County Healthcare Limited

St Mary's Care Home

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and took place on 10 February 2015. The inspection was carried out by two inspectors.

At our last inspection on 05 September 2014, we asked the provider to make improvements in respect of concerns about the lack of adherence to the Mental Capacity Act (MCA), ensuring that people's needs were met and also with the staffing levels provided. An action plan telling us how and by when the necessary improvements would be made was completed by the manager. The anticipated outcomes have been considered as part of this inspection.

During this inspection we checked on the home's improvement plan and found that action had been taken about adherence to the MCA and ensuring people's needs were met. There was also an increase in the number of staff employed.

Summary of findings

The service provides care and accommodation for up to 44 older people some of whom are living with dementia. On the day of this inspection there were 39 people living in this home.

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. 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. At the time of this inspection the manager had submitted an application to become registered with us.

Staff recognised the signs of abuse and knew what to do if they suspected that abuse was taking place. All staff received refresher training about this each year. There were thorough recruitment practices in place to help protect vulnerable people. Individual risk assessments were in place so that steps could be taken to reduce avoidable harm.

There were enough staff employed to meet people's needs although there was evidence that they were not deployed effectively so that people's needs could be met in a timely way. We have asked the manager to review how staff are deployed within the home.

People were protected by safe medication practices, although people were not receiving their medicines at the prescribed times due to the ineffective way that staff were deployed.

People made choices where they were able around daily living. Choices and options were offered to people and staff respected the decisions that people made. Staff spoke kindly and respectfully to people and encouraged them to be as independent as possible.

Staff knew about the Mental Capacity Act and Deprivation of Liberty Safeguards. They were due to receive training about this so that their understanding of this legislation and how it affected the way they supported people in their best interests was improved.

The service had a complaints procedure in place although some relatives felt that they were not listened to when they raised concerns. Some people and relatives also said that they had not been asked for their views about the quality of the service although an annual survey was sent out by the provider.

Audits were in place to ensure that the environment and all care activities and processes within the home were safe and effective.

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?

Requires Improvement

The service was not consistently safe.

Staff were trained to recognise the signs of abuse and what to do if they suspected abuse had occurred.

Safe medication processes were in place that followed good practice guideline. The timely administration of medicines was affected by issues around staff deployment. Regular auditing of medicines took place.

There were procedures in place to ensure that only appropriate staff were employed to work with vulnerable people.

Sufficient staff were employed but people were not cared for in a timely way because of the way shifts were managed.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and supported so that they fulfilled their roles effectively. A staff training programme was in place.

Staff knew about the Mental Capacity Act and Deprivation of Liberty Safeguards but were unsure how they applied to the way they supported people and acted in their best interests. Training had been arranged for all staff to attend.

People received regular food and drink, including special diets and supplements. There were mixed views about the quality of the food provided.

People had timely access to all health professionals and referrals were made appropriately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us they were cared for by kind and compassionate staff.

People were supported to make choices about their daily living and these were respected. People were listened to and staff acted in accordance with their wishes although people sometimes had to wait for staff to be available.

People's dignity was not always promoted when people had to wait long periods to receive personal care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Summary of findings

Care plans were person-centred. Staff had access to information about people so that they could provide individualised care and support.

Activities were available to people although some people did not feel that they reflected their choices and preferences.

People knew who to speak with if they were dissatisfied with the care they received.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were mixed views expressed by staff about the management of the home. Staff worked well as a team and there were management processes in place to share information with staff.

Only formal complaints were considered and investigated with an outcome recorded. Day to day expressions of dissatisfaction with the service were not included in the quality monitoring.

Regular audits about the quality of the service took place but did not always identify shortfalls in the service. There was senior management oversight of the home.

The manager was not registered at the time of inspection but was about to submit their application for registration.

St Mary's Care Home

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 took place on 10 February 2015 and was unannounced. This inspection was completed by two inspectors.

Before the inspection, we reviewed notifications that had been sent to us by the service. These are reports required by law, such as the death of people, safeguarding, accidents or injuries. We also contacted the local authority quality monitoring team to seek their views about the quality of the service provided for people.

During the course of the inspection we gathered information from a variety of sources. For example we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The records we looked at included staff rotas, medication records, Mental Capacity Act and Deprivation of Liberty Safeguard assessments and applications and the care records for five people.

We also spoke with approximately 10 people, four visitors and visiting health professionals. We also spoke with eight staff on duty including care staff, chef, activities co-ordinator and manager.

Requires Improvement

Is the service safe?

Our findings

People told us that there were not enough staff to provide them with support when they needed it. One person said, "All of the staff are lovely but there are not enough of them, especially at mealtimes". However, a relative said, "I feel that there are enough staff on duty and that my [family member] gets attended to in a timely way". Another relative told us, "All of the staff assist with kitchen duties which means people in their rooms cannot get any assistance".

