Care Quality Commission

St Anne's Court Care Limited

St Anne's Court

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on the 13 September 2016 and was unannounced.

St Anne's Court is registered to provide residential accommodation without nursing. The service is registered to provide accommodation and residential or nursing care for up to 26 people. The service does not providing nursing care. At the time of our inspection the service was providing residential care to 19 older people. Rooms are on the ground and first floor and all have en-suite facilities. There are also adapted wet rooms on each floor. Rooms on the first floor can be accessed by a lift or stair lift.

The service has 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.

People were not always receiving their medicines in a proper and safe way.
People had not consistently had their medicines administered safely. Some people took medicines that were covered by the Misuse of Drugs Act. We found they were not always administered in line with the act. One person had eye drops that once opened needed to be discarded 28 days later. We checked the date on the bottle and they were being used 12 days after they should have been discarded. Staff told us that prescribed creams were being administered but records did not confirm this. One person had been administered medicine covertly. There are national guidelines for the administration of medicine being administered covertly and they were not being followed. Staff medicine administration practices were not identifying errors and taking the appropriate actions. Medicine was stored safely. Medicines were checked when they arrived in the home and records showed us that any discrepancies with the orders were identified and the appropriate actions taken. Medicine audits being carried out were not robust enough to identify issues we found. We discussed this with the managers who recognised this was an area that required immediate action.

People and their families told us they felt the care was safe. Staff had received safeguarding training and understood how to identify any possible abuse and how to report it. Risks to people had been identified and actions put into place to minimise the risk whilst respecting people's freedoms and choices. People were involved in decisions about how risks they lived with were managed.

There were enough staff to meet people's needs and they had been recruited safely. Processes were in place to manage unsafe practice.

Staff received an induction and on-going training that enabled them to carry out their roles effectively. Some training had been specific to people living at the home and included dementia awareness and diabetes. Formal supervision was not consistently taking place regularly but staff felt supported and had

opportunities for personal development.

People received care that was designed to meet their needs and staff supported people's ability and choices about their day to day care. One person had been assessed as not having the capacity to make some decisions for themselves. A best interest's decision had been made in line with the principles of the mental capacity act. The manager was aware of which people had a power of attorney in place and the decisions they could be involved in on behalf of their relative.

People were supported by staff who understood their eating and drinking requirements. Fresh water was available in people's rooms. People had their weight monitored monthly and actions were in place to minimise any identified risk

People had access to healthcare which included GP's, chiropodists, occupational therapists and dentists.

People and their families described the staff as caring and felt their dignity and privacy were respected. We observed staff talking and having fun with people. Support was provided at a persons' pace and not hurried or rushed. Staff were knowledgeable about people's interests and events that were important to them which meant they were able to have meaningful conversations. People had been involved in decisions about their care and these had been respected. Advocacy information was available to people.

Care and support plans contained clear information about people's assessed needs and the actions staff needed to take to support people. We observed practice that reflected what we had read in people's care plans. People's changing needs were identified and acted upon promptly. Information was shared at handover that kept staff up to date with people's care needs. Daily notes however were sparse at times and not easily linked to care plans but reflected general observations.

People had opportunities to be involved in their local community. People also were supported to enjoy opportunities for individual activities.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. Complaints that had been received had been investigated and actions taken that ensured positive outcomes for people.

The registered manager had submitted a provider information return (PIR) six months prior to our inspection that showed evidence that they had a clear idea of where they were achieving well and where they could improve people's experience of care. This had identified that improvements in medicine administration and auditing were required. . Other audits had been carried out which had successfully led to better outcomes for people. They included pressure care, accidents and incidents, complaints and checks on the environment and kitchen.

People, their families and staff all told us the service was well led. Staff had a good understanding of their roles and responsibilities and felt appreciated by the managers. They described the culture as friendly and that there was good teamwork. The managers had a good understanding of their responsibilities for sharing information with CQC and other statutory agencies. An annual quality assurance survey was carried out and included obtaining feedback from people, their families, staff and visiting professionals. Feedback had been used to improve service quality.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always having their medicines administered safely.

