St. Fillan Healthcare Limited

St Fillans Care Centre

Inspection report

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Colchester
Essex
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 September 2016 and was unannounced.

The service provides nursing care and support for up to 71 people. On the day of our inspection there were 58 people living in the service.

The service is separated into four units. Two specialist dementia units, one nursing unit and one residential unit. There is free access between the units. If people's needs change they are not moved unnecessarily.

The service had a registered manager. 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.

Care plans did not always reflect the care and support people required. Some care plans did not contain sufficient information to ensure people received the care and support they required. Information in some care plans was contradictory. Where care plans did contain information about how people wanted to receive their care and support this was not always followed.

People were not always supported to remain active and lead meaningful lives. Activities in the service were limited. A new activities co-ordinator had been recruited who was developing this aspect of care. We have made a recommendation about developing relationships between care staff and developing a community environment within the service.

The service had a quality assurance system in place which was used to identify shortfalls. However, this was not always effective and was not consistently used to drive improvement.

People did not feel there were sufficient staff to meet their needs. This was reflected in comments by people about how much time staff had to interact with them and build relationships. The service was addressing this and was recruiting more staff and developing a stable staffing team.

Staff received regular support and training. They knew how to minimise risks and provide people with safe care. Procedures were in place which safeguarded the people who used the service from the potential risk of abuse.

People were supported to make day to day decisions and interactions we observed were caring, but some people did not always feel the service was caring toward them; we have made a recommendation regarding developing relationships between care staff and developing a community environment within the service.

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 consistently safe.

Systems were in place for staff to identify and manage risks and respond to accidents and incidents. These were not always used to improve practise.

People felt safe in the service and staff were aware of the processes involved in safeguarding vulnerable adults from harm.

People's medicines were managed safely and administered by trained staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Mealtimes were not organised to provide an enjoyable experience. Food provided was not always presented in an appetising form.

People were cared for by staff that were trained and supported to give appropriate care and support.

People's consent to care and support had been obtained in line with the Mental Capacity Act 2005

People were supported to access healthcare services where necessary.

Is the service caring?

Good

The service was caring.

Although interactions were caring, some people did not always feel this way; we have made a recommendation that the service seeks guidance from a reputable source on developing relationships between care staff and developing a community environment within the service.

People were involved in day to day decisions regarding their care and support.

People's personal information was stored securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always correct and did not reflect people's individual care needs.

People were not always supported to follow their interests and take part in social activities.

People knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits did not always identify errors in documentation.

Learning from incidents was not always used to drive improvement.

The provider supported the registered manager with regular visits and audits.

St Fillans Care Centre

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 20 September 2016 and was unannounced. It was carried out by two inspectors, a specialist advisor in nursing care 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. Our expert had experience of dementia care.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvement they plan to make. We also reviewed information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about. We reviewed information that had been sent to us by health care professionals.

During the inspection we spoke with 11 people living in the service and five relatives. We also spoke with ten members of staff; this included the registered manager, a nurse, seven care staff, the activities co-ordinator and the cook.

We looked at five people's care records and records relating to the management of the service. These included policies and procedures, audits and quality assurance reports, training records and staff records.

We carried out observations of the care and support provided throughout the day. 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.

Requires Improvement

Is the service safe?

Our findings

People we spoke with did not feel there were always sufficient staff on duty to meet their care and support needs. One person said, "Not always enough staff to talk to you." Another person told us, "There are often not enough staff on duty so they do not have time to talk to you." Relatives also voiced their concerns about the lack of staff. One relative said, "I feel my [relative] is safe here but there are frequently not enough staff on duty." Another relative commented, "Frequently not enough staff on duty but a lovely home and the staff are kind."