Staff gave differing views about whether there were enough of them on duty. One staff member said, "It depends on who you're working with." Another staff member told us, "There are not enough staff and there is no time to sit and talk with people. Everything is always behind".

On the day of our inspection it was not possible to time how long call bells were ringing before being responded to as engineers were testing the system. Our observations showed that people who chose to remain in their rooms only saw staff when they were brought food and drink. We did not see any other one to one interaction taking place. We were aware that staff were rushing to assist people to get up in the morning and they told us they were having a particularly difficult morning.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that a tool was used to calculate the number of staff required to meet the needs of people living at the home. We were provided with copies of the staff rotas for the four weeks leading up to this inspection and they showed that the home was staffed in accordance with the required numbers. We discussed how staff were deployed during the shift to try and understand why people were not receiving their care in a timely way. The manager said that work was allocated to staff each shift and that this was helping with the deployment. The manager undertook to review how staff were deployed and analyse how long staff were taking to respond to call bells.

The service operated recruitment practices that included a minimum of two written references. All checks were carried out to ensure that staff were of good character and appropriate to work with vulnerable people.

We looked at the arrangements for storing and administering medicines in the service. Records showed that medicines were ordered and checked into the service appropriately and unused stock returned to the pharmacy. Medicines were safely and appropriately stored, with temperature sensitive medicines kept in a locked fridge. Controlled drugs were kept securely and only appropriate staff members had access to these drugs.

We observed a member of staff administer people's medicines. We saw that they followed safe practice, including checking the person's identity and making sure they had swallowed their medicines. However, we saw that people did not receive their medicines at the correct time. For some people their morning medicines were delayed for up to three and a half hours on the day of inspection, with early morning medicines still being administered after 11am. We were told that this was due to exceptional circumstances on the day that were exacerbated by the senior member of staff not starting the drug round until later than usual. We were aware that some people did not receive their medicine that was required half an hour before breakfast at all as it could not be taken after the person had eaten. We saw from previous records that staff were allowing four hours between drug rounds but this meant that some people did not take their final dose because they were already asleep.

Two out of nine Medication Administration Records (MAR) that we looked at had gaps where staff had not signed to say the medicine had been given, particularly in the evenings.

During the inspection we found that there was a discrepancy between the amount of one person's controlled drugs in store and what should have been available according to the controlled drugs register. We asked the manager to investigate the shortfall and we subsequently received a report that showed the reason why the person's medication was short. We are satisfied that all medicines could be accounted for.

People we spoke with told us they felt safe living at the home. Staff told us they had completed training about safeguarding people and keeping them safe. They were able to describe what they would do if they suspected that abuse was occurring and that they would refer any

Requires Improvement

Is the service safe?

concerns to the senior on duty. Two safeguarding concerns had been raised in the twelve months leading up to this inspection and appropriate steps had been taken by the service to respond to the concerns raised.

People's needs had been assessed and there were appropriate risk assessments and risk reduction plans in place. These helped to reduce people's risks in relation to developing pressure ulcers, falls and malnutrition. We saw that where one person had experienced a fall that their risk assessment had been immediately reviewed and updated.

Equipment and systems within the home were kept in a safe condition. Hoisting equipment was clean and well maintained in accordance with the manufacturers instructions. All corridors and fire exits were clear so that people could safely evacuate the building in case of an emergency.

Good

Is the service effective?

Our findings

Some staff were unclear about the Mental Capacity Act and the Deprivation of Liberty Safeguards and how it impacted on the way they supported people. However, all the staff we spoke with were able to confirm that they were due to attend training shortly about this. All the people living in the home had a completed mental capacity assessment in place that stated clearly whether they were able to make decisions for themselves. The accompanying care plan detailed what decisions the person was able to make and any decisions that staff needed to make in their best interests. The manager was conversant with their responsibilities to refer people to the authorising body in the event it was considered necessary to deprive a person of their liberty.

People were supported by staff who had the skills and knowledge to effectively carry out their role. One relative told us, "All the staff are good and understand how to care for my [family member]". Another relative said that their relative received excellent care and went on, "Even if the price was doubled we would still use this home".

Staff told us about the training and support they received to do their job. One recently recruited member of staff described their induction training. Staff described much of their training being presented as e-learning, with annual updates taking place for all statutory training requirements. Staff told us that they received training that was relevant to their role. Staff also spoke about receiving supervision and annual appraisal, although one member of staff told us their supervision was overdue. Staff told us that they felt supported in their role.

