Leonard Cheshire Disability

St Anthony's - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection visit took place on the 19,20 and 21 September 2018 and was unannounced. Following the inspection, we asked the provider to send us confirmation they had addressed some of the concerns we found during our inspection. We received this within the timeframe we requested.

St Anthony's - Care Home with Nursing Physical Disabilities is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. St Anthony's - Care Home with Nursing Physical Disabilities is registered to accommodate 35 people. The people living in the home have physical disabilities. At the time of our inspection 23 people were using the service. St Anthony's - Care Home with Nursing Physical Disabilities accommodates people in one building adapted building. There are various communal lounge and dining area, a conservatory and a garden area that people can access.

There is a registered manager in place. 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.

The overall rating for this service is Inadequate and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At this inspection we found risks to people were not managed in a safe way. Risk assessments were not always in place when needed. When incidents had occurred, the information had not been used to mitigate or reduce the risk of reoccurrence. When needed, incidents had not always been investigated or considered as safeguarding concerns by the provider. People were not protected from potential abuse as incidents were not reported appropriately when needed. People had to sometimes wait for the supported they needed as there was not always enough staff available for people. Improvements were needed to the management of medicines and all medicine was not administered as prescribed, the systems in place to monitor medicines were not effective in identifying concerns.

Peoples capacity was assessed however there was no evidence decisions had been made in people's best interests. People are not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice. Staff did not always demonstrate an understanding in this area. When people were being restricted referrals had been made however when people's needs had changed this had not been considered or reflected. Improvements were needed to training, as not all staff had received the necessary training, for example when supporting people with specialist diets. Staffs knowledge and competency was not always checked after they had received training.

Documentation did not always reflect the care people received and there were no audits in this area to identify this. Audits were completed in some areas however they were not effective in identifying areas of improvement and it was unclear how the information was used to drive improvement within the home. Some lessons were learnt when incidents occurred within the home however in keys areas such as risk this had not always been considered. The provider had not made or sustained the necessary improvements from previous inspections. The provider sought feedback from people living at the home however this information hadn't been used to make changes or improvements to the home.

People were happy with the staff that supported them and the provider had ensured their suitability to work within the home. They were encouraged to make choices, remain independent and their privacy and dignity was considered. People were given the opportunity to participate in activities they enjoyed and were happy with the food and drink that was available. There were infection control procedures in place and these were followed.

Staff offered consistent care and knew people well. When people complained they were happy with the outcome, there were complaints procedures in place that the provider followed. People were supported to access health services when needed. Staff felt listened to and knew who the registered manager was. Relatives and friends could freely visit the home. The provider worked jointly with health professionals who came into the home. The provider was displaying their rating in line with their requirements.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
Risks to people were not always managed in a safe way. When incident or accidents occurred within the home they were not always investigated or reviewed to mitigate further risk. People were not always protected from potential harm or concerns investigated or reported when needed. There was not always enough staff available for people to receive the support they needed. Some information had been used so that lessons were learnt when things went wrong however not in all areas. Infection control procedures were in place and followed. There were systems in place to ensure staffs suitability to work within the home.

Is the service effective?

Requires Improvement

The service was not always effective.
There was no evidence decisions were made in people's best interest, however when needed people's capacity had been assessed. Not all staff had received appropriate training and improvements were needed so that staffs' knowledge and competency was checked. People enjoyed the food and were offered a choice. People received consistent care and support. People had the opportunity to attend health appointments when needed.

Is the service caring?

Requires Improvement

The service was not always caring.
Staff did not always have time to spend with people to ensure they were supported in a kind and caring way. People were happy with the care staff that supported them. People were offered verbal choices and were encouraged to remain independent. People's privacy and dignity was upheld and they were encouraged to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.
Records did not always reflect the care people received. Improvements were needed so ensure people communicated in

their preferred way. People had the opportunity to participate in activities they enjoyed. People's cultural needs were considered. People knew how to complain and were happy with the provider response.

Is the service well-led?

