had identified the evacuation process as inadequate, but this had not been reviewed as recommended. Due to concerns we found we made a referral to Merseyside Fire and Rescue who completed follow up checks with the service to ensure people were protected from harm in the event of an emergency.

The provider had failed to robustly assess risks relating to the health, safety and welfare of people. This placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to address the storage of hazardous substances and update records to ensure people were supported safely.

Staffing and recruitment

- Recruitment processes were not safe, and people were at risk of being supported by unsuitable staff. Full employment histories were not always recorded or corroborated and appropriate references were not always in place.
- When information was missing from application forms, the manager failed to follow this up appropriately.
- One staff member had been employed without any recruitment process being followed.

The provider had failed to ensure recruitment processes were appropriate and safe. This was a breach of regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to meet people's basic needs. However, staffing levels were not calculated effectively as information regarding people's dependency levels was often out of date and inaccurate. We have reported on this in the well-led section of this report.
● We received mixed feedback about staffing levels from staff. Some staff felt there were not enough staff, especially of a night. Most staff felt people's needs were higher than anticipated.
● There was a high use of agency staff, particularly to cover senior roles. The provider had been recruiting but was struggling to find appropriate staff. Appropriate agency checks were in place to ensure any agency staff were suitably trained and competent.

Systems and processes to safeguard people from the risk of abuse
● Systems to safeguard people from the risk of abuse were not robust.
● Not all safeguarding incidents had been appropriately investigated and referred to safeguarding teams as required.
● Not all staff had completed recent training in safeguarding.
● The safeguarding policy had not been updated and contained some out of date information.
● Despite the lack of an up-to-date policy, investigations and staff training, appropriate actions had been taken immediately following an incident to ensure people were safe.

We recommend the provider reviews safeguarding processes in line with legislation and best practice guidance and updates their practice accordingly.

Using medicines safely
● Medicines were managed safely and administered as prescribed.
● Staff who administered medicines had been appropriately trained. Not all staff had competency checks completed as required. We raised this with the provider on day one of the inspection and this had been completed before the end of the inspection.
● One person who was prescribed a high-risk medicine did not have a care plan in place to ensure appropriate support with monitoring their health. The provider told us this would be updated immediately.

Preventing and controlling infection
● Measures were in place to ensure the risks of the spread of infection were reduced. Staff had access to appropriate personal protective equipment (PPE) and wore this as outlined in national guidance.
● We were assured effective infection prevention and control (IPC) policies and procedures were in place at the home.
● Staff and people living at the home were supported to access regular COVID-19 testing.

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

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 when this is in their best interests and legally authorised under the MCA.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Restrictive practices, such as the use of bed rails, were being used without appropriate legal authority. Processes had not been followed to ensure these practices were the least restrictive option and, in the person's best interest.

There was a failure to act within the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where DoLS had been applied for appropriately they were not always managed safely. There were two people under DoLS who had been assessed as unsafe to leave the home unsupervised. The home was unsecured, and we found people were able to leave the home without staff supervision. There were no plans in place to show how this risk was being managed. We liaised with the local authority for these people to be reassessed to ensure this placement was suitable and safe for them.

The provider had failed to robustly assess risks relating to the health, safety and welfare of people. This placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were at risk of not having their nutritional needs met. Records showed that when people required their food and fluid intake to be monitored, this was not always recorded effectively.

● Care records did not always accurately reflect people's nutritional needs and staff did not always know what people's nutritional needs were. One person's relative told us their family member had been assessed as having a blended diet. However, care records showed this person as needing a soft diet, and some care staff told us they were having a normal diet. We asked the provider to make an urgent SALT referral so this person's needs could be assessed, and an appropriate diet given.

● People and relatives told us the food was "really good and nutritious".

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 needs were not regularly reviewed and when people's health deteriorated this was not always identified in a timely manner.

● Oral health risk assessments were completed, but there were no care plans in place to ensure people's oral health needs could be met.

● People were supported to attend healthcare appointment when required.

Staff support: induction, training, skills and experience

● People were at risk of being supported by staff who did not have the necessary skills and competence to do so safely. Staff were not always sufficiently trained, supervised and appraised in their roles. The provider told us the registered manager had left in November 2021 and concerns had been identified with the lack of oversight of staff.

● Training records were poorly maintained. There was a lack of oversight of this and confusion from the staff team as to whose role it was to ensure staff training was up to date. Staff told us they hadn't always received training at the service, but they had been trained previously with other care providers. We raised this concern with the provider who was addressing training issues during and after the inspection.

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

● People's needs were assessed before admission to the home to ensure they could be met. However, people were not always reassessed when their needs had changed.

● Assessments of people's care needs had not always been completed in detail. Some care plans lacked detail around specific needs and did not always reflect information in other records. This meant people were at risk of not having their needs safely and effectively met.

