Chengun Care Homes Ltd

St Augustines Court Care Home

Inspection report

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Nottingham
Nottinghamshire
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17 April 2019

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18 July 2019

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

About the service: St Augustine Court is a residential care home that was providing personal and nursing care. 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. The service is registered for 38 people, at the time of this inspection there were 32 people living there.

People's experience of using this service:
Medicines were not always provided in a safe way.
People's needs were assessed, and risks identified, but the risk assessments were not always current and up to date.
People were not always protected against abuse as people were able to access other people's rooms uninvited. The provider did not use a dependency tool, we could not identify if the level of staff was sufficient or if staff were deployed effectively.
There were measures in place to protect people from cross infection, but they were not always robust to ensure people were protected from harm.

Staff training was not up to date. We could not ensure staff had the skills and knowledge they needed to perform their roles effectively.
People were supported to make choices and have control of their lives. Staff supported people in the least restrictive way possible.
People received a nutritious diet and were kept hydrated at all times.

People were treated with kindness and staff respected their dignity at all times.
People their relatives and known advocates were involved in reviewing people's care and making changes as required.

People's needs were assessed, and people were supported to be independent and maintain their wellbeing.

Systems were in place to monitor and respond to complaints.
The provider did not always submit notifications to CQC. The providers monitoring systems were not robust to identify and manage all risks.
The last CQC rating of the service was displayed appropriately.

Rating at last inspection: Good last report published 16 February 2018

Why we inspected: Inspection was brought forward due to information of risk or concern.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

St Augustines Court Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
Our inspection activity started on 16 April 2019 and ended on 17 April 2019. The inspection team consisted of one adult social care inspector, one assistant inspector, a specialist advisor who was a nurse 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, in this case, people living with dementia.

Service and service type: St Augustine Court is a Care Home with nursing

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager had been in post since January 2018.

Notice of inspection:
This was an unannounced inspection.

What we did:
We reviewed information we had received about the service since the last inspection. This included any notifications (events which happened in the service that the provider is required to tell us about.) We also sought feedback from the local authority who commission services from the provider.

The majority of people who lived at the home were living with dementia and provided limited views on the care they received. During the inspection we spoke with two people who used the service, four relatives, One nurse, the cook, one house keeper, one team leader, two care staff and one activities coordinator. We also spoke with the registered manager and providers representative.

We reviewed a range of written records including specific parts of seven peoples care records, five activity records, four staff files and information relating to the administration of medicines and the registered providers auditing and monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was a limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Using medicines safely

●Where people required support with their medicines this was not always provided in a safe way in line with their individual needs and preferences.

●The nurse completed the medication round in a busy dining room area. The medication trolley was left unattended with medication left outside the trolley. The nurse instigated conversation with others and was interrupted on several occasions throughout the medication round. There was a risk the nurse could be distracted, and errors could be made.

●Some medicines had passed their expiry date and had not been disposed of. There were loose tablets in the medicines trolley. This meant we could not be sure people had received their medicines as prescribed.

●People's allergy status was not always completed on medication administration records (MARs) and care plans. This meant there was a risk people could receive medicines they were allergic to.

●People were prescribed medicines on a 'when required' (PRN) basis the PRN information was not always up to date.

●The provider audits were not robust and did not identify all areas of risk.

● The treatment room was disorganised and unclean. The fridge temperatures were not always recorded as it was intermittently switched off when not in use. This meant medicine may not be kept at the relevant temperatures to ensure they were effective.

Assessing risk, safety monitoring and management

● People's needs were assessed on admission and reviewed regularly to ensure people were not at risk of harm. People's care plans contained risk assessments, which provided staff with detailed information to ensure they mitigated any risk for people. However, some risk assessments were not reviewed on a regular basis and did not have up to date information in them.

● People who lived in the service had a personal emergency evacuation plan (PEEP) in place. This provided staff with information on how to safely evacuate the person to a place of safety in an emergency.

●We saw up to date records were kept on the maintenance of fire safety and utility systems such as electric and gas appliances.

Staffing and recruitment

●The registered manager told us staff were matched to people as the majority of people were on one to one care. They said once people's one to one care had been allocated on a daily basis there would be four staff available to monitor other people in the rest of the home.