We discussed staffing levels with the registered manager. They told us that they had been actively recruiting new staff members including most recently those dedicated to provide activities in the service. The registered manager explained how they were only increasing the number of people who lived in the service slowly as they were still working to ensure a stable and consistent workforce with the right balance of skills and experience. Improvements in this area had led to a significant reduction in sickness and staff not arriving for their shift. This had resulted in a more consistent staff team. Staff commented on this improvement with one commenting, "Everyone works well in a team… and are very supportive".

There was a system in place for establishing how many staff were needed. The manager was able to explain how this was determined through assessment of people's needs. They had recruited over and above the needed nurse numbers to ensure there was enough cover for annual leave and sickness, without having to rely on outside agency cover. A staff member commented they were working with the management team to improve staffing levels in the area they worked and felt their views had been listened to. As a result they could see their work moving from being less task focussed, enabling more time to be spent providing more personalised care. As this work progresses it is envisaged that people's experience will improve.
The service had recently recruited new members of care staff and had followed safe recruitment practices checking that the person was suitable to work in this environment.

Some people using the service had care provided on a one to one basis due to their assessed needs. The manager advised that this care was arranged with external agencies. Whilst they were responsible for arranging and supervising this care their own staff did not currently provide it. The manager explained how they monitored this to limit the number of different carers and ensure that people benefited from consistent care which supported positive relationships.

Prior to this inspection we had been made aware of concerns (including safeguards) about the management of the care of people receiving nutritional support by a percutaneous endoscopic gastrostomy (PEG). Because of this we asked to review the care records for a person relating to their PEG. These did not fully cover the care of the PEG. Although there had been opportunities to ensure practice in this clinical area was improved this could not be demonstrated neither could learning from the previous concerns. This meant that people at receiving their nutrition via a PEG were put at risk of not being supported appropriately.

People told us they felt safe living at the service. Comments included, "I do feel safe here because I can talk to anyone if I am concerned about anything," and, "I do feel safe here because often staff will go by my room

and say hello, are you ok?"

People were protected from the risk of abuse because staff had received safeguarding training that helped them to understand, recognise and respond to abuse. Staff were confident of raising concerns either through the whistleblowing process, or by escalating concerns to the registered manager and provider or to outside agencies where necessary. One member of staff said, "I know about safeguarding and any concerns I have I would report to my team leader first."
Risks people may be subject to from the environment or as a result of their own care or treatment needs were assessed; risk reduction measures were implemented and staff were provided with guidance on how to support people safely. Risk information was kept updated and reviewed from time to time to re-evaluate how effective risk reduction measures were or whether further amendments and changes were needed to reduce risk levels further. Staff demonstrated knowledge of risks to people and their role in minimising these when providing care.

The premises and equipment were managed to keep people safe. During the inspection we looked around the service, including some bedrooms with people's permission, bathrooms and communal areas. People had free access around the service and into the gardens. People living in
the dementia unit had access to an enclosed secure garden. The registered manager had identified the need to improve the outside environment. They had taken steps to address this including the purchase of new outside furniture. There was a system in place to ensure any shortfalls in the maintenance of the building were addressed promptly. The system allowed staff to request routine maintenance visits during the week and for emergencies at weekends and during the evening.

People were satisfied with the way their medicines were managed. One person said, "I do not wait for my medicines, they come round and give them to me on time, and maybe have a chat." People were protected by safe systems for the storage, administration and recording of medicines. Medicines were kept securely on each unit. Medicines administration record (MAR) were received printed from the chemist. These were checked before being put into the MAR folder. This gave a clear audit trail and record of people's medicines. Staff had received training to administer people's medicines safely. Regular audits of medicines and MAR were carried out and action taken to address any problems identified such as medicines which had not been signed for. We received positive feedback from the pharmacy used by the service.

Requires Improvement

Is the service effective?

Our findings

People told us the food was not always of a good standard. One person said, "There is not much on our plate." Another person commented, "The cakes when we have them are very small." A relative said, "The soup at tea time is often very salty, and they only have two small sandwiches to eat. Some staff will go and bring yoghurt but that is not often, depends." Another relative told us, "I have complained about the food a couple of times."

