St. Matthews Limited

St Matthews Limited - The Avenue

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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 12 September 2017 and was unannounced.

At the last inspection, the service was rated Good. At this inspection we found some areas of concern and the service was rated as Requires Improvement.

St Mathews, The Avenue, provides accommodation for up to 33 people with dementia or other mental health needs who require support with their personal care. At the time of our inspection there were 30 people living at the service.

During this inspection we found that medicines were not always managed safely and medication protocols were not always followed consistently. In addition, Medication Administration Records (MAR) records were disorganised which had the potential to create confusion.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found mixed approaches to interaction with people from the staff team. Daily routines were not always person centred but were often task-led by some staff. People's care needs were not always carried out in line with their preferences.

The service had a manager but they had not registered with the Care Quality Commission (CQC) 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 found that audits in place did not always identify areas for improvement and management systems in place had not identified areas of poor practice.

People using the service felt safe. Staff had received training to enable them to recognise signs and symptoms of abuse and felt confident in how to report them. People had risk assessments in place to enable them to be as independent as they could be in a safe manner. Staff knew how to manage risks to promote people's safety. There were sufficient staff, with the correct skill mix to support people with their care needs. Effective recruitment processes were in place and followed by the service. Staff were not offered employment until satisfactory checks had been completed.

Staff received a comprehensive induction process and on-going training. Staff said they were well supported by the registered manager and had regular one to one time for supervisions and annual appraisals. Staff had attended a variety of training to ensure they were able to provide care based on current practice when supporting people.

Staff gained consent before supporting people. They were supported to make decisions about aspects of their life; this was underpinned by the Mental Capacity Act 2005. People received enough to eat and drink and staff gave support when required. People were supported to access health appointments when required, including opticians and doctors, to make sure they received continuing healthcare to meet their needs.

People's privacy and dignity was maintained by staff.

People were involved in their assessments and in putting together their support plans. The support plans were regularly reviewed and updated to reflect people's current needs. People were encouraged to participate in a range of activities. Information was available for people on how to raise any concerns or complaints about the service they received. The provider responded to complaints following their policies and procedures.

A variety of quality audits were carried out, which were used to drive continuous improvement and used to good effect in supporting people and staff to express their views about the delivery of care.

You can see what action we told the provider to take at the back of the full version of the report. Please note that the summary section will be used to populate the CQC website.

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

Systems in place were not always consistently followed to ensure that people's medicines were managed safely.

People were protected from avoidable harm and staff knew how to report potential safeguarding concerns.

Risk management plans were in place to protect and promote people's safety.

There was a robust recruitment process in place to ensure that safe recruitment practices were being followed.

There were sufficient numbers of staff to meet peoples needs and keep them safe.

Is the service effective?

Good

The service was effective

Staff had undertaken a variety of training and supervision to keep their skills and knowledge up to date.

People's consent to care and treatment was sought.

People could make choices about their food and drink and staff provided support when required.

People had access to health care professionals if required, to maintain their health and well-being.

Is the service caring?

Requires Improvement

The service was not always caring.

Daily routines were not always person centred but were often task-led by some staff.

Arrangements were in place for people to express their views about their care.

People had the privacy they needed and were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People had an assessment of their care needs before they were admitted to the service.

Care plans were detailed and provided guidance for staff to meet people's needs.

A programme of activities had been developed that was reflective of people's interests and preferences.

People knew how to make a complaint and said they would be comfortable to do so.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People's quality of care was not always effectively monitored by the systems in place and timely action was not always taken to make improvements when necessary.

There was no registered manager in place.

Staff felt supported by the management team at the service.

St Matthews Limited - The Avenue

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 12 September 2017 and was unannounced. It was carried out by two inspectors, one expert by experience and one specialist adviser. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service A specialist adviser is a person who has professional experience of people who use this type of care service.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We spoke with the local authority to gain their feedback as to the care that people received.

