Leonard Cheshire Disability

St Anthony's - Care Home with Nursing Physical Disabilities

Inspection report

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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

We inspected this service on 25 April 2016 and it was an unannounced inspection. Our last inspection took place in November 2013 and we found no concerns with the areas we looked at.

The service was registered to provide accommodation for up to 34 people. At the time of our inspection 34 people were using the service.

There was a registered manager in post. 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 currently absent from the service.

People's medicines were not managed stored and administered in a safe way. We found that medicines were not always administered as prescribed. There was no guidance in place to ensure staff understood when to give people 'as and when' required medicines.

People told us they had to wait for support and we found there were not enough staff to meet people's needs in a timely manner. Risks to people were not always manged to ensure people were supported in a safe way. Some people were not protected from potential abuse as concerns were not reported to the local authority. The provider had not notified us about significant events within the home.

When people were unable to consent, mental capacity assessments and best interest decisions were not always completed. The provider had considered when people were being restricted unlawfully but had not assessed how people could be supported in the least restrictive way. People told us they were not involved with reviewing their care and felt when they had raised concerns theses had not been actioned.

When people needed support to be made more comfortable we did not see staff provide this for them. People did not feel staff were compassionate towards them.

The systems that were in place to improve the quality of the service were not always effective. When concerns were identified action had not been taken. Records for people were stored insecurely. People's care was reviewed but we did not see changes that were made from this.

People told us staff knew them well and staff had the training to support people. People privacy and dignity was upheld and when needed they were referred to health professionals for support. Equipment was maintained and tested so that it was safe for people to use. The provider had a system in place to ensure the suitability of staff who worked within the service.

People told us they enjoyed the meals and there were choices offered to them. People were offered the

opportunity to participate in activities they enjoyed and were encouraged to be independent. People knew who the registered manager was and staff felt supported.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Inadequate

The service was not safe.
People were not safe as medicines were not managed, stored or administered in correctly. Risks to people had not always been considered. There were not enough staff as people had to wait for support. People were not protected from potential abuse as safeguarding concerns were not reported appropriately. Equipment was maintained and tested to ensure it was safe to use. The provider checked the suitability of staff before they started working within the home.

Is the service effective?

Requires Improvement

The service was not always effective.
The principles of the Mental Capacity Act 2005 were not always followed. When needed capacity assessments were not completed and decisions were not made in people's best interests. People enjoyed the food and choices were available. Staff received an induction and training that helped them support people. People were referred to health professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.
People were not always treated in a kind and caring way. People's privacy and dignity was promoted by staff and relatives and visitors felt welcomed.

Is the service responsive?

Requires Improvement

The service was not always responsive.
People were not involved with reviewing care. When people had raised concerns and complaints there were no evidence that these had been responded to by the provider. Activities that people enjoyed were available for them to participate in. Staff knew about people's preferences.

Is the service well-led?

Requires Improvement

The service was not always well led.
The provider had not fulfilled their legal responsibility about notifying us of significant events at the service. The systems in

place were not always effective in ensuring areas for improvements were identified. Records were not kept securely. People and staff knew who the registered manger was and felt listened to.

St Anthony's - Care Home with Nursing Physical Disabilities

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.

This inspection visit took place on the 25 April 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.
We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public.

On this occasion we did not ask 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. However we offered the provider the opportunity to share information they felt was relevant with us.

We spoke with 13 people who used the service, three relatives, three members of care staff, two registered nurses, the dining room assistant and the cook. We also spoke with the care supervisor. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing care and support in the communal area We looked at the care records for four people. We checked that the care they received matched the information in their records. We also looked at

records relating to the management of the service, including quality checks and staff files.

Inadequate

Is the service safe?

Our findings

We observed medicines being administered. We saw one staff member dispensed the medicines and another staff member took the medicines to the person and administered. The staff member dispensing the medicines would then sign for the medicine, even though they had not seen it being taken. This practice is known as secondary dispensing and considered to be unsafe as it increases the risk of medicines being administered to the wrong person.

We saw that one person was prescribed as required medicines for management of epilepsy. Staff we spoke with and records confirmed that for this person, this was a life threatening condition. The person needed to be administered as required medicines after five minutes of being in a seizure. We looked at records for this person. On two occasions it was documented this person was 'found in a seizure'. This had resulted in hospitalisation for this person. On a further two occasions it was documented that it took over ten minutes before the required medicines was administered. This meant the person was at risk of having unwitnessed seizures and not receiving their medicines as promptly as required.

