Chengun Care Homes Ltd

St Augustines Court Care Home

Inspection report

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Date of inspection visit:
08 September 2020
09 September 2020
10 September 2020
17 September 2020

Date of publication:
22 October 2020

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Augustine's Court Care Home is a nursing home providing personal and nursing care for up to 40 people. There were 36 people living at the home at the time of our inspection. The service provides care to people living with dementia.

The service is a purpose-built property. Accommodation is split across two floors. There are several communal living areas, an accessible sensory garden, a cinema room and a sensory room.

People's experience of using this service and what we found

Some improvements were still needed to ensure records were accurate and that audits identified shortfalls in records. These improvements were still needed to ensure effective governance and to consistently ensure the quality and safety of people's care. Some improvements were still required in falls management care to help ensure people were protected from the risk of falls.

The provider had notified the CQC of incidents and events as required. Staff understood their roles and the service was led with an open and honest management style. The provider was committed to provide personalised care in an environment that had been developed to suit their needs. Governance arrangements were in place to ensure health and safety practices were effectively operated on the premises.

People, staff and relative views were welcomed and listened to in the development of the service. Systems were in place to continuously review and learn. Effective working relationships were in place with other agencies involved in people's care.

Systems and processes were in place to help protect people from abuse and harm. Sufficient staff were available to provide safe care to people. Medicines were administered and managed safely. Processes were followed to help prevent and control risks from infections. Systems were in place to review and learn from when things had gone wrong.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (Report published 18 July 2019).

Why we inspected
We completed this focused inspection due to a number of statutory notifications submitted for incidents that involved behaviours that challenge and falls. We had also received some information of concern regarding a person's care, and this had been referred to the local authority safeguarding team.

This report only covers our findings in relation to the Key Questions Safe and Well-Led.

At our last inspection the service was rated as requires improvement, so we checked to make sure improvements had been made in these areas.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

Enforcement
The previous inspection found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was for Regulation12 (Safe care and treatment). It also found one breach of the Care Quality Commission (Registration) Regulations 2009, Regulation 18, (Notification of other incidents).

At this inspection we found enough improvement had been made and the service was no longer in breach of regulation.

Follow up
We will return to inspect 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?

Requires Improvement

The Service was Safe.

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always Well-Led.

Details are in our Well-Led findings below.

St Augustines Court Care 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. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This was a focussed inspection to check whether the provider had met the requirements for the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation12 (Safe care and treatment) and the Care Quality Commission (Registration) Regulations 2009, Regulation 18, (Notification of other incidents). It also checked that the service provided safe care to people at risk of falls and people who had behaviours that challenged.

Inspection team
This inspection was carried out by one inspector and one specialist professional advisor whose specialism was dementia care.

Service and service type
St Augustine's Court Care 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 registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced but we did announce our arrival before entering the premises because

we needed to check the current Covid-19 status for people and staff in the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and health care commissioners who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
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. We spoke with the provider company director, the registered manager and a nurse.

We reviewed a range of records. This included three people's care records and multiple medicines records. We looked at three staff files in relation to their recruitment and supervision. A variety of records relating to the management of the service, including audits and policies were reviewed.

As part of this inspection we looked at the provider's measures for infection prevention and control at the service. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

After the inspection
We made phone calls to 10 relatives to ask about their experience of the service on 9 September 2020. We made phone calls to staff including, one care team leader, three care associates (senior carers), and a care assistant to ask them about how they cared for people on 10 September 2020. We spoke with a health care professional who had involvement with the care of people living at the service on 17 September 2020.

We continued to seek clarification from the provider to validate evidence found. We requested further documents to support our evidence.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same, requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● We observed one person wearing footwear that was too large for them and was therefore a falls risk. Whilst the staff member with the person was aware of this and told us the person had chosen their footwear, they had not escalated the potential risk to the nurse in charge for their decision on how best to reduce these risks.

●Staff understood risks associated with people's individual health conditions, including from falls and behaviours that challenged and told us what care actions they took to reduce these. We observed staff reduced risks. For example, staff reassured a person who was distressed and distracted them. Relatives told us they appreciated this care. One said, "I like the fact that when I go to the home I see staff working with residents. My [family member] has improved and I am so pleased with what they are doing." We observed staff adapted an activity so there was less risk of falls.

● Risks associated with people's health conditions were assessed and reviewed using recorded individual risk assessments, which helped to inform care plans. Care plans contained clear guidance for staff on the steps they needed to follow to reduce any identified risks. For example, guidance from other professionals had been included when needed, on how to reduce risks to people's safety or the safety of others when managing behaviours that could challenge.