● We found 15 people required 12 or more hours support on a one to one basis. Four other people required between two and eight hours one to one support. Staff on duty on the day of our inspection were on long days and six staff on night duty.

● One relative said "[relation] is safe here she always has someone with her during the day and there are plenty of staff around at night. We have no worries on that score."
●Rotas we looked at did not identify if staff were deployed effectively. At the time of our inspection the provider did not use a dependency tool to deploy staff around the home. (a dependency tool is an assessment to measure people's needs of support.) The providers representative told us they were in the process of implementing a dependency tool, which will define staffing levels more efficiently.

Systems and processes to safeguard people from the risk of abuse
● Most people and their relatives told us St Augustine Court was a safe place to live. A relative said, "I feel [name] is very safe here; the staff really understand their condition. I trust them, they are well looked after and if there is anything untoward, they are straight on the phone. However, one person told us they didn't always feel safe in their room as sometimes other residents would come in during the night. One relative said, "The problem is there is no lock on the doors, so residents can wander into other residents' rooms."
●Systems were in place to monitor safeguarding incidents to ensure people were kept safe. People were encouraged to raise concerns if the need arose.
●Staff had access to safeguarding and whistleblowing policies to help keep people safe from harm.
●Staff were aware of how to identify if a person was at risk of abuse and their responsibility to escalate their concerns through the safeguarding route.

Preventing and controlling infection
●People did not always live in a clean and hygienic environment.
●The registered provider had implemented some measures to help prevent the risk of infection. For example, colour coded cloths and buckets when cleaning and personal protective equipment (PPE).
● We found some of the furnishings were not clean or in good repair. There were 17 lounge chairs that were very stained and in need of repair or destruction, as some were broken. This had also been highlighted in an infection control audit dated October 2018. The provider's representative showed us evidence that new chairs had been ordered in April 2019. This meant there was a delay of six months and a risk of infection to people as chairs were not clean or fit for purpose.
●One relative told us, "The place [care home] perhaps doesn't look as swish as some other places but it's the care that counts. Having said that I do have an issue with the chairs, some have seen better days. Also, they are not a good shape for my [relative] as she slips over, we have kept asking for them to support her with a pillow and they have now got her a cushion so that has improved things, but they aren't good. They are fine if you can sit up straight but not everyone can".
●There was discarded building material and other items stored in and around the garden area. These items were a risk and people could be harmed or injure themselves. We requested the provider to clear these areas of hazards, which they did by the second day of our visit.
●We saw staff following infection control guidelines and noted that they mitigated some of the risk for cross infection by wearing relevant personal protective equipment (PPE) and keeping areas of the home clean.

Learning lessons when things go wrong
●The registered manager ensured arrangements were in place to analyse accident and incidents, so they could establish how and why they had occurred. The registered manager gave us an example of action they took when a person was at risk of hazards on their bedroom floor, such as, clutter and debris. They shared the process put in place to reiterate to staff how they should keep the floor hazard free and the person safe.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Systems were in place to determine people's needs and preferences.
●Records showed the registered manager had established what assistance people required and the level of support needed. For example, the registered manager had calculated the amount of care hours each person required each day.
● Care was delivered in a way people liked and care plans were reviewed regularly.
● Some people occasionally displayed behaviours that challenge. Care plans did not describe in enough detail how to care for people when they were displaying challenging behaviour to ensure that they remained safe.
●There was no up to date best practice guidelines on how to support people living with dementia. Review comments were vague and did not always have recent information and guidance supplied from visiting healthcare professionals. One mental health care plan had limited information on how the person should be supported when they were unwell and how best to manage signs and symptoms of behaviours' that challenge.
●One staff told us there had been a change to the way they recorded people's one to one support daily. They were recording the person's behaviour but could not identify triggers or patterns to ensure people received effective care.