During our inspection, we observed how staff interacted and engaged with people who used the service, in particular people living with dementia. 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 seven people who used the service and observed the way in which staff interacted with them. As some people were unable to express themselves fully due to their complex needs, we also spoke with two relatives of people using the service. In addition we had discussions with nine members of staff. These included the director of operations, the deputy manager, one nurse and six support staff.

We looked at eight people's care files to see if their records were accurate and reflected their needs. We also reviewed seven staff recruitment files, staff duty rotas, training records and further records relating to the

management of the service, including quality audits in order to ensure that robust quality monitoring systems were in place.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. For example, we observed a qualified nurse, preparing medicines for several people and signing for them prior to giving them to each person.

Medication Administration Records (MAR) were disorganised and we found that for one person they had two MAR charts for the same pain relief. We saw that on one occasion this person had not received their pain relief as prescribed. In addition we found that the tablet crushing device had not been cleaned and remained covered in the residue of medication from previous uses. This could result in people receiving unknown and non-prescribed products even if only in small amounts.

We brought this to the attention of the deputy manager and a supporting manager from another service. They told us this would be dealt with straight away and they would complete a review of all MAR charts. The deputy manager also told us they would report this to the local safeguarding team.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that medicines were stored safely and were administered from a lockable trolley. When not in use the trolley was stored securely in a locked room. Some items needed storage in a medicines fridge, the fridge and room temperatures were checked daily to ensure medicines were stored at the correct temperatures in line with best practice.

We saw there was a system for recording the receipt and disposal of medicines to ensure that staff knew what medicine was in the service at any one time. This helped to ensure that any discrepancies were identified and rectified quickly. Records demonstrated that the pharmacist regularly reviewed the medicines charts and stock and we saw this had been completed recently.

People using the service were protected from abuse and avoidable harm. People told us they felt safe living at the service. One person said, "Yes I feel safe. Staff help me when I need help." .A second person told us, "It's safe here." Relatives we spoke with also told us they felt their family members were safe at the service. One relative told us, "We do have peace of mind and know this is the safest place for [name of relative] to be.

Staff confirmed they had received training on safeguarding, including the whistle blowing procedures and where aware of the safeguarding procedures. One staff member told us, "We have had training about safeguarding adults and children." They also confirmed they completed safeguarding refresher training annually. We saw that posters were on display on notice boards for people and staff to refer to regarding who to contact if they had any concerns. We saw evidence that when required the registered manager submitted safeguarding alerts to the local safeguarding team to be investigated.

Risk management plans were in place to promote people's safety and to maintain their independence. One

person told us, "I know I have risk assessments in place to keep me safe." Staff spoke to us about how risks to people were assessed to ensure people's safety was maintained. One staff member told us, "We have a lot of risk assessments in place just because of the nature of the people we care for. We have a lot around absconding and challenging behaviour. It tells us what we have to do."

Within people's support plans were risk assessments to promote and protect people's safety in a positive way. These included; accessing the community, self-harm, falls and managing peoples behaviours that could challenge the service. We saw they had been reviewed regularly and when circumstances had changed. The risk process was incorporated within each care plan and was recovery focused.

There was an emergency plan in place to respond to emergencies such as fire, loss of gas, electricity and water. Each person had an individual fire evacuation assessment plan in place. We saw clear information was on display regarding fire safety and the arrangements to follow in the event of a fire. We saw evidence that staff had been provided with fire awareness training and regularly participated in fire drills. This demonstrated a positive attitude in promoting people's safety.

There were arrangements in place to ensure safe recruitment practices were followed. We found that staff had been recruited safely into the service. One staff member said, "I had to wait until my DBS and references had come through, I think its only right they wait until everything has been properly checked." The deputy manager told us that all staff employed by the service underwent a robust recruitment process before they started work.

