

# St Quentin Residential Homes Limited







# St Quentin Residential Home

## Inspection report

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### Ratings

Overall rating for this service	Requires Improvement	
Is the service safe?	Requires Improvement	
Is the service effective?	Requires Improvement	
Is the service caring?	Requires Improvement	
Is the service responsive?	Requires Improvement	
Is the service well-led?	Requires Improvement	

### Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was unannounced. Our previous inspection took place in February 2014. The service had no breaches in regulations at the last inspection.

The service is divided into two buildings. One building provided accommodation and care to 20 people. The other building provided nursing care for up to 31 people. On the day of our inspection the service was full. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

# Summary of findings

Records were not maintained to clearly record that people had been involved in decisions about their care, treatment and support. There was limited personal information about people for staff to be able to meet people's individual preferences.

Improvements were needed in how the provider responded to people's individual care and welfare needs. For example, staff basic training was up to date, but specialised training was not available to support staff to care for the individual needs of all the people who used the service effectively and safely.

The Deprivation of Liberty Safeguard (DoLS) procedure aims to 'safeguard' the liberty of the individual by ensuring that a rigorous and transparent procedure is followed prior to any deprivation of liberty. The registered manager demonstrated knowledge of the DoLS procedure but we could not see evidence that best interest meetings had taken place where people lacked capacity.

People who used the service and their relatives told us that they were happy with the care they received at St Quentin's.

We saw that staff respected people's privacy and dignity. We observed that staff interacted with people who used the service in a kind and caring manner.

The service had a recruitment process in place. All essential checks had been satisfactorily completed, in order to ensure that people were suitable to work at the care home.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## 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.

People had not always been involved in decisions about their care, treatment and support. This was because the principles of the Mental Capacity Act were not consistently followed.

People's care plans and risk assessments did not always record the relevant information to enable staff to be able to care for them safely.

All staff had received training in safeguarding adults. The registered manager followed the correct procedures and acted appropriately when they suspected abuse.

There were sufficient numbers of staff employed at the service to meet people's care and support needs. Recruitment procedures were rigorous and thorough.

**Requires Improvement**



### Is the service effective?

The service was not always effective.

Staff had not received specialised training or training in the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). There was a risk that staff did not have the knowledge to meet people's individual needs.

People could make choices about their food and drink and were given support to eat and drink where this was needed.

Regular monitoring of people's healthcare was in place to ensure that any changes were discussed. Referrals were made where appropriate to health care professionals for additional support or any required intervention.

**Requires Improvement**



### Is the service caring?

The service was not consistently caring.

People's privacy was not always respected.

Our observations throughout the day demonstrated that staff showed dignity and respect towards people and that people who used the service were listened to.

Staff supported people in a kind and caring way. They spoke to people at a level and pace they understood.

**Requires Improvement**



### Is the service responsive?

The service was not consistently responsive.

**Requires Improvement**



# Summary of findings

The service was not responding to the needs of people living with dementia by following nationally recognised guidelines in order to meet their needs.

There was a complaints procedure in place and people and their relatives were confident that their concerns would be addressed and action was taken where necessary.

## Is the service well-led?

The service was not well led.

Staff training was not up to date and specific to the needs of people who used the service. This meant that staff were not supported to effectively fulfil their role.

Care records were not all up to date and securely maintained.

There were procedures in place to monitor and improve the quality of the service. We did not see that information from these had been used to reduce risk to people who used the service.

**Requires Improvement**



# St Quentin Residential Home

## Detailed findings

### Background to this inspection

The inspection comprised of one inspector, an expert by experience and a specialist advisor. Our expert by experience was a person who has personal experience of using or caring for someone who uses this type of care service. The advisor was a specialist in working with people who live with dementia.

The registered manager had completed a provider information return prior to the inspection, which gave us background information about this service. Notifications are changes, events or incidents that services must tell us about.

We requested and received information from a social care and health professional and from the local authority quality monitoring team prior to the inspection to gain their views of the service.