Inadequate

The service is not well led.
The providers has not made the necessary improvements since our last inspection and had not sustained the improvements they had made. We had not been notified of about all significant events within the home. Audits were not driving improvements and not identifying concerns within the home. Staff felt supported and listened to. The provider was displaying their rating in line with our requirements.

St Anthony's - Care Home with Nursing Physical Disabilities

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 visit took place on the 19, 20 and 21 September 2018 and was unannounced. The inspection visit was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We brought our inspection forward due to concerns we received following a safeguarding incident in the home and information from whistle blowers. The concern related to the management of risk and people's health and staffing levels within the home. We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information that we had received from the public. A notification is information about events that by law the registered persons should tell us about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to formulate our inspection plan.

We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service. We spoke with eight people who used the service. We also spoke with two nurses, two kitchen assistants, the cook, a team leader, an agency staff member and five care staff. We spoke with the registered manager. We did this to gain people's views about the care and to check that

standards of care were being met. After our inspection we spoke with the regional manager for Leonard Cheshire Disability.

We looked at the care records for ten people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including audits carried out within the home, staff recruitment procedures and actions plan that were in place. We gave the registered manager the opportunity to send us any information after the inspection for us to consider.

Inadequate

Is the service safe?

Our findings

When incidents occurred within the home action was not always taken to reduce the risk of reoccurrence. For example, one person's risk assessment identified they were at high risk of choking. Due to this, it had been recorded they needed a referral to a speech and language therapist (SALT) for an assessment. There was no evidence this had been completed and the person continued to eat a 'normal' diet. We saw recorded an incident where this person had choked on meat and required emergency first aid from staff. Following this incident, it was again recorded a referral to SALT should be made. We spoke with the registered manager who confirmed this had not been completed. The incident had occurred in July 2018. Since this incident had occurred the person's risk assessment had been reviewed and was not reflective of this incident. The review stated, 'no issues at present'. We also saw on the electronic incident and accident form that following the incident the person should be observed when eating and their meat cut up. Staff we spoke with were not aware the person should be observed during mealtimes and we saw this person was not always observed when eating. This meant the necessary identified action had not always been taken to mitigate the risk of choking reoccurring.

On the first day of our inspection we requested the referral was made to SALT. This was completed on the second day and we reviewed the referral form. There was no reference to the choking incident and the identified risk to this person. The form stated the person had been coughing when eating, meaning the health professional had not been provided with the necessary information and the risks. We raised our concerns with this to the registered manager. After our inspection we received reassurances from the provider this had been completed. This meant when people were at risk this had not been fully considered so appropriate action could be taken.

We saw in an incident form another person had displayed inappropriate behaviours and a serious incident had taken place. Staff told us the person continued to display these behaviours and there was an acceptance from staff these behaviours were acceptable. There was no documentation of these behaviours or when they had occurred and no risk assessment for this was in place. There was no guidance in place for staff to follow and staff supported the person inconsistently during this time, placing themselves and the person at risk. This meant staff did not have the information available to keep themselves and others safe.

For other peoples' risks, assessments were not always reflective of incidents that occurred and the levels of risk people faced. For example, one person had a falls risk assessment in place. They were identified as medium risk of falls in November 2017. Since then four falls had occurred and were recorded. The provider had taken some action, they had referred for a wheelchair assessment for example. However, the risk assessment tool that was completed in May 2018 identified they were at low risk of falls and had not considered the incidents that had taken place. Incidents had also occurred after the risk assessment tool had been completed and this was not reflective of these incidents.

We could not be sure medicines had always been administered as prescribed. For one person we saw they needed rescue medicines for management of epilepsy. We saw on two occasions these medicines had been signed as administered however we could not see a seizure recorded for this person and on a separate

occasion it was documented this medicine had been administered for agitation, this meant we could not be assured this person had received this medicine as prescribed. The systems in place to manage medicines were not always effective in identifying concerns. Since our last inspection the provider had introduced a new electronic system for managing medicines. We checked the medicines admissions records (MAR). We saw for one person there was a missing signature. No action had been taken and the registered manager confirmed the monthly audit had not identified this.