Records confirmed that appropriate checks were undertaken before staff began work at the service. We saw criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history, character references and job descriptions in staff files to show that staff were suitable to work with vulnerable people.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. People told us that staffing levels were sufficient to meet their needs. One person said, "There seems to be lots of staff around." Relatives also confirmed there was sufficient staff and that people always received the care they needed in a timely way. One commented, "When ever I visit there are always staff about."

Staff told us there were sufficient numbers of staff to provide care and they did not feel under pressure or rushed when carrying out their roles. Staff told us they thought there were sufficient staff available. The deputy manager told us they rarely used external agency staff and that staff vacancies, sickness and annual leave were covered by their own bank relief staff. One said, "Yes, we have enough staff. We do all work well together as a team."

The deputy manager told us, "If people's needs change we can make sure additional staffing is provided." We looked at the staff duty rota for the current month. The recorded staffing levels were consistent with those as described by the deputy manager and the staff we spoke with. At the time of our inspection we judged staffing levels across the service to be sufficient to meet people's needs.

Good

Is the service effective?

Our findings

People received care from staff that had the knowledge and skills to carry out their roles and responsibilities. Staff told us they completed mandatory induction training that covered areas such as, moving and handling, food hygiene, cross infection, fire safety, basic life support and the management of behaviour that challenges. One staff said, "The training was very good. We get lots of training." Staff told us that they had shadowed experienced staff within the service as part of their induction programme. .

The provider arranged for staff to complete timely refresher training. One member of staff said, "The training is quite good, we have a mix of e-learning and face to face training." Another member of staff said, "I have worked as a carer for a long time and over the years I have done lots of training, I complete annual refresher training, as it's important to keep up to date with things."
Records showed that all staff received induction training, as well as on-going training which was kept up to date.

Staff received appropriate supervision and on-going support. The staff told us that scheduled supervision meetings took place with their supervisors and that staff group meetings took place. We saw the minutes of the group meetings were on display for staff, people using the service and visitors to read.

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 checked whether the service was working within the principles of the MCA. We saw evidence within people's care plans that mental capacity assessments had been carried out along with best interests meetings when required.

Staff said and records confirmed that they had received training on the MCA and DoLS and understood how they needed to work within the principles of the legislations. We saw records of DoLS authorisations having been obtained and when they had been renewed following review.

People were supported to eat and drink sufficient amounts to maintain a balanced diet. People told us they were pleased with the meals provided at the service. One person said, "The food is quite nice, I do like a nice curry; curry is on the menu." Another person said, "There is a variety of meals, if you don't want what is on the menu you can have something else."

We observed staff serving the lunchtime meal to people that remained within the main lounge area. People were given sufficient time to eat, and staff offered full assistance for people to eat and drink where

necessary. The staff told us they knew what types of food people liked. One staff member told us, "We get to know what people like and don't like. We can provide lots of different meals to suit people's likes."

We observed people's care records contained details of their dietary likes and dislikes. If people had difficulty with food and fluid intake they were closely monitored. If needed people had access to the Speech and Language Therapist (SALT) and the dietician. Within the care plans we saw there was information on people's dietary needs, which included food allergies. Records demonstrated that people were weighed as needed and nutritional screening was reviewed monthly or when changes occurred.

People had access to the GP and were supported to attend health appointments when required. One person said, "I do see the doctor when I need to." People and their relatives told us that their health care appointments were co-ordinated by the staff; who would accompany them. Records demonstrated that people's healthcare needs were regularly reviewed. We saw there was a good range of physical health assessment tools used such as the Waterlow for Pressure Sores and records showed that physical observations were regularly checked

Requires Improvement

Is the service caring?

Our findings

We found mixed approaches to interaction with people from the staff team. People told us about and we saw occasions where staff interacted positively with regard to people's well-being, for example by offering choices. However, staff practices were inconsistent. We found the approach to the meal at lunch time was more task focused rather than person centred. For example the meals were brought to people on plates and when staff gave people their meals they said, "Here is your food," without explaining what the meal was or what it consisted of. This approach did not support people with impaired cognition such as people living with dementia, to be orientated as to what food they were about to eat. Opportunities to make the mealtime experience more enjoyable for people were not utilised. We brought our observations to the attention of the deputy manager, as an area for further service development.