Staff support: induction, training, skills and experience
●We received mixed comments from people and their relatives in relation to the skills, knowledge and competence of the staff.
● One relative said, "Some of the staff are very good and engage really well with [relative]. However, I am not sure all of them are as confident at dealing with people with dementia as they don't seem as relaxed. One of the reasons we chose here was the high level of staff, but I am not sure now if there isn't too high a percentage of people with complex and high-level needs for the staff to handle". Another relative said, "The staff are very good with [relation] and I do notice them watching them even though they are not on a one to one. (One to one is where a person is receiving support from staff on a one to one basis.)
●We observed some staff were less engaged with residents and at times they [the staff] were looking away and not watching what people were doing even if they were on a one to one observation.
● Staff told us they had completed a 17-module e-learning training programme before starting work at the service and the registered manager confirmed this. The modules covered area of training for dementia and behaviours that challenged others. However, staff had mixed feeling about the module training and some felt more face to face training for supporting people living with dementia and behaviours that challenge would benefit them.

●The provider maintained a record of each staff members training requirements and staff told us they felt supported by the manager and other senior management.
● Arrangements were in place for staff to receive both formal supervision and appraisals. These were important to ensure staff skills and development were up to date to ensure staff were competent to provide safe effective care to people. Staff had completed an induction to the service including shadowing other more experienced staff before providing care and support without supervision.
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Supporting people to eat and drink enough to maintain a balanced diet
●People were supported to have a balanced diet.
●One person said, "The food is nice; I don't know or care what I am having at the next meal time. It is always hot and there is plenty of it. I usually eat downstairs, but it depends on how I am feeling, they [the staff] are very easy going". One relative said, "[Relative] likes the food and makes comments about it. There are plenty of drinks and everything is fresh and home cooked. There are choices on the board, but pictures may be better as I am not sure people can read it". Another relative said, "The food is very good although [relative's name] doesn't always have tea she gets plenty of fluids. I bring in cranberry juice for her as she can sometimes get a water infection." Relatives also told us they were always offered refreshments when they arrived and could eat with their relative if they wished.
●We did not observe any snacks or drinks left out for people to access themselves although we did observe staff bringing drinks to people if they had asked for them. We spoke with the cook and they told us people could have drinks and snacks whenever they wanted them.
●A dehydration risk screening tool had been completed for each person. We also found fluid charts that were completed to show how many milligrams of fluid was taken, but none of the fluid charts had the amount of fluid the person required each day. This meant there was no way of establishing if people had drunk enough. We spoke with the registered manager and they told us they would address this immediately.

●The cook told us a drinks trolley went out three to four times a day and jugs of water were placed in people's rooms. They were aware of people's dietary needs and that people were offered a choice of menu. An alternative was offered should the person not want what was on the menu. We observed this during our visit.
● St Augustine Court had a five-star rating from the food standard agency. This told us the service food hygiene was very good.

Staff working with other agencies to provide consistent, effective, timely care
●Staff worked closely with other professionals to ensure people received effective care.
●Each person had care plans in place that were relevant to their physical health care needs including, tissue viability, nutrition, continence, behaviours that challenge, manual handling, vision, hearing and speech. We saw a record of visits from a range of health and social care professionals, guidance provided during these visits were recorded in people's care records.

Adapting service, design, decoration to meet people's needs
● People were involved in decisions about the environment.
● The accommodation was not designed or adapted to meet the needs of people living with dementia. There was a lack of visible signage to help people with dementia to move around the home independently and a lack of other dementia friendly decoration to support people to recognise their bedrooms. For example, some people's bedroom doors did not show the occupants name, photograph or relevant images that were meaningful, to help them recognise their room.
● On the first floor there was a sensory room. A sensory room is a specially designed environment that provides a sensory experience to people to help them relax.

Supporting people to live healthier lives, access healthcare services and support

●People were supported to access health care professionals, such as, the continence team, community psychiatric nurse, optician, chiropodist and dentist.

●There were separate wound care management files, which contained photographic evidence of individual wounds or pressure ulcers and how they were being treated. There was evidence that people had been referred to their G.P and tissue viability nurse (TVN). Recommendations had been followed, but not always reviewed within the appropriate timescales. This meant treatment may not always be effective.

Ensuring consent to care and treatment in line with law and guidance

● Staff had received training in the Mental Capacity Act 2005 (MCA) and understood the importance of obtaining consent before providing care and support.