Our observations of the lunch time meal did not demonstrate that people were supported to eat sufficient amounts and enjoy their meal. One person was given a large plate with chips, scampi and broccoli. This did not look appetising with the broccoli a yellow colour. The person did not eat much of their meal. This person's care plan said that they liked to eat little and often and that they found large plates off putting.

People came into the dining room and sat down for their meal. The menu was displayed in the dining room but was not in a format which would be easily understood by those living with dementia. When offering the choice of meal the member of care staff gave the names of the food but we did not see that people were shown what was available to ensure they understood what they were being offered. The tables were arranged in small groups but some people received their meal 20 minutes before others on the same table. Some people became restless and began losing interest in the mealtime experience. We observed that the tables had not been laid with all the necessary cutlery. One member of care staff got up from supporting a person to eat to get the cutlery but did not give the person they were supporting any explanation as to why they were leaving them. This meant that dining was not a sociable and enjoyable experience.

For those living with dementia where eating and drinking sufficient amounts was an on-going risk food and fluid intake was monitored throughout the day. This was reviewed by the unit manager daily and action taken if a person was not eating or drinking sufficient amounts. Any concerns were discussed with the GP who visited weekly and also a mental health team. Suggestions made by these professionals were acted upon.

People told us that staff had the knowledge and skills they needed to carry out their roles and responsibilities. One person said, "I do think the staff are well trained." A relative commented, "The staff appear to know what they are doing, some more than others."

Staff told us they received sufficient training to enable them to perform effectively. One member of staff said, "I am encouraged to gain more qualifications if I want to. I have nearly completed my NVQ (National Vocational Qualification) 5." Another commented, "We are offered regular update training." Records demonstrated that staff received regular training in areas such as moving and handling, safeguarding and infection control. However we did note that there was some confusion regarding nursing staff achieving competencies after completing a course, for example, venepuncture and catheterisation. We discussed this with the registered manager who told us they would check the process.

Staff members told us they had regular supervision and appraisal with their manager. They shared that they

had the opportunity to discuss any concerns at any time and had identified areas of learning they wanted to develop. For one staff member this included more in depth knowledge of dementia and how it impacted on people's lives. This was reflected in the manager's improvement plan as something needed for the whole service. They had taken action to link with other organisations, and look at ways to develop this area. Where there were concerns about staff performance this was addressed with them during supervision and support provided to improve.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had made appropriate applications under the DoLS to be authorised by the relevant authority. These were appropriately recorded and monitored.

We observed staff speaking with people and gaining their consent before providing support or assistance throughout the day of our inspection. One person said, "The care worker will ask before they do anything for me, they are very polite."

People told us they had access to healthcare services and received on-going support to maintain good health. One person said, "If there is something wrong and I do not feel well I will let a member of staff know. I told staff I did not feel well and the doctor came and I have a chest infection." Another person said, "The district nurse comes in every other day." We received positive feedback about the service from the community nursing team. Care records demonstrated that referrals were made to relevant healthcare professionals when people's needs changed, for example the speech and language team and the falls team.

Good

Is the service caring?

Our findings

We observed staff paying their respects to the funeral cortege of a person who had lived in the service. Two staff members supported their partner who still lived in the service. This person was living with dementia and the staff supported them to aid their understanding of what was happening. Compassion was shown to the family.

Staff supported people and relatives who did not use English as their first language. Staff promoted and encouraged effective communication by using technology, including a computer. A member of staff said, "We have a [nationality] person here who is unable to speak English so we have a lap top and transfer English into [language] and show them." This made the person and their relative feel they mattered and staff were listening to them.

The examples given above, of staff demonstrating caring behaviours, conflicted with the feedback we received from people using the service. People did not feel that staff had time to build caring relationships with them. One person said, "The staff do not come in the room and talk to you much." Another person told us, "I am not sure they know how I feel."

