St Philips Care Limited

Ditton Priors Care Centre

Inspection report

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Ratings

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

Overall summary

This inspection took place on 6 and 7 May 2015 and was unannounced.

Ditton Priors Care Centre provides accommodation and personal care for older people and people living with dementia for a maximum of 23, when we carried out the inspection 20 people were living at the home.

The home had a registered manager in post who was present for our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not enough staff on duty at all times to ensure people's needs were met. People did not always receive their prescribed medicines as directed by the GP and some medicines were not securely stored. The home was unclean and placed people at risk of cross contamination.

People told us that they felt safe living in the home. Staff had received safeguarding training and were aware of how to protect people from harm. Staff were aware of

Summary of findings

their responsibility of sharing concerns of abuse with the manager and other agencies. Risk assessments were in place that told staff how to support people safely and we saw that accidents were recorded and action taken to reduce the risk of it happening again.

Staff were supported by the manager and had access to regular supervision. People's consent for care and treatment was obtained. Where people lacked capacity to give consent, there was no evidence of what action the provider had taken to ensure that the care and treatment they received was in their best interest. People told us that they were happy with the meals provided and we saw that they had access to drinks at all times. We saw that people had access to other healthcare services when needed.

People told us that there were not enough social activities provided. They said they were confident to share complaints with staff or the manager and action would be taken to resolve them. We saw that past complaints had not been addressed.

The provider had identified areas in the home that placed people at risk of harm but action had not been taken to protect them. Quality monitoring audits were in place but these were not robust to ensure that people received a safe and effective service. Systems were in place to enable people to tell the provider about their experience of living in the home and to have a say in how the home was run. People and staff were aware of the management team and they felt supported.

We identified breaches of Regulations. You can see what action we have told the provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There were not enough staff on duty at all times to keep people safe and they were not appropriately supported to take their medicines. Arrangements were not in place to ensure the cleanliness of the home. Accidents were recorded and action taken to reduce the risk of a reoccurrence.

Requires improvement

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

Arrangements were not in place to support people who lacked mental capacity to consent to care and treatment. People were supported by staff who had access to regular supervision. People were provided with a choice of meals and were supported to eat and drink sufficient amounts. When required people had access to healthcare services.

Requires improvement

Is the service caring?
The service was caring.

People were not involved in their care planning but were treated with kindness and compassion. People's rights to privacy and dignity were respected.

Good

Is the service responsive?
The service was not consistently responsive.

People were not always involved in the assessment of their care needs but staff were aware of how to care for them. People were not supported to pursue their hobbies and interests. Arrangements were in place to enable people to make a complaint.

Requires improvement

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

Arrangements were not in place to protect people from harm. Quality assurance monitoring audits did not identify shortfalls within the service. People were able to have a say in the way the home was run and the management team supported staff in providing a service.

Requires improvement

Ditton Priors Care Centre

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 6 and 7 May 2015 and was unannounced. The inspection team consisted of three inspectors.

Before our inspection we spoke with the local authority to share information they held about the home. We also looked at our own systems to see if we had received any concerns or compliments about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

On the day of our inspection we spoke with six people who used the service, two relatives, six care staff, an auxiliary staff, the deputy manager, one GP, the regional manager and the registered manager. We looked at three care plans, risk assessments, medication administration records, accident reports, staff rotas and quality audits. We observed care practices and how staff interacted with people.

Requires improvement

Is the service safe?

Our findings

We looked at seven people's medicines management and found that people were not always given their medicines for pain management, constipation and dietary supplements. When we asked why this was not given to people the manager could not tell us. Another person's medicine had been stopped by their GP but staff continued to give it to them for a further six days. We also looked at how the provider stored people's medicines and found in some people's bedroom medicines that could have been harmful to others were freely accessible. This placed people who used the service at potential risk of harm. One person had been prescribed eye drops that should be disposed of after 28 days of opening. One staff member who was responsible for the management of medicines was unable to say when this medicine had been opened or when it should be disposed of. One staff member told us how they disposed of medicines safely but we found that they had not disposed of three medicines appropriately on the day of the inspection and these medicines had not been accounted for. Controlled medicines were stored and recorded appropriately to ensure the security of these medicines.

This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people were not well supported because of the lack of deployment of staff. For example, there were no staff available to support people with their breakfast but three staff were in the corridor talking amongst themselves during this time. We saw that one person required assistance with their mobility whilst in the dining room but there were no staff nearby to help them and we saw them stumble. Another person told us that they wanted a drink but there were no staff available to get them one. The manager told us that there were sufficient staffing levels provided during the day and would review the deployment of staff. Discussions with the manager and care staff confirmed that two care staff were provided during the night and this wasn't sufficient to meet people's needs. Care staff told us that five people required two staff to support them with their care needs. Whilst these people were supported they were no staff available to care for the others. This meant people's needs may not be met in a timely manner. The provider had not reviewed the staffing levels to ensure people were adequately supported.