We visited the service on the 23 July 2014. We spoke with 16 people who used the service, 11 staff members, four relatives and the registered manager. We observed people's care and looked at four people's care records. We looked at a range of other records including staff files, the staff training matrix, menus, minutes of meetings and quality audits.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

# Is the service safe?

## Our findings

The registered manager told us that the service did not provide care for anyone whose behaviour may challenge. During the inspection we were informed by a member of care staff that one person, who was being supported in their bedroom, had behaviour that challenged which often resulted in staff being injured. From our discussions with staff and the reviewing of records we saw that the care staff had sought the advice and support from external agencies in how to support this person. However, individual risk assessments had not been undertaken and care plans relating to this person's behaviour were not specific to the person. We saw it was recorded: 'leave your distance between yourself and [person who used the service] and move [person] away from other relatives'. It was not recorded what behaviours this person may express and there was no risk assessment informing staff of the risks to their health and safety. Records did not inform staff how to support [the person] whilst they needed intense support by way of diverting or diffusing the situation. This meant that this person and others were at risk of further injuries and the person was not receiving care and support that met their individual needs as guidelines to support this person were not recorded clearly.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A staff member told us that one person required medication to be administered without their knowledge. This is called 'covert' medication. We saw that it was recorded that it had been discussed with their community psychiatric nurse (CPN). From our discussions with staff and the records we looked at we could not see that a 'best interests' meeting had taken place which would have involved the person themselves or their relative, the GP and any other relevant person. Although there was a risk assessment for medication, there was no care plan informing staff how and when the medication should be given covertly. This left the person at risk of having their medication administered inappropriately due to insufficient information being available to staff.

In the care records for three people we saw that they had a do not attempt resuscitation authorisation (DNAR) in place. We did not see records that showed that people's capacity

had been assessed in relation to being involved in the decision making process for a DNAR to be implemented. This meant that we could not be sure that decisions were being made about people with their involvement.

These issues constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service and their relatives told us that they felt the care was safe at St Quentin. One person who used the service told us: "You'll be alright here they look after you". A relative told us: "My mum is as safe as she can be I suppose".

The registered manager told us that they were in the process of referring most people to the local authority for a Deprivation of Liberty Safeguards (DoLS) assessment due to the recent Supreme Court judgement. The manager told us this was because most people at St Quentin would have been encouraged not to leave the service due to the risk of harm to them, this could mean that people's liberty was restricted. This meant the service was following the correct procedures in safeguarding people from the risk of abuse or unnecessary restrictions.

All the staff had received training in the safeguarding of vulnerable adults. Staff we spoke with had a good understanding of what constituted abuse. Staff told us that if they suspected abuse they would report it to the manager. The registered manager demonstrated that they had made safeguarding referrals to the local authority and acted appropriately following incidents of suspected abuse.

Staff rotas showed and we observed that there were sufficient staff to safely meet the needs of people who used the service. Staff we spoke with told us they felt there were enough staff to be able to fulfil their role. Although the registered manager didn't show us they told us they had a tool to assess the staffing levels required at the service to meet the needs of people.

We looked to see if the provider made the appropriate pre-employment checks prior to recruiting new staff to the service. We checked four staff files and saw they had all had a Disclosure and Barring Service (DBS) check and references prior to starting work at the service. This meant the provider was following the correct procedures to ensure that new staff were suitably fit to work at the care home.

# Is the service effective?

## Our findings

We looked at the staff training matrix and saw that staff had not received any training in managing people whose behaviour may challenge or how to support people with dementia. This is despite people with these needs currently using the service and staff informing us that they had been injured as a result of not being able to meet people's individual needs effectively.

We saw gaps in the staff training matrix in relation to training on the Mental Capacity Act (2005) (MCA). The registered manager told us that they recognised that staff required training in the MCA and it was yet to be arranged. This was further demonstrated as best interests meetings had not been arranged for people who used the service as required. One member of care staff told us: "I don't know a great deal about the MCA, I had training in a past job but I can't remember much of it". Another member of staff told us, "I have heard about it but I'm not over familiar". This meant there was a breach of Regulation 23 of the Health and Social Care Act 2008 as staff were not supported to fulfil their role effectively and ensure that people received safe quality care.

New staff undertook an induction which covered all the essential areas of good practice as considered by the provider. This included safeguarding, infection control and moving and handling.

Staff told us that they had regular support and supervision with a senior team member where they were able to discuss the need for any extra training and their personal development.

We spoke with people who used the service and their relatives about whether they felt their health care needs were met. Comments included: "If I want to see a doctor the staff will arrange it and the doctor responds very quickly", "My mother has pain in her hips and legs and both staff and doctors are working closely to control that pain", and "If I wanted to see a doctor the staff would make sure I get an appointment".

We saw evidence that professionals were involved with supporting people's social and health needs. People attended health appointments, such as the opticians and dentists. The local GP visited the service twice a week to see people who may require a home visit. We saw that

people's health needs were monitored and actions taken ensured that appropriate treatment was provided when needed. One person who used the service told us: "When I had a fall they called the paramedics".