We recommend that the service seeks guidance from a reputable source on developing relationships between care staff and developing a community environment within the service.

Staff showed concern for people's wellbeing in a caring and meaningful way and responded quickly to people's needs. For example we observed a person in the lounge after dinner fall back while trying to stand. Staff came quickly and supported them to sit in their chair until they felt able to stand up.

People were involved in day to day decisions regarding their support needs. We observed staff asking people where they wanted to sit in the communal area.

Relatives told us they were involved in the planning of people's care and support. One relative said, "I am involved in my [relative's] care issues and the manager will always let me know anything different." Another relative commented, "I am involved with any issues concerning my [relative] and normally speak to the team leader."

People's privacy was promoted and respected. Information about people was stored securely. Computerised records were protected by a password system and printed care plans were locked in cupboards. When staff carried out a handover regarding people's care this was done in a separate room where confidential information could not be overheard by others.

The service had different areas where people could choose to sit either on their own or in the company of friends or relatives. Some areas were smaller and could be used by people when relatives or friends visited for a private conversation. People's relatives and friends were able to visit without restrictions. One person said, "My family can visit any time." A relative told us, "I can always come in here to visit." Contact with

friends and relatives reduced the risk people becoming socially isolated.

Requires Improvement

Is the service responsive?

Our findings

People did not receive personalised care that was responsive to their needs. One person said, "The staff would not know what my hobbies are, they do not ask." Another person told us, "I did used to go to church but it has not been mentioned."

We asked the manager about personalised activities in the service. They told us that they had recently recruited an activities co-ordinator and that they were recruiting another. One relative said about the activities co-ordinator, "The activity lady is very good but she cannot spend time with every one, she does someone to one though." We spoke with the activities co-ordinator who showed us the plan for weekly activities they were developing. There was a variety of activities planned but the plan had not been fully implemented. These were not linked to the interests of the individual. This was demonstrated when one person said, "The staff will say this is going on today do you want to join in?" Another person commented, "The things they do I would not enjoy." We asked the registered manager if the activities co-ordinator had received any training specific to providing activities relevant to older people and those living with dementia. They told us that this had not yet taken place but that it was planned.

We saw one example of a person asking staff if they could help with the washing up and another person told us, "I love to help in the kitchen and the staff allow me to help them." However, we did not observe that involving people in the activities of daily living, or supporting people with preferred activities was embedded into the culture of the service. This was reflected in the comment made by one person who said, "They do activities but you are often taken downstairs where the people with memory problems are and I don't like throwing a ball around."

Care plans did not always reflect people's individual needs or preferences. One person received their nutrition via a percutaneous endoscopic gastrostomy (PEG). The person's care records contained information on the feeding regime but there was no care plan for the care of the PEG site or for oral health care. This could mean that the person did not receive the care they needed for the PEG site or appropriate mouth care.

People living with diabetes had individual care plans relevant to their condition. We saw a good example of how staff had personalised a care plan for one person regarding how often their blood sugar was monitored. However, diabetic care plans did not contain a care plan for people's feet although we saw that people had their feet checked regularly by a visiting podiatrist. Neither did they record when the person had had their last eye test. Monitoring and care of the eyes and feet of people living with diabetes is particularly important to prevent complications related to the condition.

The information contained in people's care plan was not always accurate. For example the information in a male's care plan referred to a female by name. We could not be sure if this information was relevant to the male. Another person's care plan recorded in one section that they had, 'no hobbies'. In another part of their care plan it stated 'My hobbies and interests are gardening, eating out and Sudoku'. Care plans were recorded on the service computer. The registered manager told us that care plans were printed out regularly

and that a copy of the printed care plan was either kept in the person's bedroom or in a locked cupboard. We found that some people did not have printed care plans. Staff we spoke with agreed there were no printed care plans for these people but did not know why or where the printed care plans were. In other instances printed care plans did not reflect the information on the computer record with some information being out of date. This meant that people may not get the care and support they needed or incorrect care.

