

Mrs L Whitehouse

St Brigas Residential Home For Adults with Learning Dissabilities

Inspection report

St Brigas
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11 April 2018

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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?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

St Brigas is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St Brigas provides accommodation and personal care for up to 17 people with learning disabilities. At the time of the inspection there were 16 people living at the home. We undertook this unannounced inspection of St Brigas on the 9 and 11 April 2018.

The care service is not in line with the values that underpin the Registering the Right Support and other best practice guidance. This is because the service is currently registered for 17 people which is over our best practice guidance of registering six people or less.

At the last inspection the service was rated as Requires Improvement. At this inspection we found the service remained Requires Improvement.

At our last comprehensive inspection we found two breaches of legal requirements. We used our enforcement powers and served a Warning Notice on the provider following this inspection. This was a formal notice which confirmed the provider had to meet the legal requirements. We followed up this warning notice and found some improvements had been made but there was still a breach of legal requirements. At this inspection we reviewed these breaches and found improvements had been made in following the principles of the Mental Capacity Act. However quality assurance systems had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of service users which arise from carrying on the regulated activity.

There was a registered manager in post. 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.

People could be at risk of cross infection, due to lack of liquid hand soap and paper towels at the point of care.

Environmental risks to people posed by hot surfaces and the lack of checks to hot water temperatures were not managed in line with the Health and Safety Executive's guidelines.

People received their medicines when required although medicines were not always stored at the manufacturer's recommended temperatures. Medicines records did not always reflect the person had received their topical medicines and medicated toothpaste as required.

People's care plans contained guidelines for staff to following relating to people's individual needs and risk assessments were in place.

People were support by staff who had suitable checks prior to working with vulnerable people.

People were supported by staff who were able to identify abuse. People and relatives felt staff were kind and caring and relatives felt able to visit whenever they choose.

People were supported by staff who had received supervision and an annual appraisal and training to ensure they were competent in their role. Staff and relatives felt able to raise any concern with the registered manager and that they were approachable.

Staff demonstrated how they provided people with privacy and dignity.

Care plans had important information relating to people's individual needs, although information could be recorded about people's individual end of life wishes.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

People and staff could be at risk of cross contamination due to poor hand washing facilities within people's rooms.

The lack of hot water temperature checks and uncovered radiators placed people at risk of harm

Medicines were not always stored safely and records did not always confirm people had received their topical medicines and medicated toothpaste as required.

People's care plans contained guidelines for staff to following including risk assessments.

People were support by staff who had suitable checks prior to working with vulnerable people.

Is the service effective?

Good ●

The service was effective.

Where people lacked capacity to make decisions the service followed the principles of the Mental Capacity Act.

People were supported by staff who had received training and who felt well supported through supervisions and an annual appraisal.

People had their individual nutritional needs met including those who required a special diet.

Is the service caring?

Good ●

At this inspection the service remained caring.

Is the service responsive?

Good ●

At this inspection the service remained responsive.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

The provider's quality assurance systems had failed to identify and mitigate risks relating to the health, safety and welfare of service users which arise from the regulated activity.

People, relatives and staff spoke positively about the management and culture of the home.

People views were sought with questionnaires and resident meetings.

Staff had regular meetings with the management of the home.

St Brigas Residential Home For Adults with Learning Dissabilities

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 9 and 11 April 2018 and was unannounced on the first day. It was carried out by one adult social care inspector and an expert by experience on the first day and one adult social care inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with ten people. Four people were able to give us their views. We sought views from three relatives and managed to gain views from two. We also spoke with the registered manager, the manager along with the handyman, chef and three care staff.

We looked at four people's care and support records and two staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies and procedures, audits and complaints.

Due to some people at the home being unable to tell us of their care experience we used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks

the provider to give key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us.

Is the service safe?