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

We saw there were procedures in place in relation to safeguarding. However, when we looked at incident and accident records we saw some incidents had not been reported to the local authority as the lead agency for investigating safeguarding concerns. For example, we saw an allegation of someone scalding/burning themselves unwitnessed, an altercation between two people living at St Anthony's, an incident where a person choked and an incident involving a small fire. We spoke with the registered manager who confirmed these had not been considered or reported as potential safeguarding concerns.

Furthermore, when incidents had been unwitnessed the provider or registered manager had not conducted an investigation to consider how this may have occurred. For example, one person had unexplained bruising. Staff had recorded this on a body map and no further action had been considered. Although staff were able to give us examples of what may be considered as safeguarding, not all staff knew how to report concerns externally. One staff member said, "It's if anything happens to anyone like they choke or have a fall, anything out of the ordinary". Staff we spoke with us told us if they were concerned about anything they would complete an incident form and report this to their line manager. They told us the information would then go to the management team and they would report it if needed. They also told us they did not receive feedback on whether it had been raised as a safeguarding concern or not. None of the staff we spoke with knew how to report concerns externally. This meant people were not always protected from potential harm.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views about staffing levels within the home. One person said, "Sometimes it's a bit stretched, early evening between dinner and bed. The overnight team are very good. You press your buzzer and they're here". Another person told us, "There's definitely the right level of support for me but sometimes we feel a bit pushed, lots of agency staff lately". Other people said, "I have two staff when they come in here. There's always staff around apart from when they have a break. Weekends and nights are okay. If I press the buzzer I get two people to help and I don't wait too long" and "You press your buzzer and they are here". We saw calls bells were answered in a timely manner and there were staff available when people needed support.

Staff told us they would like more time to spend with people and our observations reflected this. One staff member said, "Staffing is better now. There are enough staff but there is a lot going on for us. We never have time to sit and talk with people it's just onto the next task". Another staff member told us, "It can be frustrating for staff, we have enough yes. However, if someone needs an escort to go out or something happens it throws us behind. We are very task focused so we get people up, then it's our breaks, then its lunch. More staff would allow us to spend more time with people". During the three mornings of our inspection we saw staff were supporting people in their rooms with personal care and staff were not always available for people in communal areas. At breakfast time there was one kitchen assistant offering support to people so people had to wait a short amount of time for this staff member to be free to offer the support

they need. On the third day of inspection we saw a game of bingo taking place, again only one staff member was supporting people with this and six people who needed physical support were participating. The staff member offered support to each person individually meaning that some people had to wait for the correct levels of support they needed so they could participate in the game.

The registered manager told us they used a dependency tool to determine the amount of staff that were needed within the home. They told us the tool considered the levels of support people needed and they were able to demonstrate to us they were using the correct levels of staff in line with this tool.

We asked the registered manager to give us examples of when things went wrong within the service and how lessons were learnt and improvements made. The registered manager showed us how they had completed a route cause analysis (RCA) following a death in the home. A RCA is a structured method used to analyse serious adverse events. They showed us how they had conducted the investigation and following this they had put action is place for the home and staff. This included training nursing staff in a specific area. We saw some of the actions had been completed whereas others were in progress. The RCA and learning outcomes had been shared with the nurses in their meeting and they were aware of the actions that needed to be taken. However, we found concerns in other areas. For example, when risks and incidents had occurred within the home the provider had not used this information so that lessons could be learnt and improvements made for people. We did not see how lessons had been learnt from our last inspections. The provider is again in breach of regulations.

There were infection control procedures in place and these were followed. The home was clean and free from infection. The registered manager also completed an audit in relation to infection control and when needed action was taken to make improvements. We saw staff used personal protective equipment such as gloves and aprons when needed. Staff confirmed this was available to them. We saw the provider had been rated as five stars by the food standards agency. The food standards agency is responsible for protecting public health in relation to food.

