St. Vincent Care Homes Limited

St Vincent House - Gosport

Inspection report

St Vincent House
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Gosport
Hampshire
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Date of inspection visit:
19 September 2017

Date of publication:
31 October 2017

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

St Vincent House – Gosport is a care home providing accommodation for up to 34 older people, including those living with dementia. At the time of our inspection there was 26 people living at the home. The inspection was unannounced and carried out on 19 September 2017.

This inspection was prompted by a notification of an incident where a person using the service died. At the time of the inspection, there was an ongoing criminal investigation into the death and as a result, this inspection did not examine the circumstances of that incident. However, the information shared with CQC about the incident did indicated potential concerns about the management of the risk of choking. This inspection examined those risks.

The home did not have a registered manager in place at the time of this inspection. This was because the previous registered manager had left in June 2017 and the current manager was still in the process of registering with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

All of the care plans and risk assessments were digital and recorded onto the provider's electronic systems. Each member of staff on duty had an individual tablet computer, which allowed them to access and update people's information and records during the day when support was provided.

People's care plans and associated risk assessments in respect of choking were detailed and provided clear guidance to staff on how to reduce those risks.

Staff knew the people who were at risk of choking and were able to explain how to help reduce those risks and the action they would take if someone started to choke.

The manager sought specialist advice from the Speech and Language Therapists (SALT) when people were identified as being at risk of choking.

Staff had received appropriate first aid training, which was managed through the provider's electronic monitoring system.

There was sufficient staff to meet people's needs. Those staff who prepared people's food knew which people were at risk of choking and their dietary needs.

There was a clear management structure and the provider was fully engaged with the home through the executive advisor.

There was a structured approach to the quality assurance of care plans and risk assessments.

Accidents and incidents were recorded; analysis and the lessons learnt fed back through staff meetings and training sessions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

Staff were aware of which people were at risk and the action they should take to reduce those risks.

The manager sought specialist advice when people were identified as being at risk of choking.

Staff had received appropriate first aid training and were able to explain the actions they would take if the thought someone was choking.

There was sufficient staff to meet people's needs. Those staff who prepared people's food knew which people were at risk of choking and their dietary needs.

Is the service well-led?

Inspected but not rated

The home did not have a registered manager in place at the time of this inspection, although the current manager was in the process of registering with CQC.

There was a clear management structure and a structured approach to the quality assurance of care plans and risk assessments.

Accidents and incidents were recorded and analysis was provided by the executive advisor who was the provider's representative.

St Vincent House - Gosport

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. The inspection of St Vincent House – Gosport was carried out on 19 September 2017 by an inspector and a specialist advisor in the care of older people and those living with dementia.

This inspection was prompted by a notification of an incident where a person using the service died. At the time of the inspection, there was an ongoing criminal investigation into the death and as a result, this inspection did not examine the circumstances of that incident. However, the information shared with CQC about the incident indicated potential concerns about the management of the risk of choking. This inspection examined those risks.

Before the inspection, we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events, which the service is required to send us by law.

We spoke with five members of the care staff, the cook, the deputy manager, the manager and the executive advisor, who was the provider's representative.

We looked at the care plans and associated records for five people living at the home, who were at risk of choking. We also looked at other records related to the running of the service, such as, policies and procedures, training records and quality assurance records.

The service was last inspected on in February 2017 when it was rated requires improvement.

Inspected but not rated

Is the service safe?

Our findings

People were supported by staff who were aware of the individual risks relating to people, particularly in respect of the risk of choking. Where people had been assessed as being at risk of choking, care plans provided clear guidance for staff on how to manage that risk. Care plans showed that people with dysphagia [swallowing problems] had access to specialist nutritional support and advice and that this was sought appropriately and in a timely manner. For example, the Speech and Language Therapist (SALT) reviewed one person who had complex nutritional needs. They had identified the person needed a diet which was soft and moist and can be broken down by a fork or a pudding grade diet. The person's care plan was clear and confirmed the type and texture of the diet the person should have. They also had their food on a coloured plate so staff were aware that they were at risk and on a special diet. When we spoke with staff, they were knowledgeable and knew the care and support that had been planned for this person. We saw staff supporting the person in line with their care plan.

