Agnes and Arthur Limited

# Agnes and Arthur

**Inspection report**

Moorland View, Bradeley
Stoke on Trent, ST6 7NG
Tel: 01782 657583
Website: www.safeharbor,co.uk/pages/agnes-and-arthur-care-home.php

Date of inspection visit: 30 June 2015
Date of publication: 04/09/2015

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires improvement |
| Is the service safe? | Requires improvement |
| Is the service effective? | Requires improvement |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires improvement |

## Overall summary

We inspected this service on 30 June 2015. The inspection was unannounced. At our previous inspection in June 2014, the service was meeting the regulations that we checked.

The service provided accommodation for up to 50 people. Thirty five people were living at the home on the day of our inspection. Some of the people were living with dementia.

There was a registered manager in post at the time of our inspection. 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. The registered manager was not at the home on the day of our inspection but there was a deputy manager on duty.

We received information, that staffing numbers in the home were low and this raised concerns for people's safety. We found staff were not provided with the knowledge and guidance they needed to support people

# Summary of findings

safely. The provider reviewed staffing levels but did not take into account people's changing needs to ensure there were sufficient staff to meet people's needs at all times.

Staff received induction and ongoing training but there were no arrangements in place to check their competences and knowledge to ensure they had the right skills to care for people. Staff told us they felt supported by the manager and able to raise their concerns. However, we found inconsistencies in the way the provider's management team responded to those concerns.

The manager and staff did not fully understand and follow the legal requirements of the Mental Capacity Act 2005 (MCA). For a person who lacked the capacity to make decisions, there was no evidence that the decision to use a door sensor had been made in their best interest.

People were supported to eat and drink enough to maintain good health but the provider did not ensure that mealtimes were a pleasurable, sociable experience.

The manager and the provider's quality team monitored the quality and safety of the service but the checks carried out were not effective in identifying shortfalls in care plans and the effectiveness of staff training.

Staff knew people's preferences and people told us they received support in accordance with their wishes. People told us they liked the staff and found them to be caring and patient. Staff promoted people's dignity and encouraged people to remain as independent as possible. People were encouraged to form friendships at the home and were able to see friends and family as they wished. Staff kept relatives informed of changes in people's care and support.

People received their medicines as prescribed and had access to health professionals to support and maintain their health. People were supported to have sufficient to eat and drink to maintain good health and to access health care services when they required.

The provider had recruitment processes in place to assure themselves that staff were suitable to work in a caring environment which minimised risks to people's safety.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

# Summary of findings

## 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 consistently safe.

The provider reviewed staffing levels but did not take into account people's changing needs to ensure there were sufficient staff with the right knowledge to meet people's needs safely at all times. Suitable recruitment procedures were in place and staff knew how to safeguard people from abuse. People received their medicines as prescribed.

**Requires improvement**

**Is the service effective?**
The service was not consistently effective.

Staff did not always receive the training they needed to provide people's care effectively. The manager and staff did not fully understand and follow the legal requirements of the Mental Capacity Act 2005 (MCA). People were supported to maintain good health and had access to health professionals when needed.

**Requires improvement**

**Is the service caring?**
The service was caring.

People and their relatives liked the staff and found them to be kind and patient and promoted their privacy and dignity. People were supported to make day to day decisions and to retain as much independence as possible. Relatives could visit whenever they wished.

**Good**

**Is the service responsive?**
The service was responsive.

People told us they received support in accordance with their wishes. People were supported to follow their interests and form friendships with other people living at the home to avoid social isolation. People knew how to raise concerns and complaints were responded to in a timely manner.

**Good**

**Is the service well-led?**
The service was not consistently well led.

Staff were supported to raise concerns but there were inconsistencies in how the provider's management team responded to those concerns. The manager sought the views of the people living at the home on the quality of the service. The provider's checks and audits were not always effective in monitoring the quality and safety of care being provided.

