Valorum Care Limited

St Anthony's - Care Home with Nursing Physical Disabilities

Inspection report

Stourbridge Road
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17 August 2023
22 August 2023

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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 Anthony's – Care Home with Nursing Physical Disabilities is a nursing home providing personal and nursing care to up to 34 people. At the time of the inspection, there were 26 people using the service. The service provides support to people with neurological and mental health conditions and people living with physical and learning disabilities in a purpose-built building.

People's experience of using this service and what we found
Right Support: People told us they felt safe when having their care needs met by experienced staff but did not always feel safe when supported by newly recruited staff who they did not consider to be competent. For example, despite staff having completed moving and handling training, people told us new staff were not always competent in supporting them with hoisting. People's medicines were not always stored and administered safely. We found examples of missed medicines and recording errors which meant people's medicines were not always being administered as prescribed. Risks were not always managed safely. For example, staff told us they had undertaken a clinical task without training as they did not have time to wait for a nurse. Accidents and incidents were recorded but the provider could not be assured that action was always taken as forms weren't always completed in full. Staff underwent stringent recruitment checks prior to employment but this did not always ensure they had adequate skills and competence to meet people's needs safely. Staff understood how to report abuse and safeguarding referrals were made when required. The home was clean, and staff had been trained in Infection Prevention and Control (IPC). However, the provider could not be assured staff always understood the training as staff told us of instances where the IPC policy had not been complied with.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care: Care was not always person centred. People told us they did not always feel safe when their care was provided by newly recruited staff who were not sufficiently competent in the English language to understand and meet their needs. People told us experienced staff at the home made them feel safe and were able to meet their needs in a way they preferred.

Right Culture: The registered manager did not promote a person-centred culture throughout the home. Staff morale was low, and staff did not feel supported by the registered manager. People and relatives were aware of the low staff morale which did not support people to be empowered. People were not always asked for feedback regarding the care received and staff felt they weren't involved or asked for feedback regarding the home. Systems in place to check the quality of care provided at the home were ineffective and failed to ensure concerns were identified and addressed. The provider had taken action following the inspection to address some of the concerns raised and improve the culture at the home.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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 good (published 28 July 2021).

Why we inspected
We received concerns in relation to medicines administration, the management of risk and governance. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Anthony's - Care Home with Nursing Physical Disabilities on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing and the governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

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 Anthony's - Care Home with Nursing Physical Disabilities

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. 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.

Inspection team
The inspection team consisted of 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
St Anthony's – Care Home with Nursing Physical Disabilities is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Anthony's – Care Home with Nursing Physical Disabilities is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this

location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, following the inspection, the provider informed us the registered manager was no longer in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 17 August 2023 and ended on 24 August 2023. We visited the location's service on 17 August and 22 August 2023.

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 professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the site visit, we spoke with 8 people who lived at the home and 1 relative. We spoke with 9 staff in detail including team leaders, nurses, care staff, housekeeping and kitchen staff. We spoke with 2 other staff members but they had difficulty with understanding us due to their English language skills so we were unable to continue these discussions.

We also spoke with the registered manager, head of quality, operations manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Following the site visit, we also spoke with 2 additional relatives by telephone.

We looked at 8 people's care records and 14 people's medicine administration records (MARs). We also viewed 4 staff files and documentation related to the governance of the service.

The provider sent us further documentation we had requested following the site visit including audit documentation and evidence of staff feedback forms and relative meetings.

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 our last inspection we rated this key question good. At this inspection the rating has changed to 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

● Care plans and risk assessments were in place to guide staff how to manage clinical risk to people. However, staff told us they did not always have time to read them. One staff member told us, "The last time I read a care plan was quite a while ago as we haven't got the time." Staff knowledge of people's risks and needs was inconsistent and they were not always able to tell us about how to support them safely. This meant people were placed at risk of receiving care that did not meet their needs safely.

● Risk assessments were not in place to manage the risk of employing staff who did not always have adequate English language skills to meet people's needs safely. This meant risk had not been sufficiently mitigated and people were placed at risk of harm.

● People told us some staff did not support them with moving and handling safely. One person told us, "The new staff don't know how to use the stand aid properly, so I don't feel as safe with them." Another person told us, "The new staff don't know how to hoist. They have to get the others. Sometimes I feel safe and sometimes they don't put the belt on properly. When it's the new staff it hurts when they don't put the belt on properly." Despite this, people told us they felt safe when being supported by experienced staff at the home.

