Chengun Care Homes Ltd

St Augustines Court Care Home

Inspection report

105-113 The Wells Road
Nottingham
Nottinghamshire
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Date of inspection visit:
29 November 2016
30 November 2016
01 December 2016

Date of publication:
06 February 2017

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

Summary of findings

Overall summary

This inspection took place on 29, 30 November and 1 December 2016 and was unannounced.

Accommodation for up to 40 people is provided in the home over two floors. The service is designed to meet the needs of older people living with dementia. There were 26 people using the service at the time of our inspection.

The registered manager was no longer working at the home. They had left the previous week and a representative of the registered provider was working as the acting manager. They were available during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff did not always safely manage identified risks to people and safe infection control practices were not always followed. However, people felt safe in the home and staff knew how to identify potential signs of abuse. The premises were managed to keep people safe. Sufficient numbers of staff were on duty to meet people's needs. Staff were recruited through safe recruitment practices. Safe medicines practices were followed.

People's rights were not fully protected under the Mental Capacity Act 2005. Staff received appropriate induction and supervision but training levels required improvement. People received sufficient to eat and drink but one person did not receive food that met their cultural needs. External professionals were involved in people's care as appropriate.

Staff were kind and compassionate and knew people well. There was some evidence to show that people and their relatives had been involved in the care planning process. Advocacy information was made available to people. People's independence was promoted and visitors could visit without unnecessary restriction. Staff treated people with respect and protected their dignity and privacy.

People received personalised care that was responsive to their needs. People were supported to take part in activities. Care records contained sufficient information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

There were systems in place to monitor and improve the quality of the service provided, however, they were not fully effective. People and their relatives were involved or had opportunities to be involved in the development of the service.

Staff told us they would be confident raising any concerns with management and that they would take action. However, some staff felt that they did not receive feedback in a constructive and supportive way.

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.

Staff did not always safely manage identified risks to people and safe infection control practices were not always followed.

People felt safe in the home and staff knew how to identify potential signs of abuse. The premises were managed to keep people safe.

Sufficient numbers of staff were on duty to meet people's needs. Staff were recruited through safe recruitment practices.

Safe medicines practices were followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not fully protected under the Mental Capacity Act 2005.

Staff received appropriate induction and supervision but training levels required improvement.

People received sufficient to eat and drink but one person did not receive food that met their cultural needs.

External professionals were involved in people's care as appropriate.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and knew people well.

There was some evidence to show that people and their relatives had been involved in the care planning process. Advocacy information was made available to people.

People's independence was promoted and visitors could visit

without unnecessary restriction. Staff treated people with respect and protected their dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. People were supported to take part in activities.

Care records contained sufficient information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor and improve the quality of the service provided, however, they were not fully effective.

People and their relatives were involved or had opportunities to be involved in the development of the service.

Staff told us they would be confident raising any concerns with management and that they would take action. However, some staff felt that they did not receive feedback in a constructive and supportive way.

St Augustines Court Care Home

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 29, 30 November and 1 December 2016 and was unannounced. The inspection team consisted of an inspector, a specialist nursing advisor with experience of dementia 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 service.

Before our inspection, we reviewed information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service and Healthwatch Nottingham to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with six people who used the service, seven relatives, a domestic staff member, a housekeeper, the head chef, the activities coordinator, nine care staff, a nurse and the acting manager who was a representative of the provider. We looked at the relevant parts of the care records of 12 people, three staff files and other records relating to the management of the home.

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

Risks were not always managed so that people were protected. A number of people had been assessed as requiring 1:1 care from staff. On two occasions we observed a staff member providing 1:1 care for two people at the same time. On another occasion we observed one staff member providing 1:1 care for three people at the same time. All these people had been assessed as requiring 1:1 care due to significant risks. By not providing the assessed level of care people were placed at significant risk of harm. We raised this with the acting manager who told us that they would ensure that people received their 1:1 care as assessed. During the inspection, we also informed the commissioners who were funding the 1:1 care so that they could ensure that that this was consistently provided in the future so that people received care that met their needs.