This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, Regulation 9, (1)(b) and (c). Person-centred care.

There were systems in place to encourage feedback from people, relatives and visitors. We saw that they had taken the opportunity to complete 'We would like to hear from you…' forms. As a direct result of concerns raised from these, the manager had introduced a notice board placed on an easel in the middle of reception. They told us this was working well and included relatives/residents meetings, events and activities taking place. A relative said, "We do have residents meetings and the manager attends and tells us what is going on." However, another relative said, "We do have a meeting but sometimes a long time apart."

People told us they knew how to make a complaint and those complaints were responded to appropriately. One person said, "I have complained about the paint coming off the bedroom wall. The room is going to be redecorated soon." Another person commented, "I did complain about a member of staff, it was acted on." There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed.

Requires Improvement

Is the service well-led?

Our findings

There were policies, procedures and systems in place for auditing and checking the quality of the service. Whilst these were being completed there were errors in some documentation which meant information was not always accurate. In some cases it was out of date, conflicting or incorrect information about people was included in their care records. Whilst no apparent harm had occurred as a result of this, staff may not be referring to the correct information about a person which could put them at risk of not receiving the right care. It also raised concerns about the quality of the audits in place which had not picked this up. This was fed back to the management team who corrected the identified errors immediately.

A provider support visit summary in August 2016 identified some issues for improvements to people's care but not ones related to PEG we identified in Caring above. Neither manager nor provider oversight had identified it. We were therefore concerned that effective learning was not always taken forward, monitored and applied across the service to benefit others. We asked the manager how they could demonstrate that improvements and lessons learned were embedded in practice. They were clear they thought this was happening but were unable to demonstrate it as nothing was written down.
We recommend that the service seek support and training with regard to organisational learning and improvement.

People living in the service did not always know who the registered manager of the service was. One person said, "I do not know who the manager of the home is." Another told us, "I have not seen the manager of the home walking about." However, they did say that they could speak to the team leader. One person told us, "The team leader is always around to speak to." Another said, "I can always speak to the team leader." Relatives were aware of the registered manager and felt that they were approachable. One relative said, "Yes I know who the manager is and she is very approachable if you need anything." Another commented, "I had to speak to the manager about a problem and she took it on board and sorted it out."

Staff told us they felt valued and liked working in the service. They felt involved in the running and they could discuss concerns or issues with the manager. The service had a monthly recognition and rewards scheme for staff to help celebrate good contributions and practice. Staff were positive about the leadership in the service. One staff member said, "Fantastic they have given me so much support." Another described unit managers as, "Approachable and helpful." One staff member said they felt able to raise any issues with the unit managers and manager and felt that when they raised concerns action was taken.

There were systems and processes in place to escalate and manage concerns identified about the quality of care being provided. This included daily meetings with the senior team to complete a "Daily Dashboard". This highlighted any issues in the previous 24 hour period that needed addressing. We observed this meeting and saw how concerns about a person's deteriorating health were being addressed. This information was submitted to the provider daily. They could also check on progress of issues. The manager felt this oversight was positive to ensure that problems were addressed, any support needed could be provided and action was taken promptly.

The provider had systems in place to support the management through weekly visits and monthly audits. Checks at the weekends, nights, housekeeping, infection control and the kitchen were being regularly completed. Records showed any action taken. This included replacing worn or damaged furniture and ensuring general maintenance was completed promptly and safely.

The manager had identified areas of further development needed in the service and had an action plan in place. It included the need to improve specific training linked to people's needs and activities. It also included work to develop relationships with other professionals to support people and staff with end of life care and dementia. They were working to establish links with other services (including other care homes) to learn more about how different approaches could benefit people. They were keen to develop these relationships to support and encourage improvement at the service. They told us they felt this would always be on-going but felt they needed a few more months to be where they wanted the service to be.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not always reflect people's needs.