**Requires improvement**

# Agnes and Arthur

**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.

The inspection was undertaken on 30th June by two inspectors and an expert by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

We reviewed the information we held about the service, information of concern we had received and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send us by law.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 11 people who lived at the home and four relatives. We spoke with five members of staff, the deputy manager and the quality manager. We also spoke with one health care professional. We observed care and support being delivered in communal areas and observed how people were supported to eat and drink at lunch time.

We looked at eight people's care records to see how their care and support was planned and delivered. We reviewed five staff files to check people were recruited safely. We looked at the training records to see if staff had the skills to meet people's individual care needs. We reviewed checks the manager and provider undertook to monitor the quality and safety of the service.

Requires improvement

# Is the service safe?

## Our findings

We received information, that staffing numbers in the home were low and this raised concerns for people's safety. People and their relatives told us the home was short staffed. One person told us, "If staff are busy, you have to wait a while". Another said, "They are short staffed at the moment, but they do their best". A relative told us, "They need more staff, it's terrible when they're trying to get people up, it seems chaotic". We observed there were times when staff had to leave what they were doing to respond to people who displayed behaviours that challenged. This sometimes meant leaving other people without support. For example, at times there were no staff in the communal lounge or the dining room. The quality manager showed us the tool they used to set the staffing numbers in the home. We saw this was based on occupancy levels and did not take into account people's individual needs.

This was a breach of Regulation18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that some people living at the home displayed behaviours that challenged. People told us they did not always feel safe. For example, some people did not feel comfortable in the communal areas when some people displayed behaviours that challenged their safety and that of others. One person told us, "Some people are loud and some people find it's hard to get peace and quiet. The only escape is for them to go to their bedroom". Another person told us, "It's night time when things are all happening, it drives me mad so I go up to my room when it gets too much".

We saw an incident where a person became agitated in a communal area. We observed that people became unsettled and some people reacted by becoming challenging to the person. Staff told us they hadn't been trained to in the best way to support people who presented with these behaviours. We saw that behaviour management plans were in place but they did not provide staff with information on people's individual behaviour patterns or identify positive actions to take when incidents occurred. We saw staff diffuse the situation by talking to the person but not having guidance on the best way to support the person meant staff did not always have the knowledge they needed to meet people's needs safely.

Staff understood their responsibilities to report any concerns that people may be at risk of harm. We saw records for a recent incident which had been reported during staff handover. The incident was recorded in the person's behaviour management plan and in incident monitoring records and the manager had followed the local authority's safeguarding protocols.

We observed medicines being administered and found that staff administered people's medicines as prescribed. Staff told us and records showed that staff who administered medicines undertook relevant training and had their competency to administer medicines checked by senior staff. Medicines were stored securely in the home in line with legal requirements. There was a protocol in place for administering medicines prescribed on an 'as required' (PRN) basis to protect people from receiving too little, or too much medicine. We saw people were asked whether they needed PRN medicines. Where people could not communicate their need for the medicine, we saw pain management assessments were in place to ensure staff could identify the person's need for pain relief.

Staff told us and records confirmed that references were followed up and a DBS check was carried out before staff started work. The DBS is a national agency that keeps records of criminal convictions. This meant the provider assured themselves that staff were suitable to work in a caring environment which minimised risks to people's safety.

Requires improvement

# Is the service effective?

## Our findings

The provider was not consistently meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The legislation set out the requirements that ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. Although care plans we looked at included a mental capacity assessment, for a person who was assessed as not having capacity, the decision to use a door sensor was not recorded. There was no evidence that the decision had been taken in their best interest.

Information we held about the provider showed that they notified us of 11 DoLS authorisations. Following the inspection, we confirmed that this number was correct and records showed the manager had submitted a further referral for authorisation. However, we found there was a lack of understanding among staff about how DoLS authorisations were obtained and some staff incorrectly thought everyone living at the home had one. One member of staff told us, "Nobody can leave the home. We have to escort them". However, they could not tell us why they were being restricted.