We saw that people's medicines were stored in the fridge. These medicines had a recommended storage range as identified by the manufacturer. The fridge temperature was monitored and recorded by staff on a daily basis. The records showed us that the fridge temperature had dropped below the recommended storage range for these medicines on several occasions which could affect their usability. We spoke with staff about this who told us that they had continued to administer the medicines during this time. The medicine administration records (MAR) confirmed this. This meant the provider could not be sure this medicine was effective and safe to administer.

We saw that daily stock checks were completed for each medicine. We saw that one person was prescribed a medicine on a daily basis. This medicine had been signed for each day and a stock check was completed and documented by staff. The current number documented in the stock check was the same as the previous day. We counted the medicines and the amount of stock present matched the amount documented for that day. Therefore this meant that there was one extra tablet available. We spoke with staff administering the medicines; they confirmed they had not picked up on this error. This meant we could not be sure that people's medicines were administered as prescribed.

Some people living in the home were receiving medicines for pain relief or to settle them when they were anxious, on an 'as and when required' basis. There was no information, known as a PRN protocol in place to help staff identify when a person may need the medicine or the frequency and maximum dosage that people could safely receive over a 24 hour period. This meant that there were no control measures in place to ensure these medicines were used appropriately.

This is a breach of Regulation 12 (g) of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

People told us they had to wait for support. One person said, "They take too long when I press my buzzer. I

ask them why are you too long? They just reply saying they are busy". Another person told us, "Whenever I press the call bell I have to wait it takes too long. I have told people here but it's made no difference". Another person explained to us how they needed two staff to support them in the morning to get up. The person said, "At the moment we are pushed so I just have the one". One member of staff said, "Unfortunately we are short staffed at the moment". We checked the records for the call bell system. This showed us that on two occasions that morning people had to wait over 15 minutes for their buzzer to be answered. We discussed this with the care supervisor who told us staffing levels were worked out using a dependency tool based on people's needs. They told us that staffing levels had been increased at the end of the previous year. However as people who used the service were experiencing delays in receiving support, we could not be sure the dependency tool used was effective in working out staffing levels.

This is a breach of Regulation 18 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

We saw there were procedures in place to report concerns of potential abuse to the local authority; however these procedures were not always followed. For example, we looked at the incident and accident forms for the home. Records showed that two people had a physical altercation that resulted in an injury to one of the people. Staff confirmed this had not been reported to the local authority and we had not received a notification about this incident. We looked at records for another person it was documented that this person had bruising. Records showed that staff did not know the cause of the bruising and they had not reported it as required to the local authority for investigation. We discussed this with the care supervisor. They confirmed that these incidents should have been reported to the local authority. This meant we could not be sure people were protected from potential abuse.

This is a breach of Regulation 13 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Risks to people were not always managed safely. For example we saw that people were in the communal areas for periods up to 30 minutes during the day without staff support. There was a call bell system that was situated on wall in the communal area however the bell was out of people's reach. We spoke with the care supervisor about this they told us that people had their own individual call bells which should be with them. We observed some people did not have an individual call bell as stated. We saw that some people in the communal areas did not have the capacity or the physical ability to use the call bell. We did not see any risk assessments that had considered this for people which meant that risks to people had not always been assessed appropriately.

We saw that equipment was maintained and tested to ensure it remained in working order. For example the moving and handling equipment was checked and we saw portable appliance testing had been completed. This demonstrated that's the equipment was maintained so that it was safe to use.

We spoke with staff about the recruitment process. One member of staff said, "I had to wait for all my checks before I could start. I had to wait for my references and my DBS. It took ages, but they wouldn't let me start". The disclosure and barring service (DBS) is a national agency that holds information about criminal convictions. We looked at three staff files and saw pre-employment checks were completed before staff were able to start working within the home. Records confirmed that checks were completed on nurses to ensure they were registered to work within their role. This demonstrated the provider ensured that staff were suitable to work with people who used the service.

Requires Improvement

Is the service effective?