Pressure relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers. However, they were not always set correctly for the weight of the person using them. For example, the mattress being used for a person weighing 64Kg was set for a person weighing over 120Kg. This put the person at greater risk of skin damage. Checks of the mattress setting had been recorded by staff two hourly as being, "firm." This indicated either a lack of understanding of staff about the mattresses and settings or a failure to check the mattress properly. This meant that there was a greater risk that people were put at risk of avoidable harm.

We observed people were generally assisted to move safely and staff used moving and handling equipment safely. However, we saw that staff moved a person without making sure that their feet were placed on the footplates. One of their feet hit a door as they were being pushed. This placed the person at risk of avoidable harm. We raised this issue with the acting manager.

Accidents and incident forms were not always fully completed to show actions taken to minimise the risk of re-occurrence. However, actions were taken, including the review of risk assessments and care plans. The acting manager told us that they would be reviewing all new accident and incident forms to ensure they were fully completed and appropriate actions taken.

Risk assessments had been completed to assess people's risk of falls, choking, nutritional risk, and risk of developing pressure ulcers. These linked with care plans which included interventions to reduce and control the risks, such as the provision of special diets or the provisions of equipment to reduce the risk of falls and pressure ulcers. Risk assessments had been reviewed monthly.

We saw that the premises were mostly well maintained, safe and secure. However, a number of bedroom doors slammed shut and could place people at risk of avoidable harm. We raised this with the acting manager who told us that they would ensure that this would be addressed. Checks of the equipment and premises were taking place and action was taken promptly when issues were identified.

There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with

guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

People raised no concerns regarding the cleanliness of the home. We observed that the environment was generally clean though some carpets in bedrooms and communal areas required further cleaning. However, we observed that staff did not follow safe infection control practices at all times and some equipment required replacement to allow effective cleaning to take place.

People told us that they felt safe. A person said, "They look after me. They are nice staff and I am very safe here." A relative said, "We are able to sleep at night now which we couldn't when [our family member] was at home."

Staff were aware of safeguarding procedures and the signs of abuse. They said they would report concerns to management, but they were also aware of the role of the local authority and that they could make a referral if necessary. A safeguarding policy was in place and information on safeguarding was displayed in the home to give guidance to people and their relatives if they had concerns about their safety. Safeguarding records were kept which showed that appropriate action was taken in response to potential safeguarding issues.

A relative said, "[My family member] is happy as long as they let [them] keep walking about." We saw people going into the garden throughout the inspection. We also saw that staff did not restrict people but allowed them to walk where they wished in the home whilst supervising them to keep them safe.

People did not raise any concerns regarding staffing levels. A relative said, "There are plenty of staff." Care, domestic, laundry, maintenance and kitchen staff all felt that they had sufficient time to complete their work effectively. During the inspection we observed staff promptly attending to people's needs and call bells were also responded to promptly.

Staffing levels were calculated according to the amount of people who used the service and whether they were defined as requiring residential or nursing care. However, the acting manager told us that they could be flexible and additional staff would be placed on duty if people's needs changed.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People raised no concerns regarding medicines. A relative told us they were pleased that their family member was receiving less sedation since moving to the home. A staff member administering medicines told us they had completed medicines training when they commenced work at the service and their competency had been checked by the registered manager.

We observed the administration of medicines and saw checks were made against the medicines administration record (MAR) for each person and staff remained with the person until they had taken their medicines. MARs contained a photograph of the person to aid identification, a record of any allergies and people's preferences for taking their medicines. We found a gap in the MAR for two people, where one dose had not been signed to indicate it was given on an occasion. We carried out a stock check which indicated they had been given and the MAR had not been signed. We talked with a staff member about this and they identified they had given the medicine themselves and immediately reported the error to the provider.

Systems were in place for the timely ordering and supply of medicines and we did not find any examples of non-administration of medicines due to a lack of availability. Medicines were stored safely in locked trolleys and cupboards within a locked room. The temperature of the room and refrigerator had been recorded daily and were within acceptable limits.

Some people were receiving their medicines covertly and when this was the case it was identified on the MAR. Care records contained evidence that the person's GP and the pharmacist had been involved in the decision to administer medicines covertly and there was a care plan describing how the medicines were to be administered. Medicines are administered covertly when they are given in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink.