People and their relatives told us they thought the staff needed more training to support people effectively. One person said, "I think some staff definitely need more training". Another person said, "Staff seem to cope alright most of the time, but I don't know if they have enough knowledge". Staff told us and records showed that staff received an induction and ongoing training and support to achieve nationally recognised qualifications in care. Staff told us and records showed they had received training to support people with dementia. However, they told us this had not provided them with the knowledge they needed to support people effectively. One member of staff told us, "It didn't really tell us how to support people with dementia". There were no arrangements in place to check staff competences and knowledge to ensure they had the right skills to care for people. Staff told us they received supervision but this was not as frequent as they would like to enable them to review their care practice and identify any training needs.

At lunchtime, we observed that people were seated at the lunch table for 40 minutes before the kitchen staff served any meals. It was very quiet in the dining room and there was no conversation between people and staff. The quality manager told us, "The staff like to wait until everyone is at the table before serving". Some people began walking away from the tables and were later observed still asking to be served more than an hour after they first sat down for their meal. This meant that people did not always get the support they needed to have a pleasurable mealtime.

People were supported to eat and drink enough to maintain good health. People told us they were given choices about their food and drinks. People's preferences were recorded, for example one person liked to have small meals and we saw this was respected One person told us, "The meals are great". Another person said, "Staff make sure I have loads of drinks throughout the day". We saw that drinks and snacks were provided by staff throughout the day.

People were offered nutrition that met their health needs and their preferences. Records confirmed that people's nutritional needs were assessed and if needed a specialist diet was provided. For example, at lunchtime we saw that people who required a diabetic diet were provided with food that met their requirements to keep them safe. People's weights were regularly checked and we saw evidence that when people's weight changed, referrals were made to the GP and dietician as needed.

We saw that people had their day to day health needs met and were supported to maintain good health. We saw one person being supported to attend an appointment with their GP and other people told us they saw health professionals including the district nurse, optician and chiropodist. One relative told us, "[Name] sees their GP, the surgery is only across the road".

Good

# Is the service caring?

## Our findings

People and their relatives told us they liked the staff and commented that they were caring. One person said, "The girls are nice". Another person said, "If they are not too busy, they will sit and chat with you". A relative told us, "They're good girls and have a lot of patience". We observed staff laughed and joked with people and conversations we heard showed the staff knew people well. One member of staff told us, "I know what people like because I've built a good rapport with them". We saw that staff were patient and treated people with kindness and compassion. For example, we saw staff spent time sitting and talking to people who displayed challenging behaviour.

People told us and we observed the ways in which staff acted to promote people's privacy and dignity. One person told us, "Staff always knock before entering the room". Another person told us the staff always closed the door when they assisted them with their personal care. We observed that when staff supported people to mobilise, they discreetly helped them to adjust their clothing to maintain their dignity. Relatives told us staff respected their relation's privacy. They told us they were able to visit any time they wished which showed the provider supported people to keep in touch with those that mattered to them. One relative told us, "If I want to, I can visit anytime".

Staff told us they encouraged people to be as independent as possible. One person told us they helped to set the tables for meals every day and this made them feel useful. Another person told us staff respected their wish to get themselves washed and dressed everyday but supported them when they wanted to have a bath. They told us, "I take care of myself, I get up and see to myself every morning, but staff help me to have a bath". This demonstrated that staff respected people's privacy and dignity and promoted their independence.

Staff told us they offered people choice in making day to day decisions. One member of staff told us, "I ask people what they want to wear and if they want to wear make-up, I help them to apply it. It's who they are". We heard a member of staff asked a person which shoes they wanted to wear to go out and saw that they brought the pair they asked for. We also observed staff offered people choice about where they sat for their meal at lunchtime and their wishes were respected.