There were very mixed views about the quality of the food with one person saying, "The food is alright; it is quite good and you get a choice". Another person told us, "I didn't enjoy lunch, it was gammon and I didn't order it. It was cold and not good. The food is variable depending on who is cooking it". Our observations at lunchtime showed that those people eating in the dining room enjoyed a good experience. People were given choices of what to eat and those who had difficulty understanding were shown the options on plates to help them decide. Some people required assistance to eat and this was given discreetly. Staff sat beside the person they were assisting and chatted quietly to them, encouraging them to eat as well as possible.

We spoke with the chef who told us that deliveries of fresh meat and vegetables were received three times a week. They described the special diets and fortified meals that were available to people. Special requirements were kept up to date on a white board in the kitchen so that the chef was advised of any changes required for people. People's food allergies were also recorded.

We looked at five care plans and these showed that people's nutritional needs were assessed and reviewed monthly, with any risks identified and acted upon. People had their weight checked each month and any changes were recorded and investigated. People were referred to the Speech and Language Therapy team (SALT) when concerns were identified. We looked at the fluid charts for people identified at risk of dehydration and found gaps in the records. For example, for one person it appeared that they had not been given any drinks after 2.30pm until the following morning although staff confirmed that they had received drinks at the time that they were provided.

Care plans and the staff communication book showed that people had access to healthcare services. These included GP, community nurse, chiropodist, SALT and optician. We were able to speak with visiting health professionals who told us they were confident in the care provided by staff. They said that staff referred quickly and appropriately and were alert to the development of concerns such as pressure ulcers. They described staff as caring and kind and confirmed that they always followed the instructions given. We were told that the only problem was that they were sometimes kept waiting because of lack of staff availability.

Requires Improvement

Is the service caring?

Our findings

One person told us, "I have to wait a long time to be assisted, sometimes up to half an hour. I try not to press my buzzer because I know how busy they are". A relative told us, yesterday my [family member] had to wait 30 minutes for staff to come to them. On Saturday they had to wait two hours. Staff would come and turn the buzzer off but then didn't come back because they were busy".

Some people told us they were able to make choices around daily living. People who were independent could get up and go to bed when they wished and spend their time wherever they preferred. However, some of those people who were not independent were not able to make those choices in all cases. For example, some people told us they had to wait a long time to receive help and support with their personal care, including being assisted to the toilet. Care delivered in this way does not promote the person's dignity.

We saw that people looked well cared for. Their clothes were clean although it took staff more than two hours to return to a person to wipe their mouth after they had finished lunch. Staff respected people's right to confidentiality and no conversations were heard between staff about people's needs or treatment in communal spaces. People had their privacy promoted, with all personal care being given behind closed doors. We observed staff knocking on people's doors before entering their rooms. We saw that most staff spoke to and about people in a respectful manner. However, one member of staff was heard to refer to a person by their room number rather than their name and this was disrespectful and compromised the person's dignity.

People told us that the staff were caring. One person said, "All the staff are lovely, even the young ones. They are very busy and run around a lot". Another person told us, "All the staff are wonderful and very kind". A third person said, "I get well looked after. The girls [staff] are lovely".

One person's relative told us how caring the staff were. They said, "All the staff know everyone's name and their needs. You see them have individual chats with people".

We observed staff interactions with people throughout the inspection. We saw one of the catering staff speaking with a person in a compassionate manner. It was evident that the catering staff knew the needs of the person well and demonstrated this through a kind and caring approach. All other staff spoke kindly with people and demonstrated that they knew them well. They spoke about things that mattered to people and it was clear that people enjoyed these conversations and took great pleasure from them. People were seen to smile a lot when staff were talking to them. We saw that staff communicated effectively with people, giving them time to respond to what they had to say. Communications were well paced and staff supported people to understand what they had said to them.

Most people were not able to be involved in planning their care due to their dementia although some were able to make decisions around daily living, such as what they had to eat and drink, where they spent their day and the clothes they wanted to wear. Those people we spoke with did not know about their care plans although some of the care plans we looked at had been signed by the person to show their involvement in planning their care. We were told that family members were consulted where necessary and we saw some care plan agreements signed by them on behalf of their relative.

Visitors told us that they could call into the home whenever they wished. Staff always made them feel welcome and knew who they were. We saw that this was the case, with visitors coming and going throughout the day and being made welcome by staff.

Requires Improvement

Is the service responsive?

Our findings

We reviewed five people's care plans and saw that their preferences, likes and dislikes had been documented. This information was detailed and included the types of food, activities and hobbies that they enjoyed as well as what they liked to wear and their preferences in relation to personal care. For example one care plan stated that the person liked to have soft toys in bed with them and we saw that this was happening. Care plans were reviewed each month and more frequently if changes occurred to the person's care needs.

