St. Martins Care Home for the Elderly Limited

St Martins Care Home For The Elderly Limited

Inspection report

22 Feckenham Road
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Redditch
Worcestershire
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Tel: 01527544592

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29 April 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21 September 2015. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Need for Consent.

After our inspection on 21 September 2015 we received concerns in relation to how people were supported to maintain their safety.

We undertook a focused inspection on 28 April 2016 to look into these concerns and also to see if they had followed their plan and now met legal requirements. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Martins Care Home For The Elderly Limited on our website at www.cqc.org.uk

The provider is registered to provide accommodation and care for up to 15 older people who may have support needs owing to physical disabilities and sensory impairment. There were 15 people living at the home at the time of our inspection.

A registered manager was in post at the time of 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.

At this focused inspection we found the provider had followed their plan and they now met the legal requirement in relation to Need for Consent.

We found there was potential risk people's rights to liberty would not be protected as the staff did not understand the processes they needed to follow to make sure people's rights were promoted. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment, 13, (2), (5) and 7(b).

We found people's safety needs were considered by the staff, who understood what actions to take in order to promote people's safety. Staff worked with other organisations, such as the local authority, so plans were put in place to keep people safe. We saw the registered manager had made checks before new staff started to care for people so they could be assured new staff were suitable to care for people. We found we had not consistently received information about incidents which affected people's safety. We discussed this with the registered manager, who then sent the information to us without delay.

You can see the actions we have asked the provider to take at the end of this report. We will follow up on the action we have told the provider to take at our next comprehensive inspection to make sure improvements are made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe because of the actions staff took to care for them. Checks on the suitability of new staff were undertaken so the registered manager had assurance staff were suitable to work at the home and provide care to people. The registered manager worked with other organisations and plans were put in place to promote people's safety.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We found actions had been taken to meet the legal requirements in respect of obtaining and acting in accordance with people's consent in relation to the care and treatment provided for them.

We found there was potential risk people may be deprived of their liberty unlawfully as legal authority to do this had not been sought, where the provider's assessment told them this was required.

St Martins Care Home For The Elderly Limited

Detailed findings

Background to this inspection

We undertook an unannounced inspection of St Martin's Care Home for the Elderly on 28 April 2016. This inspection was done to check that improvements to meet legal requirements planned by the registered manager after our comprehensive inspection on 21 September 2015 had been made.

We had also received concerns about how people were supported to maintain their safety. We inspected against two of the five questions we ask about services; 'Is the service safe' and 'Is the service effective?' This is because the provider was previously not meeting some legal requirements in relation to how effective the service was and because of the concerns we had received about how people were supported to maintain their safety.

The inspection team consisted of one inspector.

We checked the information we held about the provider and services at the home. This included notifications about people's safety. A notification is information about important events which the provider is required to send us by law. We contacted the local authority to gain their view of the quality of the service provided by staff. We also contacted Healthwatch. The local authority has responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care. We used this information to focus our inspection.

We met with people who lived at the home and spoke with five people. We spoke with a visiting friend of a person who lived at the home during our inspection. No relatives were visiting the home during our inspection, so we spoke to three relatives by telephone after our inspection. We saw the care and support offered to people for part of the morning and during the afternoon. We spoke with the registered manager and two staff.

We looked at four people's care records and records about people's safety. We also saw the checks the registered manager had made before new staff came to work at the home.

Good

Is the service safe?

Our findings

Before our inspection we had received some concerns about the way people's safety was managed and wanted reassurance actions were taken to keep people safe. These included concerns checks were not made before new staff started their employment to confirm they were suitable to care for people living at the home. We had also received concerns the registered manager had not advised and worked with other organisations where required so people's safety would be promoted.

The registered manager had assured themselves new staff were suitable to work with people living at the home. We saw the registered manager had checked with the Disclosure and Barring Service, (DBS). The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who need care. We also saw the registered manager had obtained references for potential staff, to obtain additional assurance about potential staff before staff started to work with people.