We found a system was in place to ensure nurse's registrations were valid and in date. We also saw a profile was held for the agency staff working within the home to ensure they had the relevant employment checks in place. After our inspection the provider sent us recruitment information for staff which demonstrated their suitability to work with people had been considered. This meant the provider had a system in place to ensure staff suitability to work within the home.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that decisions were not always made in people's best interests. We also found staffs knowledge and competency was not always checked after training. This area was rated as requires improvement. At this inspection we found the provider had not made the necessary improvements.

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 or 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).

At our last inspection we found capacity assessment were in place, they were clear and individual to the decision being made, however for some people we did not see any evidence that decisions had been made in people's best interests. We spoke with the acting manager at the time who told us multi-disciplinary meetings were being held with people, families and other significant people to discuss these decisions. At this inspection we found the same concerns and these meetings had not taken place.

We checked to see if the provider was working within the principles of the MCA. People consented to their care when they were able to. We saw staff sought people's consent before supporting them. We also saw when people lacked capacity to make decisions in certain areas, assessments were in place. However, as we found at our last inspection specific best interest's decisions were still not always recorded. For example, we found that some people had bed rails which they lacked the capacity to consent to, and other people had alarms to alert staff when they were having seizures. There was no record to show that a best interests discussion had taken place to ensure this was the least restrictive option. There was also no evidence the multi-disciplinary meetings had been held as previously advised. This meant the provider had failed to take the necessary actions to ensure the principles of the MCA were followed.

At our last inspection the provider had considered when people were being restricted and applications for DoLS had been made. However, there was no guidance in place for staff to follow while these applications were considered and some staff did not demonstrate an understanding in this area. We also saw documented for one person, who had a DoLS application made in 2017, some instances where 'they had been found trying to get out through fire doors and the front door'. It was also documented the person was becoming more upset and distressed by this. Although it had been documented staff had not forced the person to do anything it was unclear how this person had been supported at these times. The provider had not considered an urgent authorisation for this person nor had they alerted the DoLS team to this.

Staff told us they received an induction and training. However, at the last two inspections we could not be assured that staffs knowledge was checked. At this inspection we found this was still an area that needed improving. For example, although most had received safeguarding training they were not able to tell us how

to report concerns externally. And as we found at our last inspection staff did not fully understand MCA. When we asked staff about this they told us, "I have had training, it's to make sure people have capacity. If not, they have a DoLS in place" and "It's when they have a red sticker on their file it means they have a DoLS in place." They provided no further explanation to demonstrate their understanding.

During the mornings of our inspection we saw kitchen assistants supported people to eat their meals. They told us this was one of their key roles and that they supported people with meals every day. This included people who required a specialist diet due to their risks of choking. Although both kitchen assistants told us they had received first aid training both also told us they had not attended the training that had been completed by SALT for care staff. We spoke with the registered manager about this who felt these staff may have been overlooked as all staff including the cook had attended. This meant we could not be sure all staff had received training needed to support people effectively.

People received consistent care and support. Staff told us they had information about people which helped them deliver consistent care. One staff member said, "All information about people is in their care files." Another staff member said, "I think care plans are much better now." Although people and staff told us the home used agency staff, the registered manager had tried to ensure the same person was used to ensure consistency within the home. The home had handovers at various times throughout the day so they could share up to date information about people.

People were offered a verbal choice of meals and were happy with the food they received. One person said, "First class. Great variety. A well-balanced diet. And phenomenal sweets!" People told us they could influence the menu, for example the previous day someone had asked for beans on toast and got it. There were snacks and drinks available for people and they could independently access these when they chose. We were told that the chef individually spoke with people the previous day and offered them a choice of meals for the next day. People told us there were two options however if they wanted something different they would be able to. Although the registered manager told us these were available during the three days of inspection, we did not see any pictures or prompts used so that people could be reminded of the meals they had chosen previously or to support them to make their choice.

People had access to healthcare professionals. People gave us examples when they had needed support from health professionals including the GP. We saw documented in people's notes and the nurse confirmed that the GP visited the home when needed. Records we looked at included an assessment of people's health risks. The nurses told us they worked jointly with health professionals to ensure they delivered effective care and support.