The staff had a good knowledge of people using the service and they were able to explain the care they provided for people. We saw that some staff had positive interactions with people, sitting beside people, holding conversations, smiling and laughing with people. However we also saw one person who was on a one to one with a staff member. We saw that the member of staff stood behind the person who was sitting in a chair. There was minimal engagement with the person and whilst this was not done with intent, their stance had the potential to be perceived as intimidating and unwelcoming.

People spoke in a positive way about the staff and the care they received. One person told us, "The staff are very good. They help me a lot." Another person commented, "The staff are friendly and you can have a joke with them."

One member of staff said, "I really love my job, I enjoy helping people, it's nice to do a job where you are appreciated." Another member of staff told us , "I find working here very rewarding, when I see people smile at me, it makes me feel I have done something to help them feel relaxed and at ease with me." A third member of staff commented, "I am here to care for people, it's what I like doing."

We did see some examples of staff providing care in a way that was considerate and caring. We saw some staff had a good relationship with some people and conversation between they led to smiles and laughter. One person told us, "They [staff] don't rush me when they are helping me".

People were supported to make choices on aspects of their daily routine; their daytime activities or their food preferences. One person told us, "They always ask me what I would like to eat." Staff told us and we observed that they consulted people about their daily routines and activities. Records seen confirmed that people and their relatives were involved in the care planning process to ensure that the care provided met their individual needs.

All the staff we spoke with confirmed that people where possible people had been involved in making decisions about their care and support needs. One staff member explained, "We do talk with people about their care and when the person is able, we discuss the care plans with them." We saw evidence within the care plans we examined that people's changing needs and wishes were closely monitored on a regular

basis. Any changes that were needed were carried out in a timely manner.

Staff told us that people's privacy and dignity was promoted and they were able to demonstrate how they supported people to uphold their dignity. One staff member said, "We always try our best to treat people with respect." Staff told us that people received personal care in private; and chose what clothes they wished to wear and how they preferred to be addressed.

We observed staff treating people with respect and maintaining their privacy. For example, we saw that staff knocked on people's doors before entering. We also saw that staff asked people for their consent before they undertook any tasks and made sure they used people's preferred term of address.

People felt assured that information about them was treated confidentially and respected by staff. Staff told us that the service had a confidentiality policy which was discussed with them at their induction and they had signed an agreement to adhere to it. One staff member said, "Sometimes confidentiality is discussed at supervision and staff meetings." We saw evidence that the service shared information about people on a need to know basis and with their agreement. We found that records relating to people's care and support were stored securely in filing cabinets. Computers were password protected to maintain confidentiality.

Good

Is the service responsive?

Our findings

People's care and support needs were assessed before they were admitted to the service, to ensure the service could meet their needs. The assessment included identifying the staff support people required and if risk assessments or additional equipment would be required to meet their needs. One person told us, "We did get asked lots of questions and staff seemed to want to know about what I wanted."

Staff told us that where possible people were involved in their care. One told us, "We make sure we get as much information as we can right from the start. We always try to involve families as well." Staff also explained that people and their relatives were encouraged to visit the home or to stay for lunch to ensure they service was right for them.

Holistic care needs were identified and care plans regularly reviewed for each individual which described their care and support needs. Care plans contained information about people's medical and health needs. The plans were relevant to each person and contained guidance for staff on how people liked their care to be given and provided descriptions of people's daily routines

An activity person was employed at the service and we saw daily group activates took place along with individualised one to one activities of people's choice. Photos were on display depicting the activities people had been involved with. On the day of the inspection we saw that group activities were being facilitated by the activity person. Visits took place by external activity facilitators, such as the pets for therapy service (PAT) and musical entertainers.