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

● There was very little adaptation to support people with dementia. The service is in an older, listed building which made adaptations more difficult. We raised concerns with the provider and local authority about the suitability of the environment for some people living at the home.

● Some equipment was in use to support people to move around the home independently, for example zimmer frames.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People were not always supported to maintain their independence. Restrictive equipment was being used, for example bedrails without rationale or consideration for other equipment which would promote safety and independence.
- One person told us staff sometimes treated them like children and commented; "It's that attitude, like treating you like a child. I'm an adult and I want to be treated like an adult. I have my own pride."
- A relative told us staff were sometimes "too caring" and did too much for people and did not promote their independence with tasks.

Ensuring people are well treated and supported; respecting equality and diversity
- People living with dementia were not always supported in a meaningful way. At times staff were very busy and we saw people sat in their bedrooms with very little interaction.
- People who were on long term bed stay did not have support plans to show how staff would ensure they had positive wellbeing outcomes.
- Where people expressed distressed behaviours there was a lack of management plans to guide staff in supporting people in a dignified, respectful manner.
- Staff were kind in their response to people and their approach was observed to be patient.

Supporting people to express their views and be involved in making decisions about their care
- People told us they were able to make day to day choices about their care.
- Staff encouraged people to express day to day wishes, such as which food they wanted to eat.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care records did not contain enough detail to ensure care was delivered in a consistent way and in line with people's choices and preferences.
- Information regarding people's care needs had not always been updated. Although we saw some evidence of care plan reviews, these did not always identify changes to people's support needs.
- Some care plans contained contradictory information. For example, one person's care plan stated they were independently mobile with equipment, but another stated they were bed-bound. The senior in charge updated care plans during the inspection.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were not always identified in support plans. When communication needs had been identified there wasn't always clear information for how staff should support them.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported with their religious needs. There was mass held each morning which people were supported to attend.
- People were supported to have visits from friends and relatives, in line with current COVID-19 guidance.
- A relative told us they were happy with the care their family member received and they were kept up to date about important changes in their physical health.

Improving care quality in response to complaints or concerns

- A complaints system was in place and displayed in the home. There had been no complaints made.
- People told us they felt comfortable raising concerns. However, one person said the home was "in chaos" due to the high turnover of managers and staff. This had led to concerns not always being responded to.

End of life care and support

- Most care files contained information regarding advanced care planning. These plans were reviewed and discussed with relatives when appropriate.

● People had been able to remain at the service for the end of their lives and staff had supported them according to their expressed wishes. People's relatives had been able to visit at the end of their lives.

Inadequate

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Systems and processes to assess and monitor the safety and quality of the service were ineffective. Not all the concerns found at this inspection had been identified by the managers or provider's monitoring processes.
- Oversight and governance at the home was inconsistent. There had been a high turnover of managers which had led to a lack of leadership which was evident in records, audits and the planning of people's care.
- The registered manager had left a few months prior to this inspection, but their roles and responsibilities had not been assigned to other staff to manage. There were inconsistencies in the completion of audits and care plans being updated. There were mixed answers from staff about their responsibilities and that of the senior staff.
- Systems were not robust enough to ensure learning from incidents was implemented to further reduce risk to people.
- People were at risk of receiving poor care because risks to their safety and well-being were not always mitigated or managed appropriately to protect them from harm.
- Actions the provider told us they would take in response to incidents had not always been acted on. One person had left the home unsupervised. The provider informed CQC they had secured the building to prevent further incidents. However, during the inspection the building was unsecured, and this risk remained.

The provider had failed to effectively assess, monitor and improve the quality and safety of the service provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager was aware of what events they needed to notify CQC about. They had submitted notifications in line with legal requirements and displayed the rating of the last inspection.

The manager and provider were receptive to feedback during the inspection and implemented some immediate improvements to reduce the risk of harm to people.

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

- Records were not of good enough quality to guide staff on how to meet people's needs safely in a person-

centred way. This meant there was a risk care and support provided may be unsafe.
● There was a lack of appropriate guidance to guide staff in supporting people safely. Policies were not always reviewed regularly to ensure they were up to date.

Records were not completed accurately or contemporaneously. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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
● Staff told us they had been asked for feedback but this wasn't always listened to or acted on.
● Some staff felt there was a poor culture at the home. One staff member said "There's a bullying culture. It can be quite difficult. It's quite chaotic."
● Managers and staff understood their legal responsibility to be open and honest with people.

Working in partnership with others
● Staff at the home worked with other relevant health and social care professionals to maintain people's health and wellbeing. Staff made referrals to other services for additional input, advice and support when necessary. However this was not always completed in a timely manner.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed comply with legislation regarding consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people were protected from avoidable harm. Risks to people were not always assessed or managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor and improve the quality and safety of the service were ineffective. Records were not always accurate or well maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not followed to ensure staff employed were suitably qualified, experienced and of good character.