Staff understood the risks to people and the actions needed to minimise risk.

People were supported by sufficient numbers of staff who had been recruited safely.

Staff had been trained in how to recognise signs of abuse and knew how to report concerns.

Is the service effective?

Good

The service was effective.

People were supported by staff who had undertaken training in order to undertake their role effectively.

People were supported to make decisions within the principles of the mental capacity act.

People were supported by staff who understood their eating and drinking needs.

People had access to healthcare in a timely way.

Is the service caring?

Good

The service was caring.

People and their families spoke positively about the staff describing them as kind and patient.

People were involved in decisions about their care and daily lives.

People had their dignity, privacy and independence respected.

Is the service responsive?

Good

The service was responsive.

People had care plans that were individual and centred around how they wanted to be supported.

Staff recognised and responded appropriately to people's changing needs.

A complaints process was in place and people felt if they needed to use it they would be listened too.

Is the service well-led?

Good

The service was well led.

Audits were being completed but were not always robust enough to highlight areas for improvement.

Managers had identified areas that required improvement and had been addressing these to improve service quality.

Staff had a good understanding of their roles and responsibilities and felt appreciated by the service.

An annual quality assurance survey was carried out annually and feedback had been used to improve service quality.

Care Quality Commission

St Anne's Court

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 took place on the 13 September 2016 and was unannounced. It was carried out by one inspector.

Before the inspection we looked at notifications we had received about the service and we spoke with social care commissioners to get information on their experience of the service. We also looked at information on their 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.

During our inspection we spoke with three people who used the service and three relatives. We spoke with the registered manager, two managers, four care workers and the cook. We observed practice and people's meal time experience.

We reviewed four peoples care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff meeting records and the complaints log.

Requires Improvement

Is the service safe?

Our findings

People had not consistently had their medicines administered safely. Some people took medicines that needed to be stored and administered with more security than other medicines. To ensure safe administration the providers system was for two staff to witness and sign for these medicines. We checked the records for two people and found seven entries with only one staff signature rather than the required two signatures. Another page had two lines with no information on other than showing the reducing stock of the medicine. We discussed this with both managers who told us they would investigate this and raise with the local authority safeguarding team.

One person had eye drops that once opened needed to be discarded 28 days later. We checked the date on the bottle and found they were being used 12 days after they should have been discarded. Another person had an eye ointment and no date had been written on the tube indicating when it had started to be administered which meant staff would not know when it needed to be discarded.. We checked the medicine administration charts for people who had been prescribed creams. The records included a body map showing staff where creams needed to be applied. We spoke to senior care staff who told us that the creams were applied every day but records did not consistently demonstrate this had happened.

Staff told us about one person who had begun to regularly decline their medication in the morning. They said when this happens it is offered later in the day and the person will sometimes agree to then take it. They described how recently on some occasions the medicine had been disguised in food in order to ensure it was taken. We found no records to demonstrate that this had been carried out in the person's best interests. There are national guidelines for the administration of medicine being administered covertly and they were not being followed. We discussed this with the manager who told us they would organise a review of the person's medicine with their GP and family.

Staff had completed medicine administration training. This included reporting any medicine errors. We asked one care worker who administered medicines what action they would take if they found an error. They told us "Telephone the GP and explain what has happened. Inform the manager, family and CQC. There have been no errors in a long time". However staff medicine administration practices were not identifying errors and taking the appropriate actions.

People were not always receiving their medicines in a proper and safe way. This is a breach of Regulation 12 (1)(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine was stored safely. A fridge was used to store some medicines and the temperature was recorded daily to ensure it was within an acceptable range. Medicines were checked when they arrived in the home and records showed us that any discrepancies were identified and the appropriate actions taken. Some people had medicine prescribed for as and when it was required. This included pain relief medicine. When this was administered we saw that additional recording took place that included what the medicine was given for and the outcome for the person. A care worker told us how they recognised when a person was in pain who wasn't able to verbally communicate this to staff. They told us "We know if they are in pain by how

they move their body, they go quiet and stop walking around".