Individual health care plans were clear and comprehensive and they gave staff the relevant information they needed to care for the person in order to maintain their health. We saw that when people required specific health care monitoring such as regular monitoring of people's food and fluid intake this was completed.

Verbal daily handovers took place at the beginning of every shift. Staff told us they discussed issues and any changes to people's plan of care. This promoted staff's understanding of people's current care needs so that care and support could be delivered in a timely manner and in a way that met their needs.

People had a choice of food throughout the day. At breakfast we observed that people could have whatever they chose and different requests were catered for. Meals later in the day were discussed and agreed with people. We saw that the kitchen staff had a clear list of who required a specialised diet and kitchen staff we spoke with had a good understanding of people's individual dietary needs.

We observed lunch time in the residential service. The tables were laid attractively with individual linen napkins and plenty of cold drinks were within easy reach for people. All meals were served hot and the food was well presented. One person told us "The food is absolutely excellent, it's well presented and the portions are adequate".

Jugs of water and tea and coffee were available throughout the day. We visited some people who were being supported in their bedrooms and saw that they had drinks readily available to them. At mealtimes in the main dining rooms we observed that people were supported appropriately to eat their meals. Staff interacted well with people and were seen to be seated at eye level when assisting with meals, in order to maintain their dignity. People at risk of choking were provided with thickened drinks and soft and pureed meals so that they could eat and drink safely. Records were maintained of the food and fluid intake for people, so that staff could monitor that

## Is the service effective?

people were eating well. We saw that when necessary people's weight was monitored on a regular basis so that actions could be taken if needed to boost or reduce their dietary intake.



# Is the service caring?

## Our findings

We spoke with 16 people who used the service and their relatives and they all told us that they felt the care was good at St Quentin. Two visiting relatives told us: “The care here is amazing, the love, care and devotion shown is excellent especially by two of the care staff”, and: “We are really pleased with the care provided”. A person who used the service told us: “The nurses have seen me through a very difficult illness including depression. Their kindness I’m sure goes beyond reasonable expectations and we have a laugh and a joke. I cannot complain”.

One person who was being supported in their bedroom told us: “The staff are very good, and one member of the night staff is absolutely fantastic, I look forward to her being on duty”. Another person told us: “The staff are so kind, they bring me all sorts to eat like strawberries, and they treat me like my daughters. The cleaners and laundry staff are so kind, in fact everyone is so nice to me”.

We observed that staff spoke to people in a kind and caring manner. A member of care staff told us “I love it here; I have a good relationship with the residents”. All the staff we spoke with demonstrated knowledge of the people they cared for. One staff member told us: “I feel that the residents are safe and treated with dignity and respect”.

Staff knocked on people’s doors and waited for permission before entering and respected people’s choices. People were able to get up when they liked and we observed that several people liked to have a lie in bed. Staff supported people to get up when the person requested. One person told us: “I think they [staff] do a good job, they treat us with respect and observe our dignity.”

People who used the service told us they had access to a hairdresser every week, so that their physical appearances could be maintained as they chose. People who were being

supported in bed who we visited looked clean and well cared for. We observed that their bedding was clean and people told us that they were comfortable with the use of appropriate equipment such as pillows and pressure mattresses. People were able to personalise their rooms. We saw that when people lacked capacity due to their frailty, relatives and staff had ensured that their rooms were decorated with items of particular importance to them such as family photographs. One person told us that their family had arranged to personalise their room before they were admitted into the service.

We saw that people who used the service were supported to maintain relationships with others. People’s relatives and those acting on their behalf were able to visit the service freely. One person who used the service told us: “My family are made welcome when they visit and I’m happy here”.

Several people required the use of a hoist to support them to move from one seat to another. We observed several moving and handling transfers and saw that they were completed appropriately with the required two members of trained staff. One person told us: “The staff are very good with me, they are very gentle when moving me”. This meant that people felt comfortable when being supported with their mobility.

During our visit we saw that people’s daily notes were left on the floor outside their bedroom doors. We could see personal information on them which was easily visible to anyone visiting the service. On the day of our inspection we observed several visiting relatives within the bedroom areas. The manager told us that the night staff would have left them outside people’s rooms to save disturbing people during the night. When we saw the records outside people’s rooms it was 11am. This meant that people’s privacy was not being respected and personal information was at risk of being seen by anyone entering the service

# Is the service responsive?

## Our findings

Two people we spoke with had chosen to stay in their room and not join the communal areas. They told us that their choice had been respected and staff gave them options of how they spent their time. One person told us: “Even though they know I like it up here, they [staff] still ask me every day if I want to go down”.