● Two care staff told us they had removed people's percutaneous endoscopic gastronomy (PEG's) on occasions as they were waiting too long for nursing staff to do this. We discussed this with the registered manager who confirmed care staff had not been trained and should not be doing this. This placed people at risk of harm.

● Accidents and incidents were recorded. However, the provider could not always be assured these had been followed up to reduce the risk of reoccurrence as forms had not always been completed in full.

Using medicines safely

● People's medicines were not always stored safely. For example, medicine storage rooms and fridge temperatures were not always recorded so the provider could not be assured that medicines were stored at a temperature that preserved their efficacy. This placed people at risk of harm.

● People's medicines were not always administered safely and as prescribed. One person told us, "They occasionally offer me the wrong medication. It happened a few days ago and it's happened on more than one occasion. I always refuse."

● People told us there had been occasions where medicines had not been administered to them. Medicines stock counts did not always reflect people's Medicine Administration Record (MARs). This meant the provider could not be assured medicines had been administered as prescribed which placed people at risk of harm.

● Protocols were not always in place to guide staff when to administer 'when required' medicines. This

meant these medicines may not be administered when needed which placed people at risk of harm.
● Where people were prescribed 'when required' medicines, MARs showed they were sometimes administered as regular medication but the reason for administration was not always recorded. This meant people may have been at risk of being over medicated.
● Staff did not always record where transdermal patches had been applied which meant the provider could not be assured patches were being applied safely in line with guidance to different areas of the body.
● People told us their medicines were not always administered on time. We checked MARs and found where a person had received their medicines late, it was recorded this was due to a second staff member not being available. We found no evidence any action was taken to address this and reduce the risk of reoccurrence.

Systems had not been established to ensure people received safe care and treatment. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People were not always supported by a sufficient number of competent staff to meet their needs safely. One person told us, "The member of staff wanted to do everything themselves as they didn't have the confidence in the agency staff, so I had to wait till half past midnight to go to bed."
● Staff told us there were a sufficient number of staff but as not all staff were competent, this impacted on their response times to people. One staff member told us, "If staff were trained properly, we'd have enough staff."
● People told us they sometimes had to wait for their care needs to be met. One person told us, "Sometimes I have to wait a while for my buzzer to be answered so I think we may need more staff". We checked the call bell audit, but the registered manager told us response times were not accurate due to an issue with the internet connection. The registered manager confirmed no other checks were undertaken to assure themselves of staff response times.
● Where staff were recruited from overseas, the provider completed stringent recruitment checks to assure themselves staff were competent and able to meet people's needs safely. However, the induction process was not effective in ensuring staff had the language skills and competence to meet people's needs safely. The provider told us they had taken immediate action to check staff competency and reduce the risk of harm to people.

Systems had not been established to ensure a sufficient number of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs safely. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were required to have satisfactory Disclosure and Barring Service (DBS) checks or police certificates for overseas staff prior to starting their employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● People told us they did not always feel safe when supported by newly recruited staff. One person said, "I don't feel safe here."
● People told us there were barriers in communication with some staff which made them feel unsafe as staff were not always able to understand or meet their needs safely.
● Relatives told us they felt people were safe but had concerns regarding the competency of newly recruited

staff. One relative told us, "I do feel [my relative] is safe. I am concerned about the level of knowledge, training and level of language of the new staff." One relative told us, "I feel it may be unsafe going forward if we lose the long term staff because of morale."
● People told us they felt safe when they received support from experienced staff who were able to communicate with them effectively.
● A safeguarding policy was in place which was followed by staff. Staff knew the types of abuse and how to report safeguarding concerns. One staff member told us, "I have had safeguarding training. If I observed abuse, I would go to a team leader, if not my line manager. If I didn't want to raise with my manager, I could go to safeguarding or CQC."
● Safeguarding referrals had been submitted when needed.

Preventing and controlling infection
● People were supported by staff who had completed infection prevention and control training. However, the provider could not always be assured all staff understood and complied with this.
● Staff members told us a colleague had failed to change their PPE between supporting someone with personal care and eating and drinking. They also told us the staff member had disposed of bodily fluids in a way that placed people at increased risk of infection. We spoke to the registered manager about this who confirmed this had been addressed through supervision with the member of staff.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Visitors were permitted to enter the home in line with current government guidance.
● Visiting times were unrestricted and visitors could access the home when they wished.