People and their families told us they felt the care was safe. One person told us "I feel totally safe, partly the people and partly the building". A relative said "I have no concerns about the way mum has been looked after". Staff had received safeguarding training and understood how to identify any possible abuse. They were able to tell us the actions they would take if they suspected abuse or poor practice was happening. One care worker told us "Any concerns I have had I raise with the manager and it gets dealt with".

Risks to people had been identified and actions put into place to minimise the risk whilst respecting people's freedoms and choices. People were involved in decisions about how risks they lived with were managed. One person needed support with standing and transferring and had needed an occupational therapist assessment. They recommended the person use a full body hoist. The manager told us "They (the person) insisted they remain using a standing hoist. The occupational therapist watched them and said it's your choice". We spoke with a person who had bed rails on their bed. They told us "They are my choice. Before I came to live here I had problems with falling". Risk assessments for the use of bed rails had been completed and were linked to health and safety guidance. People's records contained clear information about the risks they lived with. Each risk was assessed as to whether it was high, medium or low. Against each risk was a summary of the actions needed to be taken by staff to minimise the risk in order to keep people safe. We spoke with staff who were aware of people's risks. One person was at risk of losing weight. A care worker told us "They are weighed monthly. We encourage them at meals and prompt them to eat and their weight has maintained".

A process was in place to record and monitor any accidents or incidents. Records showed us that the manager reviewed all accidents and incidents. Any actions needed to minimise any further risks had been taken and included referrals to a falls clinic and to GP's.

Staff had received fire training and were involved in fire drills. A record was kept of daily visual checks around the building. A check had highlighted a bush had grown and was causing a potential obstruction to a fire exit route. Arrangements had immediately been made for the bush to be pruned. People had personal evacuation plans in place so that in the event of an emergency their individual needs would be understood.

People and staff told us that there were enough staff to meet people's needs. One person told us "They come quickly if I use the bell". A care worker told us "I would say majority of time enough staff. We have used agency in the past and they have been brilliant". People were supported by staff that had been recruited safely. We checked three staff files and recruitment checks had included a criminal records check and two references. Processes were in place to manage any unsafe practice concerns.

Good

Is the service effective?

Our findings

Staff received an induction and on-going training that enabled them to carry out their roles effectively. New staff completed the Care Certificate induction standards. The Care Certificate is a national induction programme for people working in health and social care who do not already have relevant training. At induction staff received information about their role, relevant policies and procedures and safety information about the building. They also worked alongside an experienced member of staff whilst getting to know people and learn how to support them. Staff had received training that was specific to people they were supporting. This had included dementia and diabetes awareness courses. We spoke with a care worker who explained how the dementia training had helped them look at new ways to support a person living with a dementia. They told us "Rather than stop (person) doing what they want we hold their hand and walk with them to where they want to go. It really works at reducing their anxiety".

Formal supervision was not consistently taking place regularly but staff felt supported and had opportunities for personal development. Staff told us that they could always get support from senior staff. One said "We have a coffee and the manager sits with us. Yesterday I asked (manager) if you have five minutes can you catch me. She didn't forget and came and found me". We spoke with one care worker who had begun a diploma level 3 in health and social care. Another told us they had completed a diploma level 2 and had been offered the opportunity to complete the level 3. We saw in staff files that observational supervisions had taken place to check staff competencies and this included housekeeping roles.

