Care UK Community Partnerships Ltd

St Vincents House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this unannounced focused inspection on 1 November 2018. This inspection was prompted by concerns raised about the safety and the management of the service.

We last inspected this service in February 2018 where we rated the service 'good'. At this inspection we have changed the rating to 'requires improvement'.

'St Vincent's House' is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection there were 90 people using the service.

The service had not had a registered manager since the previous registered manager had resigned in April 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Since the resignation of the previous registered manager there had been several interim managers, the most recent of which had started work at the service on 29 October 2018. None of these managers had applied to become the registered manager. It is a condition of the provider's registration that they have a registered manager in place at this location.

Staff were recruited in line with safer practices. There were assessments carried out of staffing levels but we found at times there were not enough staff to safely meet people's needs. In the early morning hazards were not addressed promptly. The provider intended to improve allocations and include falls champions to reduce risks to people but these were not yet in place. People using the service told us that staff appeared very busy.

There were systems in place to assess risks to people and manage these. Care workers were trained in safe moving and handling but lacked an awareness on how to prevent falls. Records were kept of actions staff had taken to keep people safe, such as welfare checks or repositioning people, but sometimes these were filled in later. People were safeguarded from abuse and care workers understood their responsibilities to report this.

The provider kept records of incidents and accidents and had an appropriate response to falls. However, systems were not used effectively to record and detect trends accurately. There were suitable infection control measures in place.

There had been frequent changes of manager due to the provider being unable to recruit a permanent

home manager. People and their relatives told us they didn't always know who was in charge and that this impacted on communication. There was good joint working with health professionals and medicines were safely managed.

There were governance systems including internal and external audit. These were effective at detecting issues with the service but were not always consistently applied. Care plans and risk assessment were stored in different locations which sometimes lead to confusion about the contents.

We found breaches of regulations relating to staffing and good governance. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

The provider had assessed the staffing needs of the service, but there were not always enough staff to safely meet people's needs.

There were systems in place to safeguard people from abuse and improper treatment. Risk management plans were in place but sometimes records of turning and welfare checks were not complete or accurate. Care workers lacked training in falls prevention.

There were safer recruitment processes in place. Medicines were safely managed.

Is the service well-led?

Requires Improvement

Aspects of the service were not well led.

There had been several changes of management which impacted on communication with people and their families. There was not a registered manager in place.

Systems of audit were in place which had addressed concerns in the quality of the service, but these were not always consistently applied.

There was not always effective or consistent communication between the staff team.

St Vincents House

Detailed findings

Background to this inspection

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

Why we inspected- This inspection was prompted by information of concern about this service. This included notifications of serious incidents that the provider is required to tell us about. There had been several incidents of physical aggression by people using the service targeted at other people who used the service. We were aware of five allegations of alleged abuse by staff, and a high number of pressure sores sustained by people using the service. There had been some serious incidents concerning the management of medicines. We had received information of concern from other sources concerning staffing levels and the investigation and follow up of incidents and complaints. The local authority told us they were concerned about the level of unwitnessed falls. We therefore carried out a focussed inspection in the key questions of 'Is the service safe?' and 'Is the service well-led?' as we had reason to believe that the performance of the service had changed in these areas.

This inspection took place on 1 November 2018 and was unannounced. Two members of the inspection team arrived in the early morning to make observations of people's care and support. The inspection was carried out in total by three adult social care inspectors, and two specialist professional advisors who worked as a nurse and pharmacist respectively.

We looked at records of medicines management for 32 people. We looked at records of audit and governance and assessments of staffing levels. We looked at recruitment records for five staff members and records of care and support for eight people. We spoke with 15 people using the service and four of their relatives. We spoke with five members of the management team, two care workers and five nurses.

Requires Improvement

Is the service safe?

Our findings

There were not always sufficient staff to meet people's needs safely. The provider had a dependency tool which calculated required staffing hours and were able to evidence they were meeting or exceeding these on a daily basis for each shift. However, this tool did not account for the varying needs of people in different areas of the building at different parts of each shift. For example, the night shift was treated as a single period until 8am but in practice many people woke up earlier than this or did not have a steady sleep pattern. It also didn't take into account that there had been changes in medicines practice that took up more staff time than previously.

