Karuna Care Limited

St Aubyns Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 8 June 2016. This was the first inspection of this location.

St Aubyns Nursing Home provides residential and nursing care for up to 39 older people. Some people using the service may be living with dementia or may have a physical disability. On the day of our inspection, there were 36 people using the service.

A registered manager was not in place at the time of our visit. This was due to the current manager being on extended leave and as a result the registration process for becoming the registered manager was incomplete. 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.

We did not observe people participating in activities during our inspection. There were no individual activity plans in peoples care plans and no planned activities taking place. We found that people were not always supported to engage in meaningful activities that reflected their interests and supported their well-being.

Although we found that there were sufficient staff employed at the service and working on the day of our inspection, feedback from people and their relatives included concerns about there not being enough staff to meet people needs at certain times of the day. Management we spoke with confirmed that during morning times people may on occasions have to wait longer for support than expected. They agreed to review how staff were deployed and would match people's preferred times for support with available staff.

Managers and staff knew what constituted abuse and the action they should take if such an incident occurred. They received regular safeguarding training and policies and procedures were in place for them to follow.

Assessments were undertaken to assess any risks to people using the service and steps were taken to minimise potential risks and to safeguard people from harm.

There were suitable arrangements for the safe management of medicines.

Safe recruitment procedures were in place that ensured staff were suitable to work with people as staff had undergone the required checks before working at the service.

Training records showed that staff had completed an induction course and mandatory training in line with the provider's policy as well as more specialists training on dementia, challenging behaviour, death and bereavement.

Records showed that staff had received regular one to one supervision. There were also evidence of regular annual appraisals being carried out with staff.

Applications for Deprivation of Liberty Safeguards (DoLS) authorisation had been made where appropriate to legally deprive people of their liberty. 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 Mental Capacity Act 2005.

Staff showed dignity and respect as well as demonstrating an understanding of people's individual needs. They had a good understanding of equality and diversity issues, and how equality and diversity should be valued and upheld.

The complaints policy detailed how complaints would be investigated and included the nature of the complaint, whether it was a satisfactory outcome for the complainant. There were mechanisms in place to ensure learning from complaints was shared.

Audits and quality monitoring checks took place regularly and an annual service user satisfaction surveys were undertaken to ensure the service was delivering a high quality, person centred service.

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. Staff were not always deployed effectively in order to meet people's preferred times for support, particularly in the mornings.

Individual risk assessments had been prepared for people and measures were in place to minimise the risk of harm.

Staff had a good understanding of safeguarding people and knew the steps to take to report concerns.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective. Staff received induction training and relevant mandatory training to help provide people with effective support.

Staff had a good understanding of the Mental Capacity Act 2005 and how to support people using the principles of the Act.

People were offered a choice of food and drinks and received appropriate support to maintain a balanced diet.

Care records we saw evidenced input and visits recorded by health care professionals.

Is the service caring?

Good

The service was caring. Staff ensured people's dignity and privacy was respected when providing care and support.

Staff had a good understanding of people's individual's needs and preferences and was respectful of them.

Staff were trained to ensure they supported people appropriately in relation to equality and diversity.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were not always

supported to engage in meaningful activities that reflected their interests and supported their well-being.

People were involved in planning their support and decisions around how their support was delivered.

The service had a complaints policy in place and complaints were investigated when required.

Is the service well-led?

Good

The service was well-led. The provider had carried out regular audits of the care provided to people.

The provider promoted an open and transparent culture and people and their relatives thought the service was good.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

St Aubyns Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 June 2016 and was unannounced. The inspection team included an inspector and a specialist nurse advisor for nursing and dementia care.

Before the inspection, the provider completed a 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. We also reviewed the information we held about the service including people's feedback and notifications of significant events affecting the service.

During the visit we spoke with six people that used the service, five relatives, three care workers, one kitchen manager, one cleaner, one nurse and two relief managers. We observed the care and support offered to people who used the service during the time of our visit.

We looked at a sample of six care records and four staff records, reviewed records of checks relating to the management of the service and looked at policies and procedures. We checked records of team meetings, complaints and premises maintenance. We also gained feedback from local authority commissioners.

Requires Improvement

Is the service safe?

Our findings

People who used the service felt the service was safe. One person said, "I feel very safe, there's no abuse here" and another person commented, "I feel safe here and I've never seen any rough treatment."