Elements of the care plans were person-centred. For example we saw that care plans had a chart stating people's preferences around daily living. One person had a 'daily journal' that included how they spent their day and the sorts of activities they enjoyed. Staff could explain what was in people's care plans and how the person preferred to be supported. However, the way that care and support was provided was very task orientated. Staff told us they were assigned a number of tasks that they had to complete during their shift. This meant that they did not have sufficient time to sit and chat with people. We saw how animated people became when staff stopped and spoke with them but this did not occur very often other than when staff were undertaking care tasks or were passing by.

Daily records were kept in people's rooms and included food and fluid intake, repositioning charts for those at risk of developing pressure ulcers and personal care charts. We noted that there were some gaps in these charts where staff had not signed to show they had completed the task.

The home employed an activities co-ordinator who told us that they spent time on a one to one basis with people in their rooms during the morning and in group activity during the afternoon. We did not see any one to one activity taking place on the day of our inspection. In the afternoon a group of six people gathered in the main lounge to play Scalectrix. We saw that people were animated when they had a turn at operating the cars. There was an activities programme in place and one person told us, "I like to join in with the activities in the afternoon." However, other people did not feel their interests were catered for. One person told us, "There's not much to do." The activities co-ordinator told us they were new in post and still getting to know the people and the things they liked to do so that a wider range of interests and hobbies could be catered for.

We saw that people who remained in their rooms received very little stimulation and only periodic visits from staff to check they were safe or to give them food and drink.

People could choose where and how they spent their day, with some people staying in their rooms. They could also choose what they had to eat and drink. One person told us that they could get up when they wanted and go to bed when they chose and that staff respected the choices they made.

We saw that the service had a complaints procedure on display in the entrance lobby. The procedure included how complainants could escalate their concerns if they were dissatisfied with the response they received. One relative told us they were not happy with the response they had received from the manager to their complaints. They said, "The manager will not act on complaints." We spoke with the manager about this and they stated that these concerns had been looked into and action taken. We noted that there was no record of this complaint in the complaints file to demonstrate what action the manager had taken.

We spoke with the manager about how they dealt with expressions of concern or complaint. They said that all informal complaints were dealt with immediately and recorded in the person's care plan.

Requires Improvement

Is the service well-led?

Our findings

Quality monitoring was taking place in respect of the care provided to people. Medication audits were taking place daily so that any discrepancies could be identified and dealt with quickly. People's care plans were audited monthly to ensure that they remained relevant to the person's needs. Accidents and falls were analysed each month so that any patterns were identified and remedial action taken to reduce the risks to people. Weekly audits were also completed in respect of people who were at risk of or had developed a pressure ulcer. However, audits had not identified that staffing deployment had meant that people were needing to wait long periods for assistance from staff.

We looked at the complaints records and saw that they were dealt with quickly and recorded appropriately. However, only formal complaints were recorded in the complaints log which meant that the opportunity to analyse expressions of dissatisfaction for trends was lost. Expressions of dissatisfaction that were shared with us had not been recorded in the complaints log and this meant that the record did not accurately reflect the level of satisfaction experienced by people and their relatives. We saw that of those complaints recorded that they were escalated when necessary to senior managers to deal with.

We were told that all the people living at the service and their relatives were asked for their views and opinions about the quality of the service. Questionnaires were sent by the company head office and responses were collated by them with action plans being developed to address any identified shortfalls. However, the relatives we spoke with said that they could not recall receiving a satisfaction questionnaire recently.

Staff had mixed views about the culture of the service. One staff member thought the culture was very positive with excellent management, whilst another felt that it wasn't positive but that there was excellent team work between staff. Some staff said that they did not feel empowered and that information was not shared by the manager, who "…just gives instructions."

We were told that resident and relatives meetings were held every three months and copies of the minutes of the last meetings were seen. Staff meetings were also taking place regularly and minutes were seen of the last meetings. These were detailed and included information shared with staff about the provision of care and discussion about how to improve the service and experiences of people living at the home.

Staff told us that they received regular supervision, when their work performance was discussed. One member of staff described how they were able to discuss any issues with the manager and that they found the supervision process helpful to them in developing in their role.

We asked how the service encouraged people and their relatives to raise concerns and suggestions and the manager told us that an 'open surgery' was held on Thursday afternoons to allow people and visitors to speak directly with the manager. The manager told us that very few people attended the open surgery.

Audits of the environment and other functions within the home were completed. We looked at fire safety and saw that a risk assessment with an action plan for improvements was in place. We were told that the service was addressing the shortfalls identified within the assessment.

Monthly monitoring visits by the area manager were being completed. We looked at the report of their last visit and saw that an action plan had been made to address shortfalls in the service. Progress against the action plan was recorded.

We checked our records prior to the inspection and saw that we had received notifications in a timely way.

The manager was not registered with us at the time of this inspection although an application to complete the registration process has been submitted and is being processed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services and others were not protected against the risks associated with unsuitable deployment of staff. Regulation 18