All of the care plans and risk assessments were digital and recorded onto the provider's electronic systems. Each member of staff on duty had an individual tablet computer, which allowed them to access and update people's information and records during the day when support was provided. Where concerns or issues were identified these could be flagged so that they were electronically raised to the senior member of staff on duty for sharing during staff handovers. One member of staff told us, "I sit and read the care plans when I get five minutes. I use the tablet computer to check if I am not sure about something. I like to check the handovers when I have been off [for a few days]. You can skip back to whatever date you want." Staff using the system were able to demonstrate a good understanding of the system and were able to access information quickly when we requested it. Staff told us they liked the system, which allowed them to check if they were unsure about any aspect of a person's care needs or risk. For example, the amount of thickener that was required to be added to people's fluids if they were at risk of choking.

People's preferences had been documented and care plans contained information necessary for staff to provide person centred care. During our inspection, we saw that these preferences had been followed. For example, in one person's plan it identified that they liked "biscuits soaked in tea." During the inspection we saw staff supporting this person in line with their care plan. Staff who prepared people's food were aware of which people were at risk of choking, their dietary needs and their likes and dislikes. People had a choice of what they wanted to eat and where they wanted to eat their meal. A member of staff, on each shift, was specifically nominated to assist the people in the lounge dining area who required support with their food. One member of staff told us when they were the nominated member of staff they "focused on one person at a time." A second member of staff was nominated to assist people who needed support with their food but chose to remain in their bedrooms.

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. For those people who were at risk of choking and lacked the capacity to make decisions about how they should be supported staff had completed the Hampshire mental capacity nutrition toolkit and best interest decision documentation.

People were supported by staff who had the knowledge necessary to enable them to respond appropriately to concerns, if people started to choke. All of the staff and the manager had received appropriate training in first aid. All of the staff we spoke with were able to explain the symptoms of choking and the actions they would take if the thought someone was starting to choke.

People told us that there were sufficient staff to meet their needs. The manager told us that staffing levels were based on the needs of the people within the home. We observed that staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner.

Inspected but not rated

Is the service well-led?

Our findings

The home did not have a registered manager in place at the time of this inspection. This was because the previous registered manager had left in June 2017 and the current manager was still in the process of registering with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

There was a clear management structure, which consisted of the directors, the executive advisor, who was the provider's representative, the manager, the deputy manager and heads of care. Staff were confident in their role and understood the part each person played in delivering care within the home. The manager told us they felt supported by the provider, who was fully engaged in running the home and the executive advisor, who visited the home once or twice each week.

There was a structured approach to the quality assurance of care plans and risk assessments. These were digital and managed through the provider's electronic care plan system. This approach allowed the management team to quickly access all care plans and risk assessments to ensure they were accurate and up to date. We saw that all of the care plans, in respect of those people who were at risk of choking, had been recently reviewed and updated in line with people's risks and changing needs. The manager told us they were in the process of embedding people's risk assessments into their care plans, rather than as a separate document. This was to provide staff with a clear picture of people's needs and the risks associated with those needs in one place and allow for electronic oversight and review.

A team of staff from the local commissioning group was also supporting the home. They were providing advice and support in respect of the content and quality of the people's care plans and associated risk assessments and in particular, those risk assessments in respect of choking.

Accidents and incidents, which occurred at the home were recorded on the provider's electronic system and linked to the person's care plan and risk assessments. The executive advisor provided analysis of all accidents and incidents across all of the provider's homes. This enabled the identification of trends and lessons learnt which was fed back to the respective manager and at the provider's managers meetings. The lessons learnt were also incorporated into staff training sessions, such as first aid training.

The provider had an electronic system to in place to record the training that staff had completed and to identify when training needed to be repeated. We looked at the training matrix for the home and saw that staff had either recently completed their first aid training or were due to attend a training session later that month. The executive advisor, who was also the first aid trainer told us they had recently adapted the training. This was as a result of the lessons learnt following analysis of the accidents and incidents at the home.

The provider had a policy and procedure in place in respect of basic life support. This policy included the

management of choking. Following our inspection the executive advisor told us that in light of the recent choking incident they had now created a separate choking policy. This policy was being supported by the use of flash cards, which will be given to all staff as an aide memoir.