People's needs were assessed using a dependency classification form. The number of staffing hours for nurses was above that of what was required, while the staffing hours for care staff were slightly below. Overall, numbers were above what was required. We were assured that nurses worked across the service and assisted the care staff during their shifts. However, some people told us they had concerns about the high use of agency staff at the service and the effect this had on their care. One person said, "There needs to be extra staff or permanent staff, they rely quite a lot on agency staff." Another person told us people had been asking the providers about having more permanent staff for a while as it seemed the staff absences had been covered by agency staff. They also spoke about the absence of a permanent manager for over three months which some people felt was unacceptable. Two people we spoke with told us they thought staff were often rushed and not always available to meet their needs, particularly when they were working on the lower floors in the mornings. One relative told us that they felt there was a huge difference between the permanent staff and agency workers in terms of the quality of the care delivered and gave examples of where they had fallen short on some occasions. Other people told us that they felt that having agency staff was often difficult as they relied on the permanent staff to show them what to do and this slowed them down.

The relief manager told us that they had filled all permanent positions and agency staff only covered sickness and maternity leave. Staff rotas confirmed this. They also confirmed that most agency or bank staff used were familiar with working at the home but they assured us they would keep the situation under review to ensure continuity and good standards of care. They also explained that they were covering the manager's absence and this situation was regularly reviewed to ensure minimal disruption to the service. After further discussion, they told us that they felt that although staff were allocated equally across the home, as we saw on the schedule, there were times when people may have to wait a short time for assistance. This was particularly prevalent in the mornings when people often required assistance at the same time. The management team said that they would review how staff were deployed and would match people's preferred times for support with available staff. We were also told that the service were in the process of employing an extra care worker to cover the busy morning period.

We saw that arrangements for storing medicines were safe. Controlled drugs were stored in a separate locked cabinet; the cabinet was located in the nurse's room which was accessed frequently throughout the day. Processes were in place to ensure only the nurse for each shift held the keys to the cabinet in order to minimise the risk of prohibited access. We discussed this with the relief manager who told us that the provider was having discussions with the pharmacist regarding the storage of controlled drugs in order to further secure access and improve safety.

Appropriate arrangements were in place for the safe management of medicines. Each person had an

individual stock via a dossette system. These were clearly marked with each dose requirements and correlated with the individual Medicines Administration Records (MAR). When nurses gave medicines to people we saw that they were patient and reassuring. They recorded when the medicines had been taken. The nurse we spoke with commented that, "The MAR system is easy to follow" when asked about how new staff would find the process the nurse explained that, "Each resident has an individual MAR chart, this includes information such as photograph, swallowing ability, compliance, thickening requirements and any allergies or reactions."

We did not initially see a body map for the recording of the application to one person of transdermal patches (which are medicated adhesive patches that are placed on the skin to deliver a specific dose of medication). However when a nurse was told about this, it was addressed immediately and body maps were introduced.

MAR charts were clear and were being completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. People commented on how they received there medicines, one person said, "I do not have to worry, I get my tablets at the right time" and another person commented, "I get to speak to the nurse and if I need any extra I ask and get what I need."

There were appropriate systems in place for the administration and recording of medicines to people when required, known as PRN. Protocols were in place for staff to follow. However, planned review dates had been recorded but not carried out on some of the records we saw. This was discussed with the nurse and relief manager who told us that in conjunction with the GP, reviews would take place as soon as possible. They said that any concerns regarding people's health and medicines were discussed with health professionals on a regular basis. Records we saw confirmed this.
Staff had received training in safeguarding adults. They were able to describe the process for identifying and reporting concerns and were able to give example of types of abuse that may occur. One of the care staff said, "I would report any problems to the manager but I've never experienced anything like that here." Another told us, "This is a safe place." There was a safeguarding adults policy in place for the service that outlined the steps to take if any safeguarding issues were identified as well as an updated version of the London multi agency safeguarding procedures.

A fire risk assessment and regular reviews had taken place. There were also annual fire brigade visits recorded and recommendations had been completed.

Risk assessments were in place that ensured risks to people were addressed. These were detailed covering areas of potential risks, for example, falls, pressure ulcers and nutritional needs. These were reviewed regularly and any changes to the level of risk were recorded and actions identified to lessen the risks that were highlighted. Staff were able to explain the risks that people might experience when care was being provided. Where necessary professional's had been consulted about the best way to manage risks to people.

We saw evidence that appropriate recruitment checks took place before staff started work. This included obtaining two references, proof of eligibility to work in the UK and evidence of an enhanced Disclosure and Barring Service certificate (DBS).

Infection control measures were in place. Soap and paper towels were at hand basins and cleaning was being carried out throughout the day. Gloves and aprons were worn when required and cleaning staff followed appropriate systems to minimise risk of cross infection.

Good

Is the service effective?

Our findings

People told us that staff had the skills and knowledge to support them effectively. One person using the service said, "The staff are really good" and another person explained that when they came to the home over a year ago, they were unable to walk. Now they were able to walk a short way unaided and had also learnt to use a walking frame. They expressed gratitude for the staff and how they had supported there recovery.