There was no additional floating support that care workers could call on. For example, on the second floor in the early morning there were two healthcare assistants supporting people in their rooms under the supervision of a nurse, but 24 people lived on this floor. This was the pattern on three out of four units. We saw two people who needed support from two staff members were in need of attention, and care workers were unable to respond to both people. Care workers relied on calling each other across the corridor in order to obtain more support.

There was no evidence that people were got up early against their will. Some risks were not addressed promptly enough in the early morning. For example, there had been a spillage of either water or urine in one of the lounges that had not been seen by staff and was not marked as a hazard. We pointed this out to staff but this was not addressed promptly. One person was asleep on a chair in the hallway and had their legs stretched out in front of them, and there was a risk that other people walking around may trip over them, especially as the lights were dimmed at this time of day. One person was observed to be sitting precariously on the edge of their bed and another had their catheter bag on the floor, which posed a risk of cross infection and tripping.

Some staff members expressed concern about staffing levels. Comments included, "There aren't really enough staff. One nurse can't do everything. We're meant to have four care staff [on a unit]. Sometimes we can't get cover. Some days are bad, with short staff" and "We're always running around." All but one of the people we asked commented on how busy staff were. Comments from people using the service included, "The staff are busy but there are usually enough", "They are very, very good here but very busy and they are on their own a lot" and, "It's busy at night and they are very busy." A relative told us "The staffing needs to be looked at big time."

The above information constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager showed an allocations system they intended to put in place. This included allocating 'falls champions' who would serve as floating staff members and provide additional support to people with the highest needs. The interim manager said, "I've put that in in other homes and it's reduced falls." However, there were no plans in place to provide appropriate training and competency checks for these staff members. The clinical lead and interim manager told of us their plans to carry out more visits and

checks at night time to support night staff. The interim manager said, "Working with the night staff puts people at their ease."

The service had a high rate of pressure sores, although a high proportion of those reported to us were those which had developed before people came to the service. We saw examples of when people had pressure sores on admission but had improved with the support of nurses and care workers.

The provider carried out risk assessments using the Waterlow score, which were reviewed monthly. The Waterlow score gives an estimated risk for the development of a pressure sore in a given person. There were detailed care plans in place to promote skin integrity. Equipment such as pressure relieving mattresses were correctly used.

A tissue viability audit had been carried out in June 2018. This was detailed in its process and identified key actions where practice needed to improve.

Turning charts were in place for people at high risk of developing pressure sores. Care workers did not always complete contemporaneous records of the checks they carried out on people. This included welfare checks and records of repositioning. We checked these records when we arrived in the early morning. One person's chart for repositioning had not been filled in overnight when we checked it at 6.37am. When we checked this document in the afternoon we saw that two entries had been added in which stated the person had been repositioned overnight. At the same time we looked at one person's record of welfare checks which showed that they had last been checked at 4.01am. When we checked this log in the afternoon a further two entries had been added stating the person had been checked at 5.28 and 6.02am. A further two logs of welfare checks had had a single entry added to them retrospectively.

A governance audit had been carried out in June which had highlighted that repositioning checks had been 'falsified' but did not go into detail about how this had been determined. A follow up review in July had found no evidence that this practice had continued, but there did not appear to be further checks to prevent a recurrence.

This was a breach of a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were measures in place to safeguard people against abuse. Care workers had up to date training in safeguarding adults and had the skills and ability to recognise when people may be unsafe. Staff we spoke with were aware of guidelines and contact details of the local authority safeguarding team, and this information was displayed around the home. When abuse was suspected the provider reported this promptly to the local authority and took measures to safeguard people and investigate incidents of concern. Comments from people and their families included "I do feel very safe and being here I don't need to worry about anything" "I feel safe and my things are well looked after" and "[My family member] is definitely safe and well cared for and loved."

Where a person had behaviour that may challenge the service there was a behavioural support plan in place. This included identifying specific medical conditions which could precipitate such behaviour and ways in which care workers could prevent this. There was information on what care workers could do to address behaviour but this lacked guidance from specialist professionals such as specialist nurses, psychologists or doctors. There were specific care plans on record for people who displayed behaviours of concern. However, sometimes information was kept on the paper notes and was not transferred to the electronic care plan. This could result in confusion between staff members on what plans were in place. For

example, one person's care plan summary on their file didn't contain guidelines on how often they should be turned, however the electronic system stated they were to be turned two hourly during the day.