Our findings

The environment was not always safe due to the provider not monitoring, assessing and mitigating risks relating to health and safety and people's individual risks. This was due to the hot water temperatures not being checked to ensure they were within current guidelines to reduce the risk of scalding to people. The Health and Safety Executive guidelines state hot water temperatures (particularly temperatures over 44°C) can create a scalding risk to vulnerable people who use care services. Records confirmed on one occasion that the inlet and the outlet were both 45°C. The home's risk assessment confirmed, 'Water temperatures should not exceed 43°C'. It also confirmed, 'Monthly checks of water temperatures outlets' should be checked. This meant during the inspection we found baths, sinks and shower temperatures were not being checked in line with the provider's risk assessment. Staff confirmed they did not check people's water temperatures prior to showering or bathing them. People could be at risk due to hot water outlets not being checked.

People could be at risk of a burn injury due to no bedroom radiators being covered and a lack of suitable measures to manage these risks. People's beds were situated close to these radiators and posed a burning risk where the person was unable to react quickly to a hot surface. There were no risk assessments that identified the risk to the person should they fall, roll or lean against the radiator when it was hot. The Health and Safety Executive guidelines confirm, 'Serious injuries and fatalities have also been caused by contact with hot pipes or radiators. Where there is a risk of a vulnerable person sustaining a burn from a hot surface, then the surface should not exceed 43°C when the system is running at the maximum design output. Precautions may include insulation or providing suitable covers.

This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of cross infection due to inadequate hand washing facilities within people's rooms. For example, care staff confirmed most people within the home required support and assistance from staff with their personal care. Standard infection control methods included care staff wearing personal protective equipment such as gloves and aprons and being able to wash their hands after supporting the person with personal care. We found where staff were supporting people with personal care staff had no access to liquid hand soap and paper towels. We also found there was no suitable bin for staff to put used paper towels in. People had no hand soap or towels to wash and dry their hands following using the toilet. Three people's taps had been disconnected and were unable to be used. There was no available risk assessment that identified the risk to why taps had been disconnected. Following the inspection the registered manager confirmed risk assessments were now available in people's care plans. There was no other suitable arrangement to enable people to wash their hands. This is important as by having adequate hand washing facilities prevents the risk of cross contamination of infections. This meant people and staff were touching various door handles in between. This was an infection control risk due to other people, staff and visitors within the home being exposed to cross contaminated door handles. The provider was not ensuring risks which arise from carrying on the regulated activity were being assessed, monitored and mitigated.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff to receive their medicines safely and when required. Medicines were not always stored within optimum temperature range and medicines administration records (MARs) did not always confirm the person had received their topical medicines and medicated toothpaste as required. For example, during the inspection we found various medicines required storage below 25°C. The records confirmed four days out of nine that the medicines had been stored above this optimum temperature. The medicines were being stored in a trolley in the conservatory during the day and were likely to be exposed to an increased risk of rising temperatures.

Where people required topical medicines to be applied to their skin and medicated toothpaste, MAR charts did not always confirm people had received their medicines as required. The shift leader confirmed they were encouraging staff to record when creams and toothpastes had been administered. However during the inspection we found various missing signatures that did not confirm the person had received their medicines as required.

People who required their medicines to be administered 'given in food' had records in place. Records confirmed who had been consulted with and any guidance sought. This was also confirmed in people's care plans. Staff had received training in administering medicines safely. Staff were assessed as competent at administering medicines prior to being given this responsibility.

People were supported by staff who had checks completed on their suitability to work with vulnerable people. Staff files confirmed checks completed including Disclosure and Barring Service (DBS), identification checks and reference checks. All were undertaken prior to staff starting their employment. A DBS check helps providers make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable people.

People were supported by staff who felt the home was safe. Staff were able to demonstrate a good understanding of abuse and who to go to. Staff told us, "Safeguarding is about protecting vulnerable adults from risk of harm". Another member of staff told us, "Physical, mental, I would go to my manager, CQC or social services".

People had risk assessments completed within their care plan. This identified any risk and what measures were in place to reduce the risk. Risk assessments included allergies, nutritional risks and any individual needs the person might have.