●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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Where restrictions had been put in place these were done in the least restrictive way. DOLS assessments were in date and had good personal details on record.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
● People and their families told us staff were caring, kind and treated them with respect.
We observed staff speaking nicely to people and at times touching their [the persons] hands and reassuring them. We observed staff were kind and caring. Staff interacted with people with cognitive difficulties, staff spoke to people in a calm, clear way and gave them time to answer. One person was crying and was upset. Staff were very good at reassuring the person. They were holding the persons hand. The member of staff sat with the person for a few minutes and encouraged them to go in to the dining room to eat their lunch.
● One person said, "The staff knock, and I say come in. Sometimes people [who use the service] walk in and will say 'I am in the wrong room'." Another person said, "They [the staff] always knock before they come in and will pop in at times during the day".
●One relative told us "The staff are really nice and friendly and always offer us refreshments when you come, nothing is too much trouble. We are happy [name] is safe and well cared for". Another relative said, "All staff top to bottom are very good, very caring. I trust them, and I can go home at night and relax knowing [relative] is cared for and safe".

Supporting people to express their views and be involved in making decisions about their care
●People were supported to express their views and be involved about their care and treatment where possible. We observed one person expressed their needs and tell staff what they wanted throughout the day.

● Staff supported people to make decisions about their care. The registered manager told us there were leaflets and notices in the reception area mainly for family if needed. Advocacy services were available to people if they needed support to make decisions. Lay advocacy services are independent of the service and the local authority and can support people in their decision making and help to communicate their decisions and wishes. At the time of our inspection no one was using an advocacy service.

Respecting and promoting people's privacy, dignity and independence
● People were able to do things how they wished. We noted people wearing their night attire. We enquired with people and they told us that it was their choice for comfort. Staff respected this.
●One person told us they could get up and go to bed when they wished.
●Staff were aware of how to maintain people's dignity and respected their wishes and independence. One staff member said, "We encourage people to make choices and be independent."
● We found that suitable arrangements had been made to ensure that private information was kept confidential.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

●Not everyone joined in the activities and some relatives felt this may be an area that could be improved. One relative felt there was a lack of stimulation. They said their relation had lost their enthusiasm in the last couple of months," [name] doesn't seem to have the same interest in things that they did". Another relative said, "[name] doesn't want to engage with much, but they [staff] do take them out for a walk to get some fresh air. They (staff) do their best to try and encourage [relation] to engage but it is difficult. I come most days as I just want to see them". A third relative said "there does seem to be a lack of stimulation although since the weather has improved, they [the staff] have been taking them [the residents] out. There doesn't seem to be too much in the way of entertainment though. They do have a dance on a Friday, but I am not sure if the residents really connect with what is happening. There is the cinema room too but again I am not sure [relative] would be able to understand a film".

●People's needs were assessed. Care was person centred and people and their relatives were involved in planning their care. We saw that individual care plans focussed on supporting people to live well and maintain their optimum level of independence and well-being. For example, we saw "This is me page" which highlighted what was important for people, one person wanted hugging and kissing. We observed staff give the person a hug and a kiss as they entered the room for breakfast.

●People made choices about their care and treatment. They were often in control and independent, this empowered people to make decisions about their life. One person said, "I like to go to the pub as I have friends there. I catch the bus and have a shandy and watch telly there". Another person said, "I'm really not interested in doing anything like that".

●We spoke with the activity coordinator. Each person had an activities file to identify individual and group activities they had attended. The activity coordinator was enthusiastic and cared about what was important for people. They said, "I always read care plans to find peoples interests." They went on to share some examples and said, "One person liked fishing. We take them to Cowlick fishing lakes. Another person likes trees. We take them to look at the oak trees in the nearby park.".

Improving care quality in response to complaints or concerns

● People told us they would speak to the registered manager if they had any problems and felt that she would listen and act to rectify things.

● One relative said "if I had any problems I would speak to (registered manager) or the owner they are both very approachable. in fact, all of the staff are. In the past things have been sorted out straight away".