At our last inspection in May 2014, the provider was in breach of the regulation relating to cleanliness and infection control. Prior to this inspection we spoke with the Infection, Prevention and Control Team, Clinical Commissioning Group who had worked with the provider to improve hygiene standards within the home. Staff told us that they had received infection prevention and control training and the manager told us that they had an Infection Prevention and Control (IPC) lead. This person was responsible for maintaining hygiene standards within the home but the home was unclean. In the ground floor bathroom we saw brown matter on the bathroom wall, on and behind the toilet. Brown matter was smeared on the hand sanitizer container located on the first floor. The manager confirmed that this was faeces and appeared to have been there a long time. Surfaces and floors were unclean and this placed people at risk of cross contamination. The manager told us that one staff was provided on a daily basis to clean the home. We spoke with this staff member who told us that they were responsible for cleaning the home and laundering people's clothes. They said it was difficult to maintain standards on their own. The regional manager was confident that sufficient hours had been allocated for cleaning tasks to be carried out. We saw that staff's attitude did not ensure the cleanliness of the home. We saw a staff member cause a spillage and no attempt was made to clean it up and this placed people at risk of slipping. The regional manager told us that cleaning schedules were in place but staff did not always sign them to show that the work had been completed. Cleaning schedules were not made available to us. We have shared these concerns with the Clinical Commissioning Group who will carry out their own inspection.

People told us that staff were kind and they felt safe living in the home. Staff knew how to protect people from harm and told us that they had received safeguarding training. Staff told us that they would share any information of concern with the manager or other outside agencies to safeguard people. The manager was aware of the provider's safeguarding policy and when it was necessary to share concerns with the local authority under safeguarding procedures.

Staff told us that they had access to risk assessments that told them how to care and support people safely. We saw that these assessments had been routinely reviewed to ensure staff had access to up to date information. We saw

Requires improvement

Is the service safe?

risk assessments that told staff how to support people with their mobility, how to prevent pressure sores and to ensure people's nutritional needs were met. One person who used the service had sustained a number of falls and this had been recorded. Discussions with the manager and the care records we looked at showed that action had been taken to reduce the risk of further falls. Records showed that the GP had been contacted to find out if their prescribed medicines had contributed to these falls. A pressure mat had also been placed in the person's bedroom room to alert staff when they required support with their mobility.

Requires improvement

Is the service effective?

Our findings

People were cared for by staff who told us that they received regular supervision but discussions with staff and the training records we looked at showed that they did not always have access to training. We saw that not all staff had received Mental Capacity Act (MCA) training and they were unaware of the principles relating to MCA. We found that not all staff had received the Deprivation of Liberty Safeguards (DoLS) training and that they were unaware of what this meant. The manager was aware that not all staff had received this training and assured us that further training would be arranged. The manager told us that staff were provided with an induction when they started to work at the home and this was confirmed by the staff we spoke with.

The manager told us that a number of people who used the service lacked mental capacity to consent to their care and treatment. A MCA assessment had not been carried out to find out the level of people's mental capacity. The manager was unable to tell us why these assessments had not been carried out. Some people required constant supervision and were restricted from leaving the home but a DoLS was not in place. One care staff told us, "I ensure that the doors are locked so people can't escape." This meant that people's liberty was unlawfully restricted and the manager acknowledged this. The manager assured us that a MCA assessment would be carried out and where necessary an application for DoLS would be submitted to the local authority.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us that they enjoyed the meals provided. One person said, "I don't think it could be improved." One person told us that they were provided with meals of their choice. Staff were aware of people's dietary needs and the support they required to eat and drink enough. People had access to specialist equipment to enable them to eat and drink independently. During breakfast staff were not always available to support people with their meal but we saw that people were well supported at lunchtime. People were encouraged to eat and drink and where concerns had been identified that people may not eat or drink enough, charts were in place to monitor this. People had access to drinks and snacks throughout the day. Discussions with staff and the care records we looked at confirmed that people had access to a speech and language therapist and a dietician when required.

One person told us that they were feeling unwell and that staff had called the GP. Staff told us and the care records we looked at showed that people had access to other healthcare services when needed. We spoke with a GP who was visiting the home who told us that staff did call them out in a timely manner to ensure people's healthcare needs were met.

Good

Is the service caring?