People were supported by adequate numbers of staff to respond to their care needs. During the inspection we observed staff supporting people with their individual needs. When people required additional support the registered manager confirmed they were also available to support. We observed the registered manager helping staff during the inspection. The registered manager confirmed staffing numbers reflected the needs of the service on the day. This changed depending on whether people had planned activities.

Is the service effective?

Our findings

At the previous inspection, in October 2016, there was a breach in Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because where people lacked capacity to make specific decisions the principles of the Mental Capacity Act 2005 were not always being followed.

At this inspection we found improvements had been made although some people had no access to soap or running water to wash their hands in their room. Some people's hand taps were also disconnected. There was no Mental Capacity or Best interest decision in place that deemed this practice to be in the persons' best interest.

Where people lacked the mental capacity to fully consent to other aspects of their care the provider had followed the principles of the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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 had well documented processes for capacity assessments. This showed what area of capacity was being assessed and how the best interest decision had been made. Where best interest decisions were made these were decision specific. A best interest decision is relevant when people lack capacity to make decisions about the care and treatment they receive. Records also confirmed who had been involved including any significant other or health care professional.

People's health was monitored by an annual health check. Referrals were also made to a range of specialist health care professionals to make sure they received treatment as needed. This included dietitians, speech and language therapists, GP's, nurses and dentists.

During the inspection the shift leader confirmed where people had received a review of their health needs which had resulted in equipment being provided. We observed the person using this equipment which was to support their mobility whilst walking in the community. Records confirmed referrals made and the outcome including equipment issued.

People were supported to have their individual dietary needs and preferences met. Care staff and the chef knew people's individual likes and dislikes. The chef was able to confirm who had food allergies and specialist diets and confirmed these were respected and provided. During the inspection we observed people ask for their preferred meal choice. If this wasn't available an alternative was offered but an explanation was given as to the reason why it was not available. One person told us, "The food is lovely."

People were able to choose where they ate their meals. Most people eat their meals in the communal dining and conservatory area. Although some people chose to have their meals in their rooms. The lunch time experience was relaxed and people were asked by staff if they were happy with their meal and if they

wanted anything else.

People's care plans had important information relating to their individual dietary needs. For example, pictures supported staff to know what the person liked to eat, any food allergies and specialist diets. People's care plans also contained any specific equipment and guidelines for staff to follow when providing people with their meals. During the inspection we observed people have their meals provided as per their guidelines in their care plan.

People were supported by staff who had received training to ensure they had the skills and competence in their role. For example, staff had received training in; working with people in a person centred way, moving and handling, nutrition and hydration, infection control, safeguarding adults and administering medication. The training matrix confirmed what staff required refresher training and the office manager confirmed these training sessions were planned over the coming months. One relative told us, "Staff are very well trained."

Staff had received additional bespoke training so that they had additional skills and competency to support people's individual needs. For example, staff had accessed diabetes, autism, positive behaviour management, epilepsy and managing anaphylaxis. The registered manager also confirmed they had recently attended a positive behaviour management training course that they planned to share with staff so that staff received training that was individual and unique to the people they supported.

People were supported by staff who felt well supported and who had access to supervisions and an annual appraisal. Staff files confirmed staff had received supervisions and an annual appraisal. Supervisions were an opportunity for the manager and staff to meet and discuss, performance, changes to people's needs, record keeping, training needs and any other concern.

People were supported by staff with their individual communication needs. Not all people were able to verbally express their wishes. During the inspection we observed staff use various different methods to communicate to support the person in their communication. For example, staff used hand gestures and visual prompts to reply and communicate with people. People's care plans had important information relating to how the person communicated with staff and how the person might present themselves when they were wanting something. One relative told us they had a communication book that provided a clear record of what the person had been up to when they came to visit them.

Is the service caring?

Our findings

The service remained caring.

People and relatives felt staff were kind and caring. One person when we asked them what staff were like, they told us, "Good". Another person told us, "The staff are very good to me". One relative told us, "Staff are really amazing". During the inspection we observed staff treat people in a kind and caring manner. Staff spoke to people in a respectful manner that was inclusive and enabling. For example, staff asked people how they are? and talked about people's family members and friends. Staff demonstrated a helpful and cheerful approach with various conversations that were important to the person. Care staff addressed people either by their first name, or how the person chose to be addressed.

