Gail Poole, Paul Poole, Doreen Hiley, Kim Vowles

St Agnes Retirement Home

Inspection report

5-7 Neva Road
Weston Super Mare
Somerset
BS23 1YD

Tel: 01934621167

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
St Agnes Retirement Home is a 'care home'. The service specialises in care for older people and can accommodate up to 26 people. The home is made-up of two former domestic properties and laid out across two floors. To the ground floor there is a lounge, additional quiet lounge and dining room with level access to the garden. Bedrooms are situated on the ground and first floors, there is chair lift access to the first floor. The registered managers office is located adjacent to the quiet lounge on the ground floor.

People's experience of using this service and what we found
Since our last inspection, the provider, registered manager and manager had worked to develop the service and improve safety for people living in the home. However, improvements were still needed to make sure that people were not at risk of harm. This meant that not all the requirements of the warning notice had been met.
Although improvements had been made to lower the potential risk of scalds and burns to people, further improvements were needed to remove the risks completely. This meant the Warning Notice for Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was not met.

We found the service had made sufficient improvements to recruitment processes and the management of medicines and topical creams. This meant the Warning Notice for regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was met.

Rating at last inspection and update
The last rating for this service was inadequate (published November 2019) when we identified six breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Following our last inspection, we served a warning notice on the provider. We required them to be compliant with Regulations 12 (Safe care and treatment) and 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 01 November 2019.

Why we inspected
This was a targeted inspection based on the warning notice we served on the provider following our last inspection. CQC are currently trialling targeted inspections, to measure their effectiveness in following up on a warning notice or other specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-

inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was not safe.

St Agnes Retirement Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. This was a targeted inspection to check whether the provider had met the requirements of the warning notice in relation to Regulations 12 (Safe care and treatment) and 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Service and service type
St Agnes Retirement Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who was registered with the Care Quality Commission.

Notice of inspection
The inspection was carried out by one inspector and was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed other information that we held about the service such as notifications. These are events that happen in the service that the provider is legally required to tell us about. We used all of this information to plan our inspection.

During the inspection
We spoke with four members of staff, the manager, registered manager and senior care staff. We undertook visual checks around the home, reviewed care-plans, medicines records and recruitment files, including associated risk assessments.

After the inspection
We reviewed the providers action plan.

Inspected but not rated

Is the service safe?

Our findings

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

We have not changed the rating of this key question, as we have only looked at the parts of the key question we have specific concerns about. The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess all the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

● The systems in place to protect people from the risk of scalds and burns from hot water and surfaces had improved, however further improvements were needed to ensure people's safety. This meant that Warning Notice was only partially met.

● Since our last inspection, the provider had introduced covers to radiators throughout the home. The covers allowed heat out but ensured low surface temperatures to mitigate the potential risk of burns to people. However, we found that one uncovered radiator remained, was hot to touch and was accessible to people.

● At our last inspection we identified people were at risk of burns from hot surfaces because portable heaters throughout the home were hot to touch, at this inspection we found the risk remained. We found portable heaters in two peoples' bedrooms, one was switched on and hot to touch. We observed a further portable heater being removed from a person's bedroom.

● We spoke with the manager who told us they had previously removed portable heaters from the home and that staff had reintroduced them without their agreement.

● There was a generic risk assessment in place for the use of portable heaters. The risk assessment recorded that portable heaters should only be used, "As an emergency measure." At the time of our inspection, the central heating in the home was working, there was no emergency situation and so the portable heaters should not have been in use.

● The service's generic risk assessment had not considered specific risks to individuals being provided with heaters. For example, one person was living with an illness that could impact their ability to feel pain, however the generic risk assessment had not assessed this.

● The provider employed an external contractor to fit specialist valves that lowered the temperature of water being dispensed from hot water outlets. We tested the temperature of water from outlets in peoples' bedrooms and found it was within safe ranges in line with published guidance.

●Hot water dispensed from the outlet in one bath and a shower exceeded the safe limit of 44 degrees centigrade identified in published guidance produced by the Health and Safety Executive. For example, hot water dispensed from the shower reached the thermometer's maximum temperature of 50 degrees centigrade and temperatures of hot water dispensed from the bath tap reached 47 degrees centigrade. The provider had not completed individual risk assessments and no measures had been introduced to remove the risk of scalds from hot water and so people remained at risk of scalds.

● In the bathroom, a thermometer and temperature recording logs were provided. When supporting people to bathe, staff used the thermometer to check water temperatures and recorded results on the logs. However, there was no thermometer or recording log located in the shower room and there was no

evidence to show the temperature of hot water was monitored when people were supported to have a shower. This meant people remained at risk of being scalded.
● We requested the provider send us evidence that bath and shower temperatures were being tested in the month prior to this inspection, however this evidence was not provided.
● At our last inspection, we identified people were at risk of harm because a door leading to potentially dangerous areas, for example the basement, kitchen and laundry, was left unlocked, making these areas accessible to people. At this inspection, we found the door remained locked at all times. The provider had replaced the previous locking mechanism so the door could no longer be left open or ajar.
●We also identified a potential risk from asbestos. Since the last inspection, the provider had commissioned an external contractor to assess and report about asbestos in the home. We reviewed the asbestos survey report and it concluded that asbestos present in the home should be monitored by the provider but was assessed as being low risk.

Using medicines safely
● The provider had made sufficient improvements to their management of medicines and topical creams.
● The provider had worked with a specialist team to improve how medicines and topical creams in the home were managed. For example, at our last inspection we identified that medicines requiring refrigerated storage were not being stored safely because temperatures were recorded outside of safe ranges. At this inspection, we reviewed the temperature records for the medicines fridge and found the temperatures remained within safe ranges.
● At the last inspection we identified people were at risk because prescribed medicines were not always available. This was because the service had not always ordered medicines without delay. At this inspection we found enough improvements had been made and medicines were ordered far enough in advance to ensure people were not at risk from missed medicines.
● When topical creams are opened, they can lose effectiveness over time. To prevent the use of ineffective creams, the date of opening and the 'use-by' date should be recorded. At our previous inspection, we found the 'opened' and 'use-by' dates had not always been recorded. At this inspection, we found improvements had been made and dates were now being recorded.

Staffing and recruitment
● At our last inspection we found people were at risk of being supported by staff who may be unsuitable to work in care. This was because safe recruitment processes were not always followed. At this inspection we found enough improvements had been made and staff were now recruited safely.
● Previously, the provider had failed to ensure background checks were undertaken in line with relevant legislation, including those with the applicant's most recent employer in care and previous employers. At this inspection, we found relevant checks had been made with previous employers, including the most recent employer in care.
● Additionally, we had identified that staff recruitment files had not always included a full employment history, including written explanations for gaps in employment. At this inspection, we found evidence to show employment history was explored during the interview process. The provider had also redesigned recruitment records to reflect that this information was required and had identified further improvements that would be made.