We saw one example of a person being handled roughly by care workers when providing personal care, which we reported to the interim manager. However, the rest of the day we saw people being supported to move in a suitable and reassuring way. The provider's training matrix showed that 11 staff were overdue for refresher training in moving and handling people, and 22 staff were yet to complete this.

Care workers we spoke with told us how they ensured safe moving and handling and reported that they had adequate equipment in place to meet people's needs. Hoists had up to date service records and were clean and in good working order, although one sling was being used for several different people which was a possible infection hazard. A person using the service told us "The nurses help me with their machine [hoist], they get me in to bed and make sure I'm comfortable."

Falls risk assessments were completed and reviewed monthly. Where falls had taken place the provider carried out appropriate incident reporting and completed post-falls monitoring processes. Care workers did not receive training in how to prevent falls. A staff member said "You can't always prevent falls because you can't always be around the person. We make sure people are safe and comfortable. Unless you're there with [people] then I don't see how you can avoid a fall" and another said, "We've done moving and handling training but we don't have any training on prevention." We confirmed this by checking staff training records.

At our previous inspection we made a recommendation about the operation of the lift in order to reduce the risk of a person being able to leave the service without support. At this inspection we saw the provider had acted on our recommendation, and it was no longer possible to operate a lift in an unsafe manner.

There were processes in place to ensure that the premises were safe and suitable for their use. This included a series of daily, weekly and monthly checks to look at issues such as the safety of floors and handrails, room temperatures and bedrails. There were monthly checks of furniture in people's rooms, radiators and plug sockets.

The call bell system was checked monthly to ensure it was safe to use. Care workers were encouraged to record any faults in the system for the maintenance team to address. People we spoke with were able to use calls bells safely and these were kept in reach of people. People told us that care workers responded to their calls, but that response could vary based on how busy staff were. Comments included, "I use my bell and they do come quickly night and day.", "Usually you don't wait that long, sometimes 10,15 minutes maybe 20 minutes at night but that is rare" and "I have noticed you wait longer times when carers are doing personal care like in the morning."

An external fire risk assessment had been carried out in August 2018. This showed that there were good management systems in place. Where action points had been identified these had been addressed by the provider. Maintenance team members understood the building well and identified the causes of issues that had occurred.

Medicines were safely managed across the service. Comments included "They assist [my relative] with [his/her] medication and they are very gentle", and "They bring me my medication and watch me take it. Then they write it down and I do get it at the same time each day".

Care workers received suitable training in administering medicines and were assessed for their competency to do so. People's care plans contained medicines records in the form of an individual information sheet

and a medicines administration recording (MAR) chart. If covert medicines were in place this was also documented. MAR charts we checked were accurately completed including, where appropriate, reasons why medicines had been missed or omitted. Additional medicines with specific administration requirements or extra monitoring requirements were recorded on separate sheets.

Medicines were safely secured in drugs trolleys, clinical rooms, fridges and controlled drugs cupboards as appropriate. These were locked and accessed by keys held by nursing leads. Controlled drug registers were accurate and fully completed. Fridge temperature recording had been carried out consistently. There were suitable processes in place for disposal of medicines including unused, waste and denaturing controlled drugs. Provider level and local level medicines management policies were available and clear.

In the event of a medicines error, the provider carried out additional checks of staff competency and encouraged them to reflect on the causes of the error. Medicines errors were reported using a management system and all were caused by minor omission or incorrect dose administration errors which did not result in harm. Where more serious errors had occurred, these were investigated in order to determine the root causes, but did not indicate a systematic problem. Monthly audits were carried out on the ordering and supply of medicines and a biannual audit of medicines was carried out by the clinical lead. There were also external checks carried out by the pharmacist.

There was good communication between the provider, pharmacist and GP. The GP was able to make changes in people's medicines instantaneously through the use of electronic ordering systems.