The home was decorated in accordance with people's choices and needs. People had their own belongings in their bedrooms. There was a garden area that people could access with support. The home had also been suitably adapted so that people's physical conditions had been considered. For example, corridors and door were wider to allow wheelchair access and bathrooms and bedrooms were adapted with suitable moving and handling equipment.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated caring as good. At this inspection staff did not always have time to spend with people this meant people were not always supported in a kind and caring way. We have rated caring and requires improvement.

People were happy with the staff and the support they received. One person said staff were, "Really, really kind." Another person said, "They're so genuine, they're like family." However, our observations and staff confirmed they did not always have time to spend with people. One staff member said, "We can spend time with people while we are doing personal care and we don't really rush them but that's it, we don't have time to sit and chat after. Sometimes in a morning if the call bells are going off we have to leave the person whilst we go and see if the other one is okay." Another staff member told us, "Its care, care, care. Some people need emotional support if they are a bit low or upset. We would never ignore them but you are always conscious of the time as there is the next person to do." We observed there were periods where staff did not offer support to people in communal areas as they were supporting people in their bedrooms. For example, on the morning of the inspection on 19 and 20 September 2018, we observed one person ate their breakfast independently. On both occasions the person dropped a large amount of the breakfast on the table, there were no staff available to support with this. The kitchen assistant cleaned away the breakfast they had dropped and the person was not offered any support or a replacement for this. This meant staff did not have time to treat people in a kind and caring way.

People were encouraged to be as independent as possible. One person gave us an example of the support they had received from the in-house physiotherapist. They described to us the treatment they had received, the exercises they had completed and how this had positively impacted on their life. Staff gave examples of how they promoted independence. One member of staff said, "Encouraging people to do what they can for themselves and not doing it for them." A breakfast club had been introduced since our last inspection and people who attended this had the opportunity to prepare their own breakfast. People also had motorised wheelchairs. They told us how they had to pass a test so they could mobilise independently within the home and in the community. The records we looked at had information about people's levels of independence and stated what people could do for themselves and how they should be encouraged to do so. Staff we spoke with were aware of the levels of support people needed. This showed people were encouraged to be independent.

People were encouraged to make verbal choices for themselves. People told us they choose when to get up, go to bed and have a bath or shower. A staff member gave examples of how they encouraged people to make their own choices. They said, "We have one person who is visually impaired. I ask the person what they would like to wear. If there say the red jumper and there are two I describe them both for the person to make sure it's the right one they have chosen." Another staff member told us, "We ask people different things, that is the best way to find out." Records we looked at gave examples how people were able to make choices and the levels of support they would need with this.

People's privacy and dignity was promoted. Staff told us how they promoted people's privacy and dignity.

One staff member said, "We knock on people's bedroom doors before we go in and make sure the door is shut whilst we are in there supporting so others can't see anything." The records we reviewed gave examples of how people liked to receive their care and how their dignity could be maintained.

People were encouraged to maintain relationships that were important to them. One person gave an example of a friend they wanted to visit who lived a distance away after they moved into St Anthony's - Care Home with Nursing Physical Disabilities. They told us the staff had supported them to visit this person and it was an enjoyable day. Another person told us how they kept in contact with people via skype and spoke positively about this. We saw that friends and relatives visited the home freely throughout our inspection.

Requires Improvement

Is the service responsive?

Our findings

The care people received was not always documented to reflect their current needs. For example, one person was at risk of developing sore skin and had been assessed as being at high risk. There was a skin and pressure care plan in place that stated they should have 4 hourly turns at night. The registered manager and staff confirmed to us this should also be during the day and the position record stated this should be every 4 hours. We checked the repositioning charts for this person and records stated they had not received a position change in line with their care plan, meaning they were at risk of developing sore skin. It was documented that on 15 September 2018 they went over ten hours with a change of position and on 16 September 2018 over seven and a half hours.