When medicines had been handwritten on the MAR there were two signatures to demonstrate they had been checked by a second person for accuracy of transcription. A person was receiving a medicine which had to be given at specific times to ensure it was effective and this was clearly highlighted at the front of the MAR folder. Staff were aware of this requirement and took steps to ensure it was given in a timely manner. When medicines had been prescribed to be given less frequently than daily, this was clearly identified on the MAR.

Protocols to provide additional information about medicines which were to be administered only as required were mostly in place but we found two examples of medicines which did not have a protocol in place when they should have been. One was a sedative medicine given for agitation and it is important there are clear directions for the use of this medicine to prevent over use. We raised this issue with the acting manager.

Requires Improvement

Is the service effective?

Our findings

We saw that most staff asked permission before assisting people and gave them choices. However we observed at lunchtime that staff put clothing protectors on a number of people who used the service without explanation or asking the person whether they wanted one or not.

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.

When people were not able to make some decisions for themselves mental capacity assessments had mostly been undertaken and documentation about how best interest decisions had been reached were completed. However, one person who lacked capacity to make a decision about their personal care did not have the appropriate documentation in place. This was particularly important as the person was not happy to receive personal care from staff, so it was important to demonstrate that the personal care was being provided in their best interests. Another person was receiving covert medicine and MCA and best interests' documentation had not been completed. This meant that there was a greater risk of these people's rights not being protected. We raised this issue with the acting manager.

A relative said, "We looked at a number of places before we came here. The main thing was that [our family member] is safe. [They have] a DOLS in place because [they] can wander so it is reassuring to know [they] can't get out." When people's freedom was being restricted in order to keep them safe, DoLS applications had been submitted to the local authority. However no staff member we spoke to had an awareness of whether any DoLS applications had been authorised by the local authority. This meant that there was a greater risk of people's rights not being protected.

We saw staff responded well to people with behaviours that might challenge. However, care records did not contain sufficient guidance for staff on supporting people with behaviours that might challenge. Care records generally contained details of the person's behaviour and the associated risks, but did not contain information for staff of appropriate interventions to manage the behaviour or how to distract the person's attention. This meant that there was a greater risk that staff would not effectively support people with behaviours that might challenge.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. Five DNACPR forms had not been fully completed. The acting manager agreed to contact the relevant

professional to review the documentation immediately. This meant that there was a greater risk that people's rights had not been protected in this area.

People told us that staff were sufficiently skilled and experienced to support them effectively. We observed that staff competently supported people and interacted appropriately with them. However, one staff member's understanding of English required improvement to allow them to interact more effectively with people who used the service. The acting manager told us that the staff member was receiving ongoing training in this area.

Staff told us they had received an induction. Staff felt they had had the training they needed to meet the needs of the people who used the service. However training records showed a large number of staff had not completed a number of training courses. The acting manager told us that staff had received training with the previous provider, but they had decided to start again with training which was why records showed a low level of training attendance. Staff told us they received regular supervision. Supervision records contained appropriate detail. The acting manager told us that appraisals were planned to take place.

A person said, "The food is good. I really enjoy my meals." We observed the lunchtime meal. Food was served promptly and was appetising, a good portion size and hot. People were given extra helpings when they asked for them. Some people ate their meal independently while others received appropriate assistance to eat and drink. However we saw that one staff member did not effectively assist one person to eat. A person was not eating and the staff member asked them whether they wanted some help. They agreed but the staff member put too much food on a spoon and the person pushed it away. The staff member then returned to assist another person and the first person ate their food with their fingers.

Nutritional risk assessments had been completed and eating and drinking care plans were in place. We saw people were weighed monthly and if they started to lose weight action was taken and a referral made to an appropriate professional. Following advice from a dietician or speech and language therapist, care plans were re-written to reflect the recommendations made. Records of people's food and fluid intake were consistently completed and indicated adequate amounts were consumed.

However, one person's care records stated that they enjoyed eating food in line with their cultural needs. We spoke with staff who were not aware of this and records showed that the person was not receiving food that met their cultural needs.