We talked to people, their relatives and the registered manager and staff to find out how people's safety was managed. We also spoke with local authority staff who have responsibilities for keeping people safe. The registered manager had taken the action necessary to work with the local authority when needed so people's safety needs would be met.

We talked with the registered manager about actions taken to notify us about any concerns they had for people's safety. We found there had been two occasions in the previous twelve months where the notification required to advise us of concerns for one person's safety had not been sent to us. We saw the registered manager had taken action to promote the people's safety on both occasions. This had included working with the local authority so plans were put in place to promote people's safety. The registered manager explained they had not understood reporting requirements for these concerns and sent the notifications to us without delay.

Three people we asked who lived at the home told us the actions staff took made them feel safe. One person told us, "I was worried I might fall, but staff are so good and help me." Another person we spoke with said they felt safe because of the staff and said, "Staff are marvellous." A third person we spoke with told us they felt safe, as they got on well with staff.

We spoke with three people's relatives and one person's visitor. Each of the relatives and the person's visitor told us they had no concerns for people's safety. One relative told us, "Some of the carers have a good rapport with [person's name]. They know how to talk to [person's name] and what's best to make them feel more settled." This relative told us staff had taken action to improve their family member's well-being, and their anxiety had reduced. The relative told us "This means [person's name] is no longer frightened." A second relative told us, "Staff keep [person's name] as safe as he can be." The relative explained staff had found out about some of the things which made their family member anxious. The relative told us how staff had taken action and supported their family member in ways which helped to reduce the anxiety they felt. The relative told us staff, "Try to keep [person's name] on safe things. Staff care for him very well."

Another relative told us how staff had made sure their family member had the right equipment to make them safe, and told us, "I have no safety concerns for [person's name]." The relative went on to explain their family member's GP had suggested she went into hospital, and said, "[Person's name] preferred to stay at St Martins. She seems happy there." The relative told us staff had taken action to promote their family member's safety as their needs changed, and had been involved in the decision to move their family member to a room which was more suitable to their needs.

Staff told us they knew how to raise concerns for people's safety with the registered manager, the local authority and CQC. We talked with staff about how concerns for people's safety were managed. Staff told us they were aware the registered manager took action to keep people safe.

Requires Improvement

Is the service effective?

Our findings

At our previous comprehensive inspection on 21 September 2015 we found the provider was not meeting the law in respect of obtaining people's consent and that people's capacity to consent to care had not been reviewed over time.

At this inspection, we found the provider had taken action and the legal requirement was now met. This was because people told us staff checked they were happy to receive care and respected their right to refuse care. People told us they made their own day to day decisions and they were able to make choices about things which were important to them. We also saw staff obtained people's consent before supporting them. People's care records we checked showed staff had checked people's capacity to consent to care over time.

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 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit application to a "Supervisory Body" for authority to do so.

We checked whether the service was working within the principles of the MCA. We looked at the systems the provider had in place to assess whether they needed to make any applications to lawfully deprive a person of their liberty. We checked the provider's assessment for one person. The provider's assessment told them they needed to make an application to lawfully deprive the person of their liberty. No application had been made for this person. The registered manager told us the provider's assessments for two other people also told them they should make applications to lawfully deprive these two people of their liberty. The registered manager confirmed applications had not been made to the supervisory body for the three people where the provider's assessments told them this should be done. The registered manager told us they had not understood the results of their assessments told them they should make applications to lawfully deprive people of their liberty. This showed there was a risk people would potentially be deprived of their liberty when this was not lawful.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment, 13, (2), (5) and 7(b).

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.

Staff told us they had received training so they knew how MCA affected the way they needed to support people to make their own decisions and promote their rights. We saw staff supported people to make their own decisions. This included making sure people had enough time to consider their options and by staff checking people's reactions to the choices offered, when people did not communicate verbally. The registered manager told us additional staff training was planned to further develop their own and staff

knowledge about the way MCA affected how they needed to care for people. This was planned so potential risks of failing to comply with the laws to protect people's rights would be addressed.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was potential risk people may be deprived of their liberty unlawfully as legal authority to do this had not been sought, where the provider's assessment told them this was required.