Five people who used the service told us they did not know what was included in their care plan. In the four care records we looked at we could not see that people who used the service or their relatives had been involved in the process of assessing the person’s care needs or their mental capacity. The registered manager and nurse were unable to show us that all people or their representatives had been involved in their own or their relative’s assessment. This meant there was inconsistency in the involvement of people in their own or their relative’s care plan.

A large proportion of people who used the service were living with dementia. There were no visual prompts, photographs or other signs to support people in orientation of time and place. This would have supported people to maintain their independence. The National Institute of Health and Care Excellence (NICE) guidelines state: “The care provider has the ability to control and change the environment to a much greater extent. They should be aware of the value of creating homely settings that enable people to participate in day to day living activities; of having simple layouts that are easy to follow; of the impact that contrasting colours, good signage and effective lighting can have.” We spoke to the registered manager about the lack of visual prompts for people and they told us: “I don’t like that kind of thing”.

Staff were employed to support people to pursue their hobbies and interests. We saw that planned activities were advertised on a small board in the reception area and in the residential service in the staff room, which most people would have not been able to see. On the day of our visit a religious service was conducted in a main lounge area. We observed that staff were giving out drinks at the same time as the service and potentially disturbing people’s enjoyment. We asked if people in the lounge had been asked whether they wanted to participate in the service. We were told that they had not. Due to their mobility needs some people would have been unable to leave the room if they didn’t want to participate in the religious ceremony. This meant that people were not receiving support which was responsive to their personal religious needs.

We looked at the care records for four people who used the service. One person’s care records stated that the person required the use of a pressure cushion, thickened drinks and that they wore spectacles. We observed that these were provided. This person was also observed to complain of pain, the nurse responded by offering them pain relief which they took.

From our discussions with people who used the service, staff and reviewing of care records we saw that staff responded quickly by raising referrals to appropriate health care professionals if there were any concerns about a person’s health. Staff supported people who were unable to communicate their needs during these times.

The provider had a complaints procedure. Relatives we spoke with told us they felt confident if they had any issues about their relative’s care it would be dealt with. One person who used the service told us: “Sometimes we have meetings with other residents to discuss our needs and the staff always respond well to my grumbles and sort them out quickly”.

# Is the service well-led?

## Our findings

During our inspection we found that not everyone had been involved in the decision making about their care, treatment and support. This was because the principles of the Mental Capacity Act (2005) (MCA) were not consistently followed and best interest meetings had not been held for people that required support in decision making.. People's care plans and risk assessments did not always record the relevant information to be able to care for them safely. Staff had not received specialised training or training in the MCA and Deprivation of Liberty Safeguards (DoLS). This meant that people were not being cared for by effective, trained staff. The service was not responding to people living with dementia by following nationally recognised guidelines in order to meet their needs.

Service satisfaction questionnaires were completed by people who used the service or their relatives. Comments recorded on them were overall positive. However, we did not see that the information from the questionnaires had been collated or any areas for improvement identified.

People's individual incidents and accidents were recorded electronically on their care records. We did not see that information from these had been analysed and used to reduce risk to people who used the service.

This indicates a breach of Regulation 10 of the Health and Social Care Act as the management team had failed to identify these shortfalls through their own quality and safety monitoring processes.

Health and safety audits were conducted on a regular basis. Audits included: nurse call systems, window chain checks and an infection control audit. We saw fire safety and maintenance of equipment were undertaken in a timely manner.

There was a registered manager in post. People who used the service and their relatives told us that the management team were approachable. One relative told us: "Staff will phone the family if they have any concerns".

Regular staff support and supervisions took place every eight weeks. Staff had opportunities to contribute to the running of the service through regular staff meetings. Staff told us that the management team were open and approachable if they had any concerns.

Meetings for people who used the service and their relatives took place. We saw minutes of these which showed that when people had concerns they were dealt with.

Our records showed that we had received all the required health and safety notifications in a timely way. This meant the service followed the correct procedure and notified us of significant events.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records</p> <p>The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from the lack of proper information about them by means of maintenance of-</p> <p>an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user</p> <p>The registered person must ensure that the records referred to in paragraph 1 are –</p> <p>kept securely and can be located promptly when required</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff</p> <p>The registered person must have suitable arrangements in place in order to ensure that persons employed for the purpose of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by –</p> <p>receiving appropriate training, professional development, supervision and appraisal</p>

This section is primarily information for the provider

## Action we have told the provider to take

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

The registered person must protect service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to

Regular assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this part of the regulation

Identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

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.