End of life care and support

●There were systems in place to record people's end of life wishes. People had DNAR's (Do not attempt Resuscitation) in place and the registered manager had reviewed and ensured these were in date.

●Staff were aware of people receiving end of life care. One staff said, "We give tender care, turn the person

and provide mouth care when needed."

●We saw when a person had been identified as near the end of their life that staff had worked in partnership with the person, their relatives, their GP and other supporting healthcare professionals to promote a pain free and dignified death or recover as they responded to care and treatment.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture the created did not always support the delivery of high-quality. Person-centred care. Some regulations may or may not be met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● The provider is required by law to notify CQC of reportable incidents. This enables the CQC to monitor the service and ensure they are following regulatory requirements. We found the lift had broken down two weeks prior to our inspection, but we were not notified of the incident. Three incidents were recorded in the accident and incident book. One person had received a head injury, another person had a skin tear. A third person had absconded when out in the community. However, no incident forms were submitted to the CQC. We spoke with the registered manager who told us they were aware this was a requirement. We checked after the inspection and the provider had submitted some notifications including the lift and when this was expected to be repaired.

This was a breach of regulation 18 health and social care act (Registration) Regulations 2009

●Records relating to care and treatment were not always kept up to date. Fluid charts had relevant information missing from the records. Risk assessments were not always reviewed or contained up to date information to mitigate all risks.

●Staff training records was not kept up to date. A High number of staff had not completed training or refresher courses relevant to their role.

●The providers monitoring systems were not sufficient to identify all risk. For example, the medication audit did not identify the concerns we found during the inspection. Fluid charts were not fully completed. Monitoring charts for behaviour and daily one to one support did not identify triggers and trend when people's moods changed.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● We received mixed comments from family members regarding the management of the home and how it was run. Most relatives told us they thought the home was well run and organised. However, one relative said "I am not sure [registered manager] really has a grip on the place. In my view some of the staff could do with more understanding of the conditions people present with. I also feel that the registered manager lacks some of the leadership qualities required. Another relative said "I would recommend them they have a good bunch of staff and they tend to stay. I think the staff put up with quite a lot at times as the owner does shout

a bit at times, but they stay so the management must be doing something right". We observed the owner raise their voice to staff during our visit. We heard the owner shouting across the dining room to staff to 'engage' with residents. We spoke with the registered manager and they said they would address this. Another relative said "They [management] are very approachable and the owner keeps on top of the staff he is often telling them to engage with the residents. We have a resident meeting quite often and the family representative will always take things to it if you can't make it, he is always here with his wife. The meetings are good, and we can make suggestions or bring up issues, they minute the meetings, so you can see what has happened, they leave a copy in the foyer".

●Staff felt supported by the registered manager and that they could approach them if they had concerns.

● It is a legal requirement that a provider's latest CQC inspection report is prominently displayed. This is so that people living in the service and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed at the main reception area and on the provider's website. In addition, the registered manager's certificate was on display.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●People and their family were encouraged to meet with the management of the home. Relative meetings did take place and there was a relative representative who spoke on relative's behalf if they had any issues or concern to raise. However, some people told us communication with the service could be improved. One relative said, "I think the communication between the home and relatives could be improved. As I have already said having pictures of (relative) going about their life here would be lovely and perhaps a home news letter telling us what is going on, for example the outcome of the inspection. There is a relative's forum, but it is always during the day so unless I take leave I can't attend".

●The registered manager told us they arrange meetings for people and their families. They said there was also a handover each day between staff. The registered manager promoted an open-door policy to ensure people and their relatives could speak with them whenever they wanted.

Continuous learning and improving care

● The management team were working closely with the local authority and clinical commissioning group.

●There was an action plan with clear timescales of improvement to be made and by when.

●Staff felt supported through regular supervisions and appraisals. Team meetings were productive, and staff felt confident their views and opinions mattered and were listened to.

Working in partnership with others

●The staff team worked well with other healthcare professionals, identifying concerns when they arose. Such as, managing skin integrity and followed guidance from the tissue viability nurse.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications of incidents had not always been reported as required. 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating to the care and treatment of people were not always completed or accurate, detailed or kept up to date. 17(2)