People's privacy and dignity was respected. Staff gave examples of how they supported people with their dignity and privacy. This included ensuring people were always dressed appropriately, bedroom and bathroom doors were shut when providing care along with curtains to maintain people's privacy. Staff also confirmed they would knock on people's doors before entering. Where conversations with people needed to be private these were held away from others that might be able to hear important information.

People were supported by care staff who were able to demonstrate an understanding of equality and diversity. One member of staff told us, "It is about choice and inclusion. Not to discriminate against race, beliefs, disability, religion, age and gender". Staff were respectful when talking about how they supported people with their individual needs. Another member of staff gave examples on how they individually supported someone with their individual characteristic. They confirmed it was about supporting the person with their own individual wishes in how they wanted to live their life.

People were encouraged to maintain their independence. People were able to walk around the building and communal areas of the home. Some people undertook daily living tasks such as shopping. Staff were able to support them with this task if required.

People were encouraged to maintain relationships that were important to them. During the inspection we observed people having visitors. The shift leader confirmed some people spent time with their families at weekends. This they felt was beneficial and something people looked forward to. Two relatives confirmed they were able to visit the home at any time and every time they visit they feel welcome. One relative told us, "[Name] comes home once a month. I can go and visit at any time". Another relative said, "We visit whenever we want and they are always happy to see us".

People were able to spend time in the communal areas or in the privacy of their own room. We observed people doing this throughout the inspection. People could sit in the dining area, conservatory, art room, or one of the two lounges.

Is the service responsive?

Our findings

The service remained responsive.

People were able to access a range of activities according to their individual interests. Some people had an individual activity timetable which was developed from knowing the person and what activities they enjoyed. The registered manager confirmed activities were important to people and that they aimed to provide an activity two week timetable for people. This included skittles, music and relaxation, cinema, art, shopping, hydro therapy, horse riding, cooking, massages and gym. Three people told us when asked about the activities, "I like everything". Another person said, "My favourite is going to McDonalds". Another person said, "I love my room, I watch TV in my room." One relative told us they felt the person had a meaningful life with lots of stimulation. They told us, "My (Name) gets lots of stimulation, such as making things and drawing. They also go to the theatre and discos."

During the inspection we observed people access some of these activities in the community. Although when we reviewed people's individual timetables the records for the care provided that day did not include if the person had received their activity or if they had refused and why. The registered manager and shift leader confirmed people were receiving their activities however by not having accurate records meant the service was unable to evidence this.

Care plans were personalised and individual to each person. Each care plan had specific likes and dislikes that helped inform staff about what the person liked to eat, important friends and family, their health needs, care and communication. People had their care plans reviewed monthly, records confirmed this.

No-one at the time of the inspection was on end of life care. People's care plans contained limited information relating to people's wishes. The registered manager confirmed they were in the process of reviewing this and had identified a lead member of staff who would be responsible for implementing this in people's care planning.

People were supported by the service to maintain relationships that were important to them. Staff confirmed people could visit and spend time with their relative's homes. Some people did this regularly and staff felt this was something people and their relatives looked forward to. People were able to spend time with friends and one person spoke positively about how they were looking forward to visiting their friend again very soon. People were also able to keep in contact with friends and family by phone calls and care staff confirmed that people could use the home's phone to call people or to take calls if they wished. One relative told us, "We speak regularly on the phone. I feel up to date with any changes".

People had access to a complaints policy. This was available in people's rooms and accessible to anyone should they raise a complaint at any time. There was an easy read version of the complaints policy which gave pictures that the person could tick or circle to answer if they were happy or sad about a situation. The registered manager had a complaints file that logged all complaints however no formal complaints had been raised since 2014. People and relatives that we spoke with were happy with the service. Relatives felt

able to raise any concerns with the care staff and the manager should they need to. One person told us, "If I'm not happy, I'd get upset, then I'd tell (my keyworker)."