Records showed that advocacy services were involved in helping one person to discuss who should manage their finances. An advocate is an independent person who is appointed to support a person to make and communicate their decisions. This showed people were supported to be actively involved in making decisions about their care and support.

Good

# Is the service responsive?

## Our findings

People's needs were assessed prior to moving into the home and care plans were reviewed. For example, risk assessments were updated following a fall and one person's medicines had been reviewed in response to deterioration in their mental health. Relatives told us they were kept informed about changes. One relative told us, "Any problems, they [staff] ring me at home".

Staff told us about people's likes and dislikes and about things that were important to them and this was recorded in their care plans. For example, we saw that one person's preferences for having a newspaper and a special biscuit with their tea were being respected. Staff told us that some people had keys to their rooms and knew the codes to the key pads within the home. One person told us, "Some people like to get into other people's rooms so I have a key and lock my room to be on the safe side". Another person told us they had a key to their room because some of their belongings got lost when they first came to the home. This demonstrated that people received support in accordance with their wishes.

People were supported to follow their interests and form friendships with other people living at the home to avoid social isolation. A person living with dementia told us they enjoyed gardening and helped maintain the gardens at the home. They told us, "When I came here, it was all weeds outside but I designed the garden and planted some of the trees". We saw that risk management plans were in place that took into account the person's views about their levels of independence and what they wanted to achieve to ensure they had a good quality of life.

A relative told us that their relation had started knitting again. Other relatives told us how their relations had made friends and settled in quickly. One relative told us, "When [name] came in, she was withdrawn and quiet but you can see how [name] is now". The person told us, "We're such good friends, I'm glued to her arm".

People told us there were activities on offer at the home. They told us, "A lady comes in and we do skittles, darts and other things but we could do with a list to keep us informed of what is going on". Relatives told us there was always something going on at the home. One relative told us, "They play board games, go shopping and go out on trips".

People told us they felt able to raise any concerns with the staff or manager and felt confident they would deal with them. One person told us, "If I have concerns, I talk to the staff, I tell them what's wrong and they write it down". Information on how to make a complaint was on display in the home and was detailed in the home's welcome pack. We saw that complaints were investigated and responded to in accordance with the provider's policies and procedures. The quality manager told us complaints were reviewed and discussed with staff as an opportunity for learning and to make improvements to the service.

Requires improvement

# Is the service well-led?

## Our findings

We had we received information that raised concerns about the management of the home. On the day of our inspection, the manager was not at the home but the deputy manager was working alongside the staff throughout our inspection visit. All the staff we spoke with told us they liked working at the home and felt supported by the manager and deputy manager. One member of staff told us, “The manager is very approachable. I don’t feel on edge or that I’m being watched”. Another member of staff told us, “ I feel very supported by the manager. It’s a nice place to work”.

Staff told us they were aware of the whistleblowing procedures at the home and said they would whistle blow if they felt their concerns were not addressed properly. A whistle blower is someone who reports wrong doing in the place they work. Staff told us they felt well supported at a local level and received feedback from the manager when they raised concerns. However, if their concerns were escalated to senior management, they sometimes felt they were not informed of any outcome.

The provider’s quality management team monitored the quality and safety of the home in some areas. However, we found that the checks had not identified the shortfalls we identified in relation to behaviour management plans and the effectiveness of staff training. We did see checks carried out by the manager which recorded incidents and accidents such as falls and medicine errors and reviews were undertaken to identify patterns and trends. We saw an action plan was put in place which meant the risks to people were recognised.

People told us they knew who the manager was. The manager sought the views of people living at the home through resident’s meetings and questionnaires. Staff were also asked for their views on the running of the home through an annual questionnaire. We were advised after the inspection that a recent survey had taken place but the responses had not yet been collated and the results were not available to us.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The provider determined staffing numbers based on occupancy levels and did not take into account the individual needs of people to ensure there were sufficient staff to keep people safe at all times.<br><br>Regulation 18(1) |