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 for 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 found that the service was working within the principles of the MCA. People received care that was designed to meet their needs and staff supported people's ability and choices about their day to day care. Most people living in the home were able to make decisions about their care and they did so throughout our inspection. One relative told us "They keep me informed but they know mum is able enough to tell me if there is anything she's not happy about". One person had been assessed as not having the capacity to make some decisions for themselves such as the decision to consent to their care plan. We saw that a DoLs application had been sent to the local authority. A best interest's decision had been made which included support with personal care, bedtimes, food and activities and had involved people who knew the person and their past history. Decisions were recorded clearly and formed part of a person's care plan. We observed staff asking for consent before providing support to people. The manager was aware of which people had a power of attorney in place and the decisions they could be involved in on behalf of their

relative.

People were supported by staff who understood their eating and drinking requirements. We saw that fresh water was available in people's rooms. We spoke with the cook who told us they had completed a training food course at a local hospital. They told us "It included information about different textures of food and about fortifying food with milk and cream". They told us that one person was on a plan to lose weight so didn't have anything fortified. We observed lunch being served. Most people chose to go to the dining room for their lunch although we saw that people also had the option to have their meal served in their room. The dining area had a calm and sociable atmosphere and staff encouraged conversation between people. People had their main meal served individually to them at the table and staff offered choices of vegetables and drinks. People who needed support were offered it discreetly in an unhurried way. Staff saw one person struggling to manage their knife and fork and offered a spoon so that they could eat their meal independently. Another person had a plate guard to support them manage their meal independently. One person told us "Food is the best the kitchen staff are extremely good. The night staff will get you a cup of tea in the night". Another told us "Food is beautiful. One girl makes me specially coleslaw. I ask for small portions and they do. Sometimes I just have a sandwich". People had their weight monitored monthly. We read in one care file that a person had been identified as at risk of weight loss. The care plan had put actions in place to minimise the risk. We observed the person being supported in line with their care plan and noted there weight was being maintained.

People had access to healthcare which included GP's, chiropodists, occupational therapists and dentists. A relative told us "Mum has kept the same GP and it's really helped with communication".

Good

Is the service caring?

Our findings

People and their families described the staff as caring. One person said "The girls (staff) are lovely. They come in and have a chat. If I have a little cry they come and cuddle me". Another told us "They give me plenty of time". We saw a compliment that read '(They) were very happy here and always appreciated being surrounded by so many kind dedicated people who became her extended family'". We spoke with staff, many who had worked at the service for many years, and they all spoke in a positive and kind way about people. We observed staff talking and having fun with people. Support was provided at a person's pace and not hurried or rushed.

Staff were able to tell us about people's life histories and family and friends that were important to them. Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. One person was excited about attending a special family event and they told us a member of staff on their day off had done some shopping for them. Staff had joined in with the excitement of the family occasion and had all sorts of fun ideas planned to support on the day.

People had been involved in decisions about their live and these had been respected. One person had requested a female care worker only and this had been noted in their care plan. One person told us "I am a worrier. They gave me strong meds in hospital and anyway I decided I was going to drop off. I have cut right down, I made that decision". Another person told us "Getting up in the morning I said about 7.15 but now thinking about leaving it a bit later. If I want something different the staff are quite good at changing things." A relative said "Every time I come in they discuss things with me such as medication or hospital appointments". We saw that advocacy information was available to people who may feel they would like somebody to speak on their behalf.

People had their privacy and dignity respected. One person said "The staff are respectful. If you ask for anything they always say yes. Always knock on the door". Staff called people by their preferred name. Staff were able to tell us how they respected people's dignity. One care worker said "When I'm helping someone I always explain what I'm doing and ask them what they are able to help with. People feel better if they can be independent".

When people had decided to spend time in their room we saw that staff regularly checked whether they needed anything but respected that they wanted some quiet time. People were asked if they would like their bedroom doors open or closed.

The home was registered with the Gold Standard Framework for end of life care and had achieved beacon status. The Gold Standard Framework is a standard of care that people can expect when they are near the end of their lives. It is designed to meet the physical, spiritual and emotional needs of people who are dying, with a focus on the management of symptoms, comfort, dignity, and respect.

Good

Is the service responsive?

Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. We observed practice that reflected what we had read in people's care plans. One person was not able to effectively communicate verbally. They had a communication plan that described how they liked their hand held and didn't like to be supported by their arm or shoulder. We spoke with staff that were able to demonstrate they understood the person's communication plan.

Care plans were reviewed regularly. We spoke with a senior care worker who told us "We review monthly but can have extra time for doing them. We get information from other carers, handovers and daily care notes. If anything dramatic changes we review earlier. Over the weekend (person) was not good on mobility and so we have talked with their GP and daughter". This demonstrated that people's changing needs were identified and acted upon promptly.

We checked care files and found that reviews however were not consistently taking place on a monthly basis. The staff kept records which included some references to personal care people had received; how they had spent their time and physical health indicators. These records were sparse at times and did not always link clearly to people's care plans but rather reflected general observation about them. Staff described handovers at the start of their shifts as a good way of keeping up to date with people. We found that handover sheets contained information that linked to people's care plans. We read that one person had been calling out in the night and saw that the actions that had been taken by staff reflected the agreed care plan. Records are important tools in monitoring the quality of care people receive and ensuring it can be reviewed effectively. We discussed this with the manager who told us they would discuss with the staff team.

People had opportunities to be involved in their local community. We spoke with a person who told us "When I first came nothing much was going on just a bit of music. Much better now. I went on a tour around a lake, went to see school kids singing, also been to the museum, fantastic experience". We saw photographs around the home of people and staff enjoying social occasions. A coffee morning had been organised for the following week to raise money for a national charity. The manager told us about a local film club that visit and people choose a movie and have a cinema experience including people from the film club dressing up as ushers and providing popcorn. People also were supported to enjoy opportunities for individual activities. We saw that the mobile library visited monthly and one person had a collection of audio books they had chosen.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. One person told us "Complaints information was given at admission". A relative said "If any concerns are raised then actions are taken to put it right". We looked at the complaints records. They contained details of concerns raised and the actions that had been taken. Actions had included discussing complaints at handover, staff supervisions and having face to face meeting with the complainant. The

procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government ombudsman.

Good

Is the service well-led?

Our findings

The registered manager had submitted a provider information return (PIR) six months prior to our inspection that showed evidence that they had a clear idea of where they were achieving well and where they could improve people's experience of care. This had identified that improvements in medicine administration and auditing were required and read 'Change of Medication System with additional training and audit trails'. At our inspection we found that the medication system had been changed and staff, including night staff, had undergone additional medicine training. An external audit of medicines had been carried out by the supplying pharmacist and the managers were awaiting the results. Internal medicine audits being carried out were not robust enough to identify issues we found. We discussed this with the managers who recognised this was an area that required immediate action.

However other audits had been carried out which had successfully led to better outcomes for people. They included the risks to people of skin damage, accidents and incidents, complaints and checks on the environment and kitchen.

People, their families and staff all told us the service was well led. The day to day management of the service was job shared by two managers and overseen by the registered manager. One person told us "I think this place is remarkable. They work well together and I find them very helpful". Another said "Managers are very efficient. I only have to go to the office and ask something". Another told us "I'm aware of the management arrangements. I understand the relationship. It works quite well. Both very nice". A care worker told us "Can go to both of them and no problems at all. Even if something negative to say will talk to me. Very supportive and understanding".

Staff had a good understanding of their roles and responsibilities. Some staff had multiple roles such as working as a care worker and also a cook. They told us they felt appreciated by the managers. One said "I feel appreciated; I always get a thank you at the end of a shift". We spoke with staff who had worked at the service for many years. They described the culture as friendly and good teamwork.

The managers had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

An annual quality assurance survey was carried out and included obtaining feedback from people, their families, staff and visiting professionals. The last survey had been completed in June 15 and as a result of feedback some of the bathrooms had been upgraded to wet rooms. The manager told us Quality assurance was planned for this year.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being administered or recorded safely.