● Relatives told us they were informed of any safety incidents and most were reassured that staff had taken all appropriate steps to reduce the risk of harm. Most relatives were of the view that their loved ones settled well and any behaviours that challenged were reduced. For example, one relative said, "[My relative] has challenging behaviour. They now divert [name's] attention and distract them when [name] is becoming aggressive."

● Actions were taken to protect people from risks to their safety associated with their general environment. A programme to replace uneven flooring was in progress and corridors had hand rails should people require these to walk safely. Fire precautions were in place and these included relevant fire safety equipment and regular fire alarm tests. People had individual emergency evacuation plans in place to help guide staff as to what actions were required to keep them safe should there be a fire. A water system risk assessment and legionella risk management plan were in place to reduce any risk from legionella.

Using medicines safely

● The provider's medicines management arrangements had improved since our last inspection. We checked how people's medicines were administered, stored and disposed of and found these followed safe processes. Relatives felt medicines were managed well. One relative told us, "[My family member's] medication is all okay and staff always let us know if they are changing it"

● Protocols for the safe administration of 'as required' medicines were in place and people received their medicines when needed and as prescribed.
● Medicines administration records (MARs) were up to date and showed what medicines were prescribed and administered. Photographs of people were used to help staff confirm their identify before administering medicines; some of these required updating. The registered manager told us they would take action to update these.

Learning lessons when things go wrong
● Systems were in place to help identify any learning or care improvements needed from when things had gone wrong. For example, falls meetings were held regularly for staff to discuss and review any falls incidents. This helped to identify any trends and patterns and to help inform any care actions that may be needed to reduce risks further.
● Incident reports of people's behaviours that challenged included details of any factors that could have influenced the person. This included their environment and any interactions with people. This helped staff to understand any contributing factors to people expressing behaviours that challenged and helped them to learn from this.

Systems and processes to safeguard people from the risk of abuse
● The provider had taken steps to protect people from the risk of abuse and avoidable harm. Staff had been trained in safeguarding vulnerable adults and knew how to raise any concerns. Staff also knew they could raise concerns under the provider's whistleblowing policy.
● Safeguarding referrals had been made for any incidents when required and the service had worked with the local authority safeguarding teams to provide information for any investigations.
● Staff received training in other areas relevant to people's needs and this had been kept up to date; this helped to safeguard people as staff had been supported to obtain the necessary skills to care for people safely.

Staffing and recruitment
● Relatives spoke highly of the staff group. One told us, "The staff are absolutely amazing." Staff recruitment procedures were in place to check staff were suitable to work with people. These checks included references, previous work history and any criminal record checks. Interview questions were relevant for the job role.
● Staff completed an induction programme of training relevant to people's care needs and related health and safety practices, at the start of their employment. Staff told us they also worked with a senior care staff during their induction to gain experience and knowledge of people's needs. Relatives were of the view staff were well trained. One relative told us, "I have seen the nurse giving training courses. The training must be good because when they have new staff they do the training and after a couple of weeks it seems like they have been there a good while."
● Staffing levels were planned to ensure there were enough staff to meet people's needs. Some people required staff with them all the time for a number of hours each day. This was to help reduce any risks associated with their healthcare conditions. We saw that this level of care was provided to people when needed.

Preventing and controlling infection
● Cleaning schedules were in place and records showed these were followed; this helped to ensure the environment and equipment was systematically cleaned. The areas of the environment we checked were visibly clean and were free from any malodour.
● Staff told us they had sufficient stocks of personal protective equipment (PPE) such as face masks, aprons

and gloves. We saw staff used PPE when they should throughout our inspection. This helped to prevent risks to people from infection through cross contamination.

● At the time of our inspection, St Augustine's Court Care Home had no-one with a test positive Covid-19 diagnosis. Procedures were in place to help reduce risks from Covid-19. This included the regular testing of staff and people living at the service. Additional hand sanitisers had been made available and staff wore face masks. Relatives' visiting had been arranged to help reduce any risks of transmission from Covid-19 and we saw socially distanced visits taking place an the outdoor visiting area.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At this inspection this key question has remained the same, requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection, records were not always fully completed for fluid intake charts and behaviour monitoring when needed. Risk assessments were not always reviewed and did not always contain up to date information and staff had not always completed training relevant to people's needs. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 (2). At this inspection we found enough improvement had been made and the provider was no longer in breach of Regulation 17 (2). However, some improvements were still required.