We also found the same concerns when people had a daily target of fluid. For example, one person had a catheter in place. The care plan for eating and drinking stated they should receive 2500mls of fluids per day. We checked fluid monitoring charts for this person and records stated they had not received the amount that was stated in their care plan, meaning they were at risk of not receiving adequate fluids. It was documented on 17 September 2018,1500mls had been received and 16 September 2018, 800mls and 15 September 2018,1600mls. This meant the documentation in place demonstrated that people did not always receive support as required.

The manager and staff were not aware of accessible information standards (AIS) and that this was an area that needed developing. AIS were introduced by the government in 2016, it is a legal requirement for all providers of NHS and publicly funded care provision to make sure that people with a disability of sensory loss are given information in a way they can understand. We saw people had communication passports and care plans in place stating their preferred method of communication with people. However, we did not always see staff implemented this. For example, one person used specific signs. The home had introduced a 'sign of the week' to raise awareness and support staff to use this form of communication. It was not until the third day of our inspection that we saw a staff member use this method to communicate with the person. There was equipment in the home for people to use for example, there were adapted computers. For other people we did not see information was available in different formats such as pictures or visual prompts, when they were unable to communicate verbally. The registered manager told us this was available for people in the home and was unsure why this was not being used during our inspection.

Peoples cultural needs were considered and when people needed support with this we saw guidance was in place for staff to follow and consider.

People were given the opportunity to participate in activities they enjoyed. We saw a notice board was in place identifying when various groups of interests were taking place, such as knitting and musical exercise. People had the opportunity to add their name to up and coming events like trips to the theatre. One person told us about a holiday they were going on in a few weeks. During our inspection we saw various activities taking place including bingo, breakfast club and an exercise class.

People knew how to complain and felt more confident in complaining if they chose to. One person said, "Yes

I know how to raise my concerns". There was a procedure in place to manage complaints and we saw when formal complaints had been made they had been responded to by the provider in line with these procedures. This demonstrated there were systems in place to deal with concerns or complaints.

At this time the provider was not supporting people with end of life care, so therefore we have not reported on this at this time.

Inadequate

Is the service well-led?

Our findings

At our last inspection in December 2017 we found further improvements were needed to ensure audits being completed identified areas of improvement. The provider sought feedback from people who used this service however this information wasn't always used to make changes. We rated this domain as requires improvement. At this inspection we found the provider had not made the necessary improvements and further improvements were needed.

Since our first comprehensive inspection on 25 April 2016, St Anthony's - Care Home with Nursing Physical Disabilities has been rated as either requires improvement or inadequate. We have now inspected this location on six separate occasions during this time. Despite two meetings with the providers and four action plans, we have found that the provider has not made the necessary improvements to comply with regulations. We have taken previous enforcement action and issued warning notices and we have removed the previous registered manager from their position.

When improvements had been made we have found these have not been sustained. For example, the provider has been in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 since our first comprehensive inspection in April 2016, where we issued a warning notice. At our last inspection we noted improvements and this breach was removed, however at this inspection we have noted new concerns and the provider is again in breach of this regulation. This demonstrated the management systems in place were not driving improvements and were inconsistent.

We saw some audits were taking place such as medicines management and infection control, however there were no recorded audits of other aspects of care such as daily records or monitoring charts including fluids and positioning. Some people had a daily target of fluid, this was identified in their care plan and was due to identified risks or as they had a medical condition. Although the management team told us the night staff would check and total these fluids, there was no formal system to ensure people had reached these targets. We found people had not received their daily targets and no action had been taken. There were also no audits of repositioning charts which meant the management team could not be sure people were getting the care and support they needed to manage their risks. As noted in the responsive section, the records we reviewed did not demonstrate that people were repositioned when needed.

When incidents had occurred, we did not see adequate action was taken to mitigate further risks. Although some risks had been assessed and considered for people, it was not until serious incidents had occurred that appropriate action was taken to keep people safe. When accidents or incidents occurred and forms were completed, we saw initial action was taken. For example, when people fell they would be physically checked over by a nurse. However, appropriate further action was not always taken. For example, it was recognised a person needed to be referred to SALT however this referral had not been made.