Since our last inspection the provider had changed pharmacy and there were changes in how medicines were now managed. Instead of using blister packs nurses administered medicines from the original packs. This resulted in an improvement in clinical accountability and medicines safety. However, it meant that medicines rounds took an average of two and a half hours during which they could not be disturbed. This impacted on staffing levels elsewhere. Similarly, nurses were required to complete a lot of documentation on each medicines round, which could impact on staff time and may not be sustainable if nurses became overwhelmed.

We observed care workers using appropriate personal protective equipment to promote good infection control. There were infectious waste bins available, however at times we noted care workers left bags of waste in corridors when providing care. Care workers offered cleaning wipes to people before they started to eat meals. Staff were aware of which bags to use for infection control. Sharps bins were also available and not full. Comments from people included "They're very clean, they look after the place" and, "There is a nice atmosphere and it is very clean here "

The provider had systems in place to record and monitor when incidents had occurred. However, aspects of this were not effective. For example, it underreported when people had been subjected to physical aggression. The local authority had expressed concern that the number of unwitnessed falls was high. The provider had analysed incidents that had been categorised as such and found that this was too broad and included other incidents, which meant that this did not provide an accurate picture of incidents that had taken place. Falls were discussed in clinical meetings but did not routinely consider arrangements for sharing learning across the service. There was no real analysis or trend monitoring completed and discrepancies in the level of falls reported, but after the inspection the provider showed us information on how they would instruct staff to complete this.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection in February 2018 the registered manager had left the service. There had been three interim managers since this time and the provider had been unable to recruit a permanent manager. The current interim manager had started in the service the week of our inspection and did not intend to register as manager. Not having a registered manager in place is a ratings limiter and therefore we have changed the rating from 'good' to 'requires improvement' in this key question as it is a condition of the provider's registration that they have a registered manager in place.

People told us there was uncertainty about who the manager was. Comments included, "They keep changing. The area manager is a bit busy but she does say hello when she is here", "There has been lots of managers and there is a new one but I'm not sure of her name. I know it's a woman because she came to introduce herself when we were having lunch the other day" and "The manager is very nice and kind. She sits to chat and doesn't lean over you like some. She hasn't been here long and I don't know her name". A relative told us "I haven't a clue who the manager is this week there have been quite a few and we don't get told of these changes or the reasons".

Some people told us that communication had suffered as a result of changes. A relative told us "Since March there's been three managers, one manager was there, we had a big meeting and we put out concerns to her. She said we'll sort this out then she left. Then another manager came in. Same thing happened." Some people told us they did not know who the manager of the service was. The interim manager had scheduled a relatives' meeting so that people would have an opportunity to meet her. Some relatives told us they felt communication with the service was poor. One relative said "I phone up to check on [my family member], they slip up and say [my family member] is fine but they haven't asked who I'm speaking about." Other comments from relatives included ", "I call weekly and they update me. I always ask to and get to talk to his carer" and, "They answer questions and find out info for you quickly but you just can't talk to the manager often as there hasn't been one."

There were quality assurance audits in place. Unit managers carried out documentation audits across the units, including people's risk assessments, care plans and records of the care people received. A further audit was carried out of a sample of documentation across the plan. There were variable results to these audits. For example, an audit of a single unit had shown that most documentation was of a good standard, but a month later a comprehensive audit had shown that 17 out of 24 documents examined were of insufficient quality. Where quality issues were identified an action plan was in place by managers and followed up to ensure that appropriate changes were made.

There was also an audit schedule for the home manager to complete throughout the year. This included themed audits around nutrition and choking, activities, tissue viability and health and safety. This was taking place as planned, although the interim manager informed us that there had been some delays in completing these due to the change in manager.

The service had previously operated a daily "11 at 11" briefing for departmental heads to share key

information on the service. However, we saw that this was no longer happening regularly. Managers told us that they delivered a "flash briefing" if they were unable to do this, but there was not a clear process to disseminate information in the absence of a daily briefing. At times care planning systems were difficult for staff to navigate, as some information was held electronically and some held on paper systems.

Clinical review meetings had been taking place fortnightly, but there were no records of these taking place in October. Clinical review meetings included discussions of broad themes of concern and medicines errors, which allowed people to learn from mistakes or actions to be taken to prevent a recurrence. In recent months the section on medicines management lacked detail, which was likely due to changes in management. There was evidence of good joint working the local GP, pharmacist and other health professionals.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user 17(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed 18(1)