● Whilst staff knew about falls risks to people and care plans reflected these risks, falls risk assessment records had not always been completed accurately. The provider's falls risk assessment template identified multiple medicines should be identified a potential contributory factor to an increased risk of a fall. However this had not been accurately completed for when people were on multiple medicines. Risk assessments had not improved from our last inspection as falls risk assessment records were not always accurate. The registered manager took immediate action from our related feedback at the inspection to review these and sent us examples of their updated falls risk assessments.
● Systems were in place to assess, monitor and improve the service and reduce risks. These were mostly, but not always effectively operated. Whilst audits and checks were made on a variety of areas relating to the care people received and the premises, audits had not identified people's fall risk assessment records were not always accurate.
● Relatives told us they thought the service was well managed. One relative said, "I think the home is well managed, I am happy with everything, my [family member] can't usually get out so they are safe. I can't fault them." Another relative told us, "I do think the home is well managed. It is the way the staff operate and work together. The manager always speaks to you, never any problems."
● Records to monitor people's fluid intake and of any behaviours that challenged had improved since our last inspection. Sufficient information was recorded to enable a thorough review and identification of any patterns and trends.
● Records of staff training for both internal and external training courses were up to date and complete. Staff were trained in areas relevant to people's needs. This included challenging behaviour training. This was an improvement from our last inspection. One professional we spoke with felt the service would benefit from additional training for staff on how to manage actual or potential aggression. We discussed this with the Director who told us they would consider this training going forward.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection the provider had failed to notify CQC about incidents and events when required and this was a breach of Regulation 18(1) of the Care Quality Commission (Registration) Regulations. At this inspection we found enough improvement has been made and the provider was no longer in breach of regulation 18 (1).

● Providers are required to display their latest CQC inspection report and rating on their website, so that members of the public can be informed of our latest inspection findings. The latest CQC inspection report rated 'requires improvement' published in July 2019 was not displayed. The previous CQC inspection report was displayed instead. We were concerned the provider had not been proactive and fulfilled their legal responsibilities to ensure people were informed of the latest CQC inspection rating at the service. We made the provider aware of this and they took action to display the correct CQC report.
● Statutory notifications had been submitted to CQC as required. Statutory Notifications are changes, events or incidents that providers must tell us about.
● The registered manager and director understood their duty to be open and honest with people when things went wrong at the service. Incident reports were clearly documented, and relatives had been kept informed when needed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The director wanted to provide good quality care and achieve good outcomes for people. Investments had been made so that a variety of materials and equipment were available, and adaptions had been made to the environment to make it beneficial for people living with dementia. We saw people enjoy a variety of activities, activity resources and the different spaces around the service. These included a cinema room, sensory room and accessible garden areas. Relatives appreciated these investments. One relative told us, "They are always doing work on the garden. They seem to like to keep everywhere nice."
● Staff provided person-centred care and they acted in ways that supported a positive culture. For example, one person told a staff member they wanted to go into the garden and the staff member helped them to do this straight away. Relatives also told us they appreciated the individualised approach to care. One said, "[Family member's] main carer is lovely. She is very helpful. [Family member] likes to eat their pudding first so staff give that to them first, then after they have had their mains, then they want another pudding. They just do what is best for them."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives spoke highly of the service. One relative told us, "The manager always pops and sees me when I am visiting. When [family member] moved there I said they needed a room on the ground floor with a bathroom and they made sure they got that. I don't think they could be in a better, more caring place."
● Records showed people were asked about their experiences of living at St Augustine's Court Care Home. We could see where improvement actions had been taken in response to people's feedback.
● Arrangements for relatives to visit their loved ones safely, while reducing risks from Covid-19 were in place. This meant relatives continued to be involved in people's lives where possible. One relative told us, "I feel that we have been fully informed about Covid, they are still Covid free which is good. I believe they are doing testing of the residents, [my family member] has been tested twice. They send us emails and we get a weekly call from the activities person to tell us what they have been doing."
● Staff told us they felt their views were listened to. One staff member told us their views had been taken

into account to help develop new ways of grouping staff to work in teams for people's care. Relatives also shared this view. One relative provided an example of how the service took on board one of their ideas around visiting arrangements.

● Staff had roles to help champion effective care. Some of these roles were in development, and others had commenced, such as for falls prevention.

Working in partnership with others

● Staff told us they had good working relationships with relevant health professionals, such as the falls team, GP and dementia outreach team. We saw referrals were made to these services when needed, so as to help ensure people received effective care outcomes.

● Care plans detailed any related care advice given by external health professionals. Staff we spoke with were knowledgeable about the advice given by other professionals and felt it was helpful.