People were supported by staff that had the necessary skills and knowledge to meet their needs. One person said, "Staff are very good and aware of what I need" and another person told us, "Staff here are well trained". Training records showed that staff had completed an induction course and mandatory training in line with the provider's policy as well as more specialists training on dementia, challenging behaviour, death and bereavement. Most staff had completed a national vocational qualification and managers were in the process of arranging for new staff to undertake the new care certificate. Staff who were qualified nurses had been supported to complete training that meant they could maintain their nursing registration. A training matrix was used to identify when staff needed training updated. Staff said the training helped them feel confident about carrying out their role and meeting people's needs.

Documentation showed that care staff and nursing staff received regular supervision. Staff we spoke with were happy with the support they were given, one staff said, "I have supervision regularly or if I have a concern or any personal issues my supervisor will arrange one for me." Team meetings were also held regularly and minutes were made available to staff after the meeting. However, there did not seem to be a formal process in place for managers to feedback information from the residents meetings to staff to ensure improvements and learning could take place. The manager we spoke with agreed to implement a process where relevant actions from residents meetings would be shared at staff meetings with immediate effect.

The 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.

We checked if the service was working within the principles of the MCA. People told us they were able to make choices and were included in any decisions about how they were supported. We observed staff asking people what they wanted in terms of their support, for example, what food they would like, if they needed assistance with washing and dressing. Each care record had a consent form, which was signed by the person or their legal representative, to agree with the support to be provided. Managers and staff we spoke with had a good understanding regarding the MCA and had received up to date training on the MCA and DoLS.

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 saw that applications had been made to legally deprive people of their liberty appropriately and information regarding this was kept in people's care records. The home had also devised a useful checklist that was completed prior to an application being made, to ensure the appropriateness of the application. For example it made reference to people's mental capacity and why an application was being made.

Where appropriate, care records contained Do Not Attempt Resuscitation (DNAR) forms to record people's wishes on this matter. These were completed by the GP and we saw records of discussions had taken place with the person and their relatives depending on the circumstances.

People were receiving a balanced diet supplied by an external supplier. People we spoke with told us they enjoyed the food and that menus were varied. Menus were displayed on notice boards and on dining room tables.

We observed lunchtime and saw that people were supported to eat when they needed to be. One person said, "The food is good" and another person told us, "We have a choice". One person went on to tell us that the food had improved recently and after consultation with residents they now had a variety of foods on the menu, including smoked haddock, curries and fresh fish at least once a week.

Information relating to peoples diet and nutrition were seen in people's care records. This included people's preferences and any particular dietary needs. Staff told us that they always received written guidance for people with swallowing difficulties to ensure they were aware of how to support people with eating and drinking in a safe way and according to individual guidance.

People were supported to access health care services when they needed to. There was evidence of multi-disciplinary team input from the GP, palliative care services, dietician, dental and audiology services in the records that we saw.

The GP attended the service weekly and was visiting at the time of our inspection. Most people were registered with the visiting GP and some had retained their GP prior to staying at the home. Systems were in place to arrange a consultation as required and information regarding the outcome was recorded in people's individual records.

Good

Is the service caring?

Our findings

People told us they felt the service was caring. One person told us, "The staff always listen to what I need ". Another person commented, "There [staff] always conscious of my dignity and always close the door when helping me to have a wash". One relative we spoke with said, "We can't fault the staff, nothing is too much trouble".

Staff spent time talking to people and engaged in meaningful conversations. They were seen encouraging people to be independent and to do as much for themselves as possible. We also saw people engaging with one another in a friendly manner.

Staff developed positive and caring relationships with people. There was a warm and friendly atmosphere and we saw good interaction between staff and people using the service. Staff knew people's names and was addressing them according to their preferences.

We saw that people's bedrooms were individual in décor and contained many personal items such as photos and ornaments as well as larger items of furniture. Staff told us that people were encouraged to bring their own personal items with them when they came to the service and that it helped them to settle and feel at home.

There was a policy in place for ensuring that equality and diversity was upheld and valued and staff we spoke with had a good understanding of the ways in which this could be achieved and spoke of having training in this area. Staff were aware that homophobia, racism and other forms of discrimination were also forms of abuse that should be challenged.

One staff member said, "I like getting involved with the history of residents, it helps me with looking after them and gives me a chance to talk to them about their past". Another staff commented, "Peoples likes and dislikes are important and they are written down for us." Some information regarding people's life histories was in their care records although this was not always consistent. We were assured by the relief managers that this was an area of development.

We found that people's relatives and those that mattered to them could visit them when they wanted to. One relative told us, "Everyone is really friendly when we come in". Another relative told us, "I come in everyday and it's very friendly". We saw a relative assisting with some gardening and clearly felt at home at the service.