Our findings

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 or 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked to see if the provider was working within the principles of MCA. Staff confirmed that some people living in the home lacked the capacity to make certain decisions. When people were unable to consent we saw mental capacity assessments and best interest decisions were not always completed. People, who staff told us lacked capacity had capacity assessments in place in relation to living in the home but we did not see any assessments that were decision specific. For example, we saw and records confirmed that one person used bed rails. There was no capacity assessment in place for this decision or a consent form to show the person had agreed to this. Staff confirmed this person would not be able to consent to this as they lacked the capacity to do so. We did not see and staff confirmed that this decision had not been made as part of their best interest. We did not see any best interest decisions for other people living in the home. Staff we spoke with did not demonstrate an understanding of the process to follow when people lacked capacity. This meant that people's rights under MCA were not addressed.

This is a breach of Regulation 11 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Staff we spoke with did not demonstrate an understanding of DoLS and were not aware if any person living in the home was restricted unlawfully. One staff member said, "I can't say I am aware if anyone comes under DoLS, I'm not too sure what this is". Another member of staff told us, "I don't know individual's names if we are restricting people". We spoke with the care supervisor who confirmed that four applications had been made to the local authority. Initially they were unsure if any approvals were in place. They later confirmed that no approvals had been received. We did not see any evidence that risk assessments were completed to ensure people were being supported in the least restrictive way whilst approvals were being considered.

Staff told us they received training that helped them to support people .One member of staff told us about their induction. They explained they had the opportunity to complete face to face training and also shadow more experienced staff. The staff member said, "It was reassuring and gives you more confidence". This demonstrated that staff shared knowledge to offer support and care for people. Another staff member gave an example of how moving and handling training was important for them. They told us, "It's essential as we are using equipment all the while here". They commented, "It's so important we get this right for people". This showed us that staff were provided with training that supported them to meet people's needs.

The care supervisor told us how they were implementing the care certificate. The care certificate has been

introduced nationally to help new care workers demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. The care supervisor told us there was an expectation that all new starters would undertake this. They told us one person had completed the care certificate and a further five people were currently undertaking it.

People told us they enjoyed the food and there were choices available. One person said, "The food is lovely". Another person told us, "We get plenty of choice here". At lunch time we saw people were offered a choice of three meals. The cook told us that people were offered a choice of meal the previous day. They told us that people often changed their mind on the day. They said, "It's never a problem we can just make something else for that person". There were cold drinks available in the communal areas for people to access and hot drinks were offered to people at various times throughout the day. When people had specialist diets such as soft diets we saw this was provided for them to ensure their needs were met.

Staff told us they referred people to health professionals when required. One member of staff explained to us that they identified that one person who had their nutrition through via a percutaneous endoscopic gastrostomy (PEG) had put on weight. A PEG refers to a flexible feeding tube which is placed through the abdominal wall and into the stomach. Staff told us that they had monitored the persons weight increase and had referred them to the dietician for advice with this. They explained the dietician had looked at the information and had reduced the persons feeding regime. We looked at records for this and saw this referral had been made. Other records we looked at confirmed people had access to their GP, tissue viability nurses and speech and language therapists.

Requires Improvement

Is the service caring?

Our findings

People were not always treated in a kind and caring way. One person told us, "One bad point is sometimes the staff cause problems when I'm using the wet room. They talk too much and take too long". Another person told us that staff were discussing another person who used the service saying, "They had caused a drama on the day of the unannounced inspection". We observed that one person was in an uncomfortable position due to the specialist equipment they required. Staff did not recognise this or offer assistance to this person to make them more comfortable. Staff only noted this when it was lunchtime and they were offering the person support with this.

Where people were able to mobilise independently they told us they made choices about their day. One person said, "I have a look at the activities and see what's on and then decide what I want to do". Another person explained that sometimes they would remain in their room as it was quieter and more private.

People told us their privacy and dignity was promoted. One person said, "They shut all the doors and curtains when they are helping me". Staff gave examples of how they promoted people's privacy and dignity. One staff member said, "We shut doors and knock doors, we are just generally respectful of people's privacy". We observed staff knocking on people's doors and speaking to people discreetly when needed. This demonstrated that people's privacy and dignity was promoted.

Relatives and visitors we spoke to told us staff were welcoming and they could visit anytime. One person said, "I have my friends come see me when they choose" A relative told us, "The staff always say hello to me". We saw that people's friends and relatives visited throughout the day

Requires Improvement

Is the service responsive?