People were supported by staff who responded and supported people when their health needs changed. This included, making referrals and arranging a medical review with a GP or a district nurse. Care records also confirmed visits by other health care professionals such as speech and language therapists, occupational therapists, dietitians, chiropodists and dentists. People's health action plans reflected people's individual health needs which were reflected in their care plans. If people's needs deteriorated including any visits to hospital they had a hospital passport which gave hospital staff important information relating to the support, health and any other care needs the person has.

Is the service well-led?

Our findings

At the last comprehensive inspection in February 2017, we found quality assurance systems were not identifying shortfalls relating to medicines management and people's care plans. Following this inspection we told the provider they needed to take action to ensure quality assurance systems were in place and issued a Warning Notice. We followed up this Warning Notice and found some improvements had been made although there were still areas the provider needed to improve on. At this inspection we found improvements had been made to the quality assurance systems although the audits in place had failed to identify shortfalls found during this inspection. The provider has been in breach of this regulation since July 2015.

During this inspection we found concerns relating to the environment due to the provider not monitoring, assessing and mitigating risks relating to health and safety and people's individual risks. For example, we found people and staff at risk of cross infection due to inadequate hand washing. There was no liquid hand soap or paper towels in people's rooms so that people and staff could wash their hands to prevent cross contamination. These shortfalls had not been identified through the cleanliness and housekeeping audit that confirmed all hand soap, paper towels were, 'Where needed'. It has also not been identified in the January 2018 audit of the work place. This audit had been ticked to confirm there was adequate hand drying facilities and sufficient supply of soap.

We found radiators were uncovered and could be rolled onto or lent against which could burn or scald the person. There was no risk assessment that identified this risk or how it was being managed. This had not been identified on any health and safety or environmental audit.

Not all hot water taps were being checked to ensure they were not exceeding the recommended temperatures. Medicines were not being stored in line with their recommended limited temperatures which could mean the medicines efficiency is affected. The health and safety audit and the medicines audit had both failed to identify these shortfalls. This included assessing and mitigating the risk relating to the health, safety and people's individual risks which arise from carrying on the regulated activity.

Following the inspection we were sent a number of quality assurance systems which would be implemented following the concerns we identified.

This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Quality assurance systems were in place for monitoring people's care plans, incidents and accidents, mental capacity and deprivation of liberty safeguards (DoLs).

The management team consisted of a registered manager, an office manager, an administrator, a maintenance man, shift leaders, and a team of care staff, kitchen staff, laundry and cleaning staff.

People's views were regularly sought through resident meetings. Areas discussed were meal choices, any complaints, activities, fire evacuation and important people such as friends and family. Records confirmed people's comments and views. The provider sent customer satisfaction surveys to people and relatives. Where actions were required an action plan was in place to address and improve the service. Records confirmed actions taken following receiving this feedback.

Staff attended team meetings. These were an opportunity to discuss and changes to people's needs and raise any concern. Records confirmed areas discussed included recent training undertaken and plans for future training.

People, relatives and staff spoke positively about the management of the home. Staff were happy and felt the culture of the home was good. Staff told us, "I am happy. The management are approachable; they are good people to work for". Another member of staff told us, "I am happy working here. Good home. They have put loads in place since the last inspection". All staff felt the management of the home were approachable and were working hard to improve the service. During the inspection we observed all staff including the registered manager and the maintenance person support people in a sensitive and supportive manner when people needed their support.

During the inspection we observed staff going about their work in a cheerful relaxed manner. The registered manager understood the legal obligations relating to submitting notifications to the Care Quality Commission. A notification is information about important events which affect people or the service. The Provider Information Return (PIR) had been completed and returned within the timeframe allocated. This explained what the service was doing well and the areas it planned to improve upon.

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 12 HSCA RA Regulations 2014 Safe care and treatment People and staff were not always able to wash their hands when required to prevent cross contamination.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider's quality assurance systems had failed to identify shortfalls found during this inspection relating to the management of medicines and health and safety relating to hot water checks and infection control risks.</p>

The enforcement action we took:

Imposing a condition on the providers registration.