A relative said, "If [staff] are the slightest bit worried they call the doctor and they let us know as well. The doctor visits regularly and we have a number for them so we can contact them ourselves if we are worried at all." Another relative said, "Everything is here for people. The hairdresser and the chiropodist come every week. They don't hesitate to call the doctor if [my family member] is unwell."

There was evidence in the care records of people's access to specialist advice and support when appropriate. For example, advice had been sought from a physiotherapist and occupational therapist about the best way in which to position a person with complex needs when they were cared for in bed. There was also evidence of the involvement of the dementia outreach team, a dietician, a speech and language therapist, and optician. A staff member told us that staff had good access to the local GP who visited the service every two weeks to review people using the service.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were extremely kind and caring. A person said, "I'm very happy. [Staff] are very cheerful and nice." A relative said, "My [family member] has been here a long time and the staff really care about [them]. There have been three times when we thought [my family member] was at the end [of their life] and the staff member stayed on after the end of shift because they didn't want to leave [my family member]."

Staff had a good knowledge of the people they cared for and their individual preferences. We saw staff respond appropriately and promptly to people showing signs of distress.

Staff were attentive to people's needs and we observed warm interactions between staff and people using the service. However, the manner or tone with which some staff talked to people was sometimes directional and patronising when they were talking to people with advanced dementia. For example, we saw staff saying to a person who sometimes started to sing spontaneously, "Sing [name], are you going to sing?" which sounded like an order. We also observed another staff member putting Lego bricks in front of a person and telling them to, "Build!"

There was some evidence to show that people had been involved in the care planning process. Care records contain evidence of consultation and involvement of relatives when care plans were reviewed for people who did not have capacity to be involved themselves. A relative said, "We had a thorough conversation when [our family member] came here so they know everything [they] like and don't like and the best way to handle [them]. We have been involved every step of the way." Another relative said, "[Our family member] has been here for a long time and we have decision making meetings every year and if there are any changes in between then we can come and deal with it as the need arises." Advocacy information was available for people if they required support or advice from an independent person.

Three people with limited or no ability to communicate verbally did not have care plans in place for their communication needs. However, other care records for people which had been developed more recently did have communication care plans in place. The lack of communication care plans meant that there was a greater risk that staff would not be able to effectively communicate with people.

People told us that staff were respectful and polite and observed their rights and dignity. We saw examples of staff promoting people's privacy and dignity, such as whispering when they asked a person if they wanted to go to the toilet and when another person quickly removed their trousers in a communal area, staff immediately approached them and suggested they helped the person put their trousers back on. When the person refused they persuaded them to leave the room and go somewhere where they could have privacy.

We saw staff take people to private areas to support them with their personal care and saw staff knocked on people's doors before entering. Staff told us they closed the door and curtains when providing personal care to maintain people's privacy. However, most communal toilets did not have locks or signs to show when they were engaged. This meant that that there was a greater risk of people's privacy not being respected. We

raised this with the acting manager who agreed to make sure this was addressed.

We saw that staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner. However, some staff used terms which did not respect people's dignity. We informed the acting manager who told us that they would remind staff to use appropriate language when describing people's needs.

People were encouraged to be as independent as possible and were monitored, with staff stepping in to provide assistance when it was needed. Staff talked about encouraging people to maintain their independence when they were able and providing discreet support when they needed assistance.

Relatives were able to visit their family members without unnecessary restriction. Relatives visited throughout our inspection.

Good

Is the service responsive?

Our findings

People raised no concerns regarding whether they received care that was responsive to their needs. A person said, "I get up when I want." We observed that people received care that met their personalised needs. A person said, "I want a cup of tea. I don't like these [cups of] water." We saw that staff responded quickly and provided the person with a cup of tea. Another person told us that they were cold and a staff member immediately went and found a blanket and wrapped it around the person.

Care records mostly contained sufficient information for staff to provide care that met people's individualised needs. At the front of each care record there was a profile of the person with brief information about things which were important to them, things they enjoyed, their personality and personal care needs. An admission assessment had been completed for each person and they had a range of care plans in place to provide information about their care and support needs.