Learning lessons when things go wrong
● The provider did not always learn lessons when things went wrong.
● Where a high number of medicines errors had occurred, adequate changes were not made to systems to reduce the risk of reoccurrence.
● Where concerns had been raised regarding the language skills of some staff members and the impact this was having on the care people received, the provider failed to take adequate steps to address this.
● The provider has taken immediate action following the inspection to address the areas of concern raised and learn from where things have gone wrong.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

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 our last inspection we rated this key question good. At this inspection the rating has changed to 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

- The registered manager told us they were not up to date with quality monitoring checks. This meant they had insufficient oversight to ensure risks to people were identified, managed and mitigated effectively.
- Systems in place to check staff were sufficiently skilled and competent to meet people's needs safely were ineffective. For example, the provider failed to identify that the English language skills of some staff were insufficient to communicate effectively with people and meet their needs. This placed people at risk of harm.
- Systems in place to check the quality of the service were not always effective in identifying concerns. For example, medicines quality checks were ineffective and failed to identify errors and reduce the risk of repeated medicines errors related to storage and administration. This placed people at risk of harm.
- Quality checks of people's care files did not always identify where documentation was inconsistent. This placed people at risk of harm as staff would not always know which documentation was up to date and should be followed.
- The provider failed to identify where risk assessments were insufficient to mitigate risk to people. For example, risk assessments were not always in place to manage risk related to people's clinical needs or to manage risk related to the employment of staff where English was not their first language.
- The provider did not have sufficient oversight to know when staff were undertaking tasks they were not trained to do so. This placed people at risk of harm.
- Staff supervision was not effective in ensuring staff were adequately skilled and competent to meet people's needs.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Statutory notifications were submitted to CQC when required.
- The nominated individual was clear about their role and the improvements that were required to ensure greater oversight at the home and took immediate actions to implement changes following the inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People told us they did not always think the home was well led. One person told us "I don't think it's well

managed. There are so many people who can't do their job."
● Systems in place were not always effective to ensure staff were able to meet people needs in a person-centred way that enabled them to achieve good outcomes. For example, people were supported by staff who were not always able to fully understand them and meet their needs as they would like. One person told us, "The overseas staff don't understand English, let alone my [medical condition]. They don't know how to care for me."
● The registered manager did not always speak about people in a way that was inclusive and empowering. For example, the registered manager used an inappropriate and derogatory term towards a person supported at the home during the inspection.
● Staff told us the morale in the home amongst staff was negative. One staff member told us, "The staff morale is non-existent. If you have no staff morale, you've got nothing."
● People and relatives told us there was a poor culture at the home. One person told us, "All our old staff are losing their temper with the new staff."
● Staff did not feel supported by the registered manager and did not feel confident that any concerns would be acted on.
● Following the inspection, the provider took immediate action to speak with staff to gather feedback and make changes to improve morale at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People told us they were not always given the opportunity to provide feedback regarding their care. The registered manager told us they would be implementing residents' meetings to enable people to engage more. However, the provider shared a resident survey with us that had been completed in July 2023.
● The provider had undertaken staff surveys to gather feedback regarding the home. The feedback was compiled so analysis of the feedback received could be undertaken. The provider took immediate action following the inspection to act on the feedback received.
● Staff told us supervisions were not effective in involving them regarding the service. One staff member told us, "We have supervisions every 3 months. It's just paperwork, no-one looks at it and nothing is done if we bring a concern up."
● Relatives meetings were held to enable relatives to provide feedback regarding the home.

Continuous learning and improving care
● The provider had made significant changes to quality assurance to give accountability to the registered manager at the home rather than quality checks being undertaken centrally. However, these arrangements had not yet been embedded and were not always being applied consistently or effectively.
● The provider took immediate action following the inspection to increase the input provided by senior managers to improve care at the home.

Working in partnership with others
● The provider worked closely with professionals including Speech and Language Therapists (SALT) and occupational therapists to ensure people received the support they needed.
● The provider had been engaging with the local authority quality team to improve the level of care provided at the home.

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
● The registered manager understood the duty of candour.
● Where things went wrong, the provider was open and transparent. For example, where someone had a

fall, relatives were contacted to let them know what had happened and what action had been taken.

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 18 HSCA RA Regulations 2014 Staffing Systems had not been established to ensure a sufficient number of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs safely. This placed people at risk of harm.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems had not been established to ensure people received safe care and treatment. This placed people at risk of harm.

The enforcement action we took:

We served a warning notice and asked the provider to evidence how they had made improvements to evidence compliance with the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

The enforcement action we took:

We served a warning notice and asked the provider to evidence how they had made improvements to evidence compliance with the regulation.