We could not be assured all incidents and accidents were reported and recorded so that these could be fully considered. For example, staff gave us examples of minor incidents that had occurred for a person which placed them at risk of harm. We did not see these incidents documented. These incidents that were

described to us would be considered as near misses. These near misses had continued to occur and this resulted in a more serious incident taking place that had placed the person in extreme danger. It was only after this incident occurred the provider reviewed this incident and took appropriate action to mitigate the risk to the person. We also found there was no auditing of incidents and accidents taking place so that trends for people could be identified and appropriate action taken. The registered manager told us this was an area they were looking at developing.

We saw that some audits were completed within the home however they were not always effective in identifying areas for improvement. For example, we saw a monthly medicines audit had been completed. However, this had not identified the concerns we found around the management of medicines during our inspection. This meant we could not sure the audits in place were effective in identifying concerns.

An audit of call bell times was also taking place, there was no analysis of this information. This audit identified when bells had been ringing for more than 10 minutes. When this had occurred, an investigation had taken place to consider why. We saw the registered manager had introduced a 'zero tolerance' of call bells ringing for more than ten minutes. We saw since this had been introduced there were no incidents recorded, where bells rang for over 10 minutes. When we spoke with staff about this, they told us it was as they would ensure they responded to and turn off the bell within the time frame [10 minutes]. They confirmed the person did not necessarily receive the support they needed during this time and staff would go back to them when they were free. This demonstrated this had not been an effective system to ensure people received the support they needed in a timely manner.

At our last inspection we found the provider sought the opinions of people and relatives who used the service; however, this information had not always been used to bring about changes to the service. For example, we saw a survey had been concluded in October 2017, within these areas of improvement were identified. We did not see any action had been taken to address these concerns. At this inspection we found no further action had been taken and these concerns remained the same.

Although the provider was notifying us of some significant events that had occurred within the home such as some alleged abuse incidents and deaths. We had not received notification for the incidents that we refer to in safe. This included an altercation between two people, a choking incident, a fire and an allegation of inappropriate sexual behaviours that we would consider reportable to the police. This meant all significant events that occurred within the home were not always reported to us so we could ensure appropriate action had been taken and people were safe.

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

There was a new registered manager in place. They had started working within the home since the last inspection and had registered with us in August 2018. The home was displaying their rating in the entrance corridor and on their website in line with our requirements. All the staff we spoke with felt the registered manager and management team were approachable and would be happy to raise any concerns. One staff member said, "I feel listened to, there have been a lot of positive changes in the last year, the atmosphere is a lot better and staff are happier." Another staff member said, "I raised concerns about new agency staff working with people who were palliative care. I was understood and this was changed." Staff told us they had the opportunity to raise concerns and all the staff we spoke with told us they had the opportunity to attend staff meetings and individual supervisions with their line manager.

Staff knew about the whistle blowing process. Whistle blowing is the process for raising concerns about poor

practices. One member of staff said, "Yes there is a policy for this and I would raise concern if needed. Leonard Cheshire would support us with this." We saw there was a whistle blowing procedure in place. This showed us that staff were happy to raise concerns and were confident they would be supported and the concern addressed.

The home worked in partnership with other agencies including health professionals. This included working with the SALT team so that staff could receive specialist training from them to ensure people received the correct diets when they had been assessed to require a certain diet. Further work was needed to ensure the standard of care people received improved.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always managed in a safe way. When incident or accidents occurred within the home they were not always investigated or reviewed to mitigate further risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from potential harm or concerns investigated or reported when needed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The providers has not made the necessary improvements since our last inspection and has not sustained the improvements they had made. We had not been notified of about all significant events within the home. Audits were not driving improvements and not identifying concerns within the home.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always managed in a safe way. When incident or accidents occurred within the home they were not always investigated or reviewed to mitigate further risk.

The enforcement action we took:

We have imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from potential harm or concerns investigated or reported when needed

The enforcement action we took:

We have imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The providers has not made the necessary improvements since our last inspection and has not sustained the improvements they had made. We had not been notified of about all significant events within the home. Audits were not driving improvements and not identifying concerns within the home.

The enforcement action we took:

We have imposed conditions on the providers registration.