Care UK Community Partnerships Ltd

St Vincents House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We conducted a comprehensive inspection of this service on 26, 27 and 30 October, and 3 November 2016. One breach of legal requirements was found in relation to inaccurate completion of records to demonstrate people's needs were responded to in accordance with their individual care plans. After this inspection, the provider wrote to us to say what actions they would take to meet legal requirements in relation to the breach. After that inspection we received information of concern in relation to the quality of the care and support for people living with dementia. We wrote to the provider requesting information about this concern. Shortly before this unannounced inspection we received information of concern that insufficient staff were deployed to ensure people received appropriate care and support to meet their needs.

We carried out this inspection to check that the provider had adhered to their action plan, to establish if they now met legal requirements and to examine these concerns. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for St Vincents House on our website at www.cqc.org.uk.

St Vincents House is a 92 bedded care home with nursing for older people, and there were 76 people using the service at the time of the inspection. The service comprises four separate units and provides care and accommodation for older people with general health care needs and older people living with dementia. Accommodation is located over three storeys and the building has a passenger lift.

There was a registered manager at the service. 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.

At this inspection we found that the provider had improved the quality of record keeping and was continuing to support staff to maintain satisfactory record keeping. The improvement in record keeping meant that staff now had clear information to enable them to identify if people were not receiving the care they needed, for example if people were at risk of malnutrition, dehydration and either the development of new pressure ulcers or the further deterioration of existing skin damage. There were systems in place for staff to liaise with other professionals when they identified concerns, so that people's needs could be promptly addressed. The management team had established a programme of monitoring and auditing