People had made close friends and liked to go outside to the smoking area together to enjoy having a cigarette. One person said, "It's okay here, I feel I can do pretty much what I want." Another person told us they were planning on taking up some voluntary work, they said, "I like to help people, I help out with doing the teas and coffees and the washing up." This person also said they were looking forward to a trip to see the Emmerdale television series production set. People also told us they liked to go out for pub lunches and shopping.

We saw people engaging in hobbies of their choosing, for example, one person was an avid book reader and had several novels beside them that they were working their way through, another person liked to colour in pictures and another enjoyed crocheting.

All of the people we spoke with said they had never had cause to complain about their care. They told us if they unhappy with any aspect of their care they would speak directly with the deputy manager or the registered manager. People knew how to make a complaint and were confident that any complaints would be acted upon. One person told us, "I have never needed to make a complaint but I would if I had to."

People were provided with information to tell them what to do if they wanted to complain. This information was also made accessible to visitors and relatives in the main lobby of the home. We saw that the complaints procedure was also available in pictorial form for people who needed extra support.

Where complaints had been received these had been appropriately investigated, responded to and action taken to resolve people's complaints. There were arrangements in place to record complaints that had been raised and what action had been taken about resolving the issues of concern.

Requires Improvement

Is the service well-led?

Our findings

Since the last inspection the provider had informed the Care Quality Commission (CQC) that the registered manager had left the service and a new manager had been appointed. We were told by the director of operations that they were in the process of registering with the Care Quality Commission (CQC). The manager was not available on the day of our visit and we were supported with the inspection by the deputy manager and the operations manager.

We found that some of the audits in place did not always identify areas for improvement. Despite monthly medication audits taking place, these had failed to identify some of the issues we found in relation to medication practices. Therefore, the systems in place were not always used as effectively as they could have been.

We observed some areas of staff practice that did not always treat people with dignity and kindness. We observed many staff interactions were task focused. We also saw a record of a clinical observation of one nurse who was undertaking a medicines round. This had identified several areas of poor practice but we were unable to find what actions had been taken as a result. Management systems had failed to identify poor staff practice and take actions to drive improvements at the service.

People said they knew who the manager was and they felt comfortable approaching them to discuss anything. Staff were positive about the leadership and management at the service. They felt they were well trained and supported in their roles. Staff were also confident if they raised concerns in relation to poor practice they would be listened to. One staff member told us, "I would be more than comfortable raising any concerns. I know that any concerns I raise would be taken seriously and dealt with properly." Staff told us they would be happy to question practice and were aware of the safeguarding and whistleblowing procedures. Staff confirmed that they understood their right to share any concerns about the care at the service.

There were internal systems in place to report accidents and incidents. The deputy manager was aware of the need to report certain incidents, such as alleged abuse or serious injuries, to the Care Quality Commission (CQC), and had systems in place to do so should they arise.

There were quality assurance systems in place to carry out checks as the service developed. We were told that satisfaction surveys and internal audits to ensure paperwork was up-to-date and the service was operating in accordance with their policies and procedures were in place. We saw evidence of care plans being reviewed regularly and there were systems in place to monitor other areas of performance, such as staff supervision and complaints. Action plans were devised where it was identified improvements could be made in service provision.

The service had policies and procedures in place which were comprehensive and had been updated when legislation changed. Staff said policies and procedures were available for them to read and they were expected to read them as part of their induction and when any had been updated. Their understanding was

checked regularly in respect of key policies such as safeguarding, whistleblowing, mental capacity and administration of medicines. These were discussed during supervisions and staff meetings.

Information held by CQC showed that we had received all required notifications. A notification is information about important events which the service is required to send us by law in a timely way. Copies of these records had been kept.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medication systems were not consistently followed to ensure people received their medicines as prescribed. Medicines were not always administered safely and medication records were disorganised and did not always record people's medicines clearly.