Some care plans had been initially written in 2014 and the plan was no longer reflective of the person's needs. They had been reviewed monthly and the evaluations provided brief information on the major changes to the person's care, therefore it was possible to gain a picture of their care needs but the care plans would have benefited from a full review. However, other care plans had been re-written following input from other professionals. For example we saw two people's eating and drinking care plans had been re-written to reflect the advice of a speech and language therapist or a dietician.

One person had developed a pressure ulcer. A care plan was in place for the care of the wound, an initial body map had been completed and photographs had been taken at weekly intervals to indicate progress. However, there was no information about the specific dressing to be used and when should be changed. A formal wound assessment would have been helpful and when we talked about this with the nurse they told us they would initiate the use of such an assessment.

We saw activities taking place during our inspection. We observed a group of people who used the service making Christmas decorations and a person said, "I've been out to the Christmas market. It was good." Another person said, "We have music on Friday nights." Another person, who was building walls with Lego bricks said, "I was a bricklayer. I can build any wall you want me to." A relative said, "We have been really impressed with what goes on here. We see people being talked to and helped to do things, like the Lego."

A representative of the provider told us of further changes they would be making to improve activities. They said, "I am planning to change the small lounge upstairs into a sensory room. We are going to put in soft furnishings and tactile equipment that people can handle and feel. I have just signed off on home cinema equipment and black out blinds so that we can have weekly cinema nights."

We saw staff engaged with one to one activities with people throughout the day. This included picture colouring, looking at photograph albums and picture books, and building bricks. We also observed staff engaged with a parachute game with a small group of people. Care records contained a care plan for daily activities. These provided some information about activities people used to enjoy and things they currently

enjoyed.

People and relatives raised no concerns regarding complaints management. Staff were able to explain how they would respond to complaints. A complaints policy and procedure was in place. No complaints had been received by the service.

Requires Improvement

Is the service well-led?

Our findings

The provider had a system to regularly assess and monitor the quality of service that people received, however it was not fully effective as it had not identified and addressed the issues we identified at this inspection.

We saw that regular audits were completed in the areas of medication, health and safety, laundry, domestic, kitchen and personnel files. Action plans were mostly in place where required, however an action plan was not in place in response to the findings of the medication audit. We also saw that the domestic audit had identified that the cleaners' trolley was not clean and we observed that this remained the case at this inspection. Care records were not audited regularly and issues identified at an earlier infection control visit carried out by the local clinical commissioning group had not all been addressed at the follow up visit. No infection control audit was completed by staff at the home.

Meetings for people who used the service and their relatives took place. Feedback was positive. Food survey findings were also positive. The acting manager told us that more detailed surveys would be sent to people who used the service and relatives in the future.

A whistleblowing policy was in place and contained appropriate details. Staff told us they would be comfortable raising issues using the processes set out in this policy. The provider's values and philosophy of care were in the guide provided for people who used the service.

A member of staff said they felt it was a, "Fantastic care home." When asked what made it fantastic they said, "There is good staffing and it is a fantastic team. We get a lot of support from the Dementia Outreach Team and they are always only a phone call away."

The registered manager was no longer working at the home. They had left the previous week and a representative of the registered provider was working as the acting manager. We saw that the acting manager had clearly set out his expectations of staff. A staff member told us they received feedback from the acting manager following audits and said, "He lets us know when things need to be changed."

People and relatives raised no concerns regarding the availability or approachability of the acting manager. A staff member told us he was easy to talk to and understood the issues. They said, "It's easy because he's a nurse as well and if we have got issues he understands." A staff member said, "I've got to be honest. I have seen some differences with [acting manager]. He is here a lot and he pokes into everything [to check it's okay]."

However, not all staff agreed. Some staff felt that they did not receive feedback in a constructive, supportive way from the acting manager. A staff member said, "He doesn't always realise how he comes across. The main problem is his tone." The acting manager told us that he was aware that he was not as diplomatic as he could be. He told us that he was, "Passionate about care but I should sometimes take a deep breath before speaking."

We saw that conditions of registration with the CQC were being met and statutory notifications had mostly been sent to the CQC when required. However, notifications had not been sent to the CQC regarding the outcome of DoLS applications.