Staff were aware of how to protect privacy and all said they knocked before entering people's bedrooms as well as ensuring privacy when providing personal care. They told us how they promoted independence and maximised people's ability by encouraging them to do as much as possible with support if they needed it.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt they were involved in the planning and reviewing of their care and how it was delivered. One person said, "We had an interview initially and the staff came to visit me at the hospital." However, people told us they did not always feel there were enough activities for them to pursue throughout the day. One person said, "We lost our activity's coordinator so therefore we have no activities planned apart from staff doing music and a sing along now and again". Another person told us, "There are no activities at the moment. When we had a coordinator we used to do puzzles, skittles, bingo and we even had a pool table." A relative told us they had seen staff do some activities like chair exercises when they could and that the person they visited had been involved in activities like making cakes but not since the coordinator left.

Care plans contained no evidence of individual activity plans for people. There were no regular group activities advertised anywhere around the home and no record activities taking place. People and relatives we spoke with confirmed that there had not been any planned activities since the activities coordinator had left the organisation. We did not observe any activities going on during our inspection and people were seen mostly sitting in front of televisions or just sitting around. We found that people were not always supported to engage in meaningful activities that reflected their interests and supported their well-being.

There had not been an activity coordinator working at the home for at least two months and no planned activities had taken place. The provider was in the process of advertising to fill the post. We talked with management about the need for staff to be involved in individual activities as part of personalised care and support and not having to rely on an activities coordinator. This was something they agreed to review and implement immediately, along with filing the vacant coordinator post.

The above was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were reviewed to meet the changing needs of people. This included change of medicines and change of moving and handling requirements. Staff explained how they met people's needs in line with their care plans. One staff member told us about giving medicines, "I get to speak to and interact with every resident during the process and acquire a lot of knowledge that can impact on changes." Another staff member said, "They take into account the needs of each individual resident" and another staff commented, "We use the care plans to make sure we are all singing from the same song sheet."

Care records showed that people had come to the home with pressure ulcers and after careful care and treatment as well as working alongside the tissue viability nurse they had almost completely healed.

There was a key worker system in place in the service. A key worker is a staff member who monitors the support needs and progress of a person they have been assigned to support. People told us that they had received excellent care from staff at the home and along with other professionals this had improved their outcomes and in some cases assisted them to move on from residential care. One person said, "I couldn't walk when I came here and had to be hoisted. The staff and the physio got me to stand and walk and I will

soon be going back home." Another person told us they were going to view accommodation in sheltered housing as they could now manage without 24- hour care.

A copy of the home's complaints leaflet was accessible in the communal area. People said they would tell staff or the manager on duty if they were not happy or if they needed to make a complaint and staff were able to tell us how they would support people to make a complaint. The relief manager showed us a complaints file and this included the complaint's policy and a log of complaints and compliments.

There were no formal complaints raised in the past 12 months. The complaints policy detailed how the complaint would be investigated and included the nature of the complaint, whether it was a satisfactory outcome for the complainant. There were mechanisms in place to ensure learning from complaints was shared. There were several cards and letters from relatives of people using the service, praising the staff for the good work they had done.

Good

Is the service well-led?

Our findings

People and their relatives we spoke with told us that they thought the service was good and the culture was open and transparent. They told us they would feel confident discussing any concerns they may have with the relief managers and that they would be listened to. One person said "The managers are very good but we need a permanent manager."

The permanent manager started working at the service in January 2016 and had been on extended leave for several weeks. They had been in the process of registering with the Care Quality Commission to become the registered manager before they went off. The provider had employed two relief managers to provide cover in the interim. They had both worked at the home previously and this was seen to be the least disruptive option.

Staff were very complimentary about the management and told us they felt well supported. One staff member stated "I always feel as though I am listened to." As well as one to one supervision, staff meetings were held monthly and included areas such as, safeguarding and whistleblowing, person centred care, respecting dignity and working together. Meeting minutes demonstrated that previous issues were addressed and followed through. We saw that up to date policies and procedures were available for staff to refer to for guidance.

Residents meetings had taken place regularly and we saw documentation to support this. They were usually attended by the proprietor and also the chair of the residents association. People and their relatives felt able to speak to managers and the providers about any issues they may have and felt they would be listened to.

We saw that internal audit of care plans were carried out regularly and the outcomes of the audits were shared with staff

Incident and accident records identified any actions taken and learning for the service. The provider's procedure was available for staff to refer to when necessary, and records showed this had been followed for all incidents and accidents recorded.

The service conducted an annual satisfaction survey for people using the service on October 2015 and people were generally satisfied with the service. Of the 22 surveys completed, everyone stated that they were satisfied with the nursing care. Areas identified for improvement included information given to them by other agencies prior to admission. This had been addressed by management directly with the agencies involved.

The last review carried out by the local authority commissioning team in January 2016 was generally good and areas for improvement included some updating of training for care staff and organisation of care records.

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 9 HSCA RA Regulations 2014 Person-centred care Meaningful activities were not included in individual care plans or in any group activity plans to achieve service users' preferences and ensure their needs were met. Regulation 9 (b)