Our findings

People told us they were not involved with reviewing their care. One person told us, "No I don't sort my care plans, the staff do all that". Another person told us they would like to be involved with reviewing their care. The care files we looked at did not show how people had been involved with reviewing their care.

The provider had a complaints policy and system in place to manage complaints. Some people told us that they had raised concerns about having to wait for their call bell to be answered. One person said, "I have voiced this concern but there has been no change". We did not see evidence of this compliant or any action that had been taken because of it. This meant we could not be sure that all complaints had been responded to.

People and visitors told us if they had any concerns or complaints they would be happy to raise them. One person said, "I would know how to complain and would be happy to do so". A relative told us, "I would discuss my concerns with the staff or manager".

People told us staff knew about their needs and preferences. One person said, "They know what I like". Staff told us they would read people's care files to find out information about people. One staff member said, "Information on what people like and don't like are in their files, we read these when we start working here to find out the information". The care files we looked at had information in stating people's preferences. For example one person liked a bath every day. We spoke with the person about this who confirmed this happened. We spoke with the assistant chef. They explained that there was one person who had a specialist diet. They explained how this person was offered an individual choice that reflected their taste. At lunchtime we saw this person was provided with a meal which reflected their preferences. The person confirmed to us that their individual needs were catered for.

People told us they enjoyed the activities. One person said, "I'm going on a cruise soon, I can't wait" Another person told us, "There's lots to do which is good as I like socialising". We saw there was an activity co coordinator in post and activities were taking place. There was a reading group taking place in the activity room, which people could join if they chose to. There was information displayed in the communal areas about activities that were taking place within the home during the month which included flower arranging and holy communion. People told us they were looking forward to these activities. One person said, "I always go to the flower arranging its great". There was also information displayed about other upcoming outings. One person said, "I'm going to the theatre, I always put my name down when that comes up". This meant that people had the opportunity to participate in activities they enjoyed.

Requires Improvement

Is the service well-led?

Our findings

We could not be assured that the provider understood the responsibilities of their registration with us. The provider had failed to notify us of two reportable incidents that had occurred at the home. This included a safeguarding concerns and alleged abuse.

This is a breach of Regulation 18 (4) (B) of the Care Quality Commission (Registration) Regulations 2009.

There were systems in place to monitor the quality of the service. However we did not see the information had been used to bring about changes or improve the care people received. For example, we identified that there were missing signatures on the MAR. There was a weekly and monthly audit in place for medicines. On both audits these missing signatures had been identified, however no action had been taken. We spoke with the care supervisor who told us that when this happened there would be a meeting with the individual to discuss this and actions set to ensure this did not reoccur. The care supervisor confirmed this had not happened. This demonstrated when change was required no action was taken to ensure improvements were made.

We found that people's records were not kept securely. Care plans were stored in a filing cabinet in the corridors. We saw these cabinets were unlocked which meant that people's personal information was at risk of being breached or damaged by unauthorised access.

Systems that were in place to review and monitor care were not always effective. We saw care files were reviewed; however there was no evidence that changes to people's care had been made in response to these reviews. For example, an incident had occurred where one person had been injured. The persons care plan had been reviewed but no action had been taken to reduce the risk of this happening again.

These are breaches of Regulation 17 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Staff we spoke with were happy to raise concerns and knew about the whistle blowing process. Whistle blowing is the process for raising concerns about poor practices. One member of staff said, "I would do this if needed, I would be supported by the care supervisor and manager". We saw there was a whistle blowing procedure in place and was displayed around the home. This showed us that staff were happy to raise concerns and were confident they would be dealt with.

People told us they knew who the registered manger was and they were approachable. One person said, "Yes they are always around we often have a chat". Staff told us they had supervisions and meetings to discuss concerns. One staff member said, "I feel the manager listens to me if I have any problems". This showed us when staff raised concerns they felt listened to and changes made.

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
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service had failed to notify us of two reportable incidents within the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the principles of The Mental Capacity Act 2005 were not met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems that were in place were not always effective in bringing about improvements to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People had to wait for support.

Diagnostic and screening procedures

Treatment of disease, disorder or injury

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not stored or administered in a safe way. We could not be sure people were receiving their medicines as required.

The enforcement action we took:

Warning Notice