Our findings

One person said, “The staff are very good to me.” We saw that staff treated people with kindness and compassion. We saw that one person required support and this was carried out in kind and caring manner. The person displayed repetitive behaviour and staff were patient when supporting them. We heard a person shouting and saw a care staff approach and reassured them. People were unable to tell us if they had been involved in their care planning and there was no evidence to show that they had but staff were aware of people’s care and support needs and how to meet them.

People were unable to tell us if they were involved in making decisions. The manager told us that people were involved in decision making but was unable to give examples or evidence this. The manager said that people had access to a self advocacy service but acknowledged that people may not be aware of the availability of this service.

A relative told us, “Staff always respects people’s privacy and dignity.” We saw that people were taken to a private area for their personal care to be carried out. We observed staff knocking on bedroom doors and asked permission before they entered. We saw a member of the management team rearrange a person’s clothing to maintain their dignity.

Requires improvement

Is the service responsive?

Our findings

People were unable to tell us if they had been involved in their care assessment. The manager told us that people were involved but was unable to provide us with evidence of this. Staff were aware of people's care and support needs but because of people's lack of involvement staff could not be assured that people received a service the way they liked.

One person said, "There's not much to do here." During the two days of our inspection we did not see people being provided with support to pursue their interests or hobbies. We saw people sat in their armchair throughout the day with no stimulation provided. One person walked up and down the corridor throughout the day and looked agitated. The regional manager acknowledged this and engaged this person in an activity. Staff were aware of people's past history and the things they enjoyed doing but there was no evidence that this had been included in their delivery of care. One staff member told us that in warmer months people were encouraged to go into the garden. They said that church services took place within the home and people were able to attend if they wished. The manager told us that they had an activities coordinator but they were not working on the days of our inspection. Discussions with staff confirmed that people did not have access to information about activities available in or outside of the home so they may not be aware of what is available to them.

One person told us that they were happy with the service provided and they didn't have any complaints. We saw that people had access to a complaints procedure that told them how to make a complaint. The manager acknowledged that some people did not have the mental capacity to make a complaint and said they had access to a self advocacy service to support them when needed. We saw that a record of complaints had been maintained but people were not provided with a written response to tell them what action had been taken to resolve their concern. The manager assured us that the complaints procedure would be reviewed to include this. Records showed that the provider had received two complaints in 2014 about the poor cleanliness of the home. At our inspection we found that the home was unclean and this meant that these complaints had not been taken seriously or acted on.

Requires improvement

Is the service well-led?

Our findings

People's safety was compromised because the provider had not taken appropriate measures to protect them. Some areas in the home had been identified as placing people at risk of harm. Signs on doors told staff that these areas should be locked at all times but they were left open. These cupboards contained hot piping, chemicals and high electric voltage and people had access them. The manager was unable to explain why these areas had not been secured. Fire doors did not close properly and would have an impacted on people's safety in the event of a fire. The manager said that an audit of fire doors had been carried out but these defects had not been identified. We have shared these concerns with the fire safety department who will carry out their own inspection. We saw that an audit of medicines had recently been carried out. This audit did not show any shortfalls but we saw that people did not always receive their prescribed medicines. We saw that medical dressings were out of date and were unsuitable for use. The manager told us that dressings were not audited but the provider's record showed that they had and no shortfalls had been identified. At our previous inspection in May 2014, we raised concerns about the poor cleanliness of the home but on this visit the home was not clean. The provider had not taken sufficient action to address this and people remained at risk of cross contamination.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to tell the provider about their experience of using the service. Quality assurance surveys were given to people and staff and their views were listened to. Surveys showed that people had raised concerns about the quality of meals provided. Discussions with the manager and the records we looked at showed that action had been taken to improve the quality of meals. The manager told us that meetings were regularly carried out with people who used the service but records showed that the last meeting took place in September 2014, so people's views were not frequently obtained. Staff told us that they had access to regular meetings but when they shared concerns about staffing levels during the night, this was not acted on.

Staff were complimentary about the management team and were aware of the management structure and said they felt supported. The manager was aware of their responsibility of informing us of incidents that had occurred in the home but they did not ensure that mental capacity assessments were carried out. Appropriate authorisation was not obtained to lawfully deprive people of their liberty. Staff told us that the regional manager visited often to check that the home was running properly but the regional manager had not identified the shortfalls we found during the inspection.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive their prescribed medicines. Some medicines were not securely stored and were freely accessible to people that they had not been prescribed for. Staff had failed to adhere to instructions and continued to give a medicine that had been stopped by the GP.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Arrangements in place to promote quality standards were not robust. Quality monitoring systems did not ensure people received their prescribed medicines. Action had not been taken to protect people from harm where risks had been identified. Insufficient monitoring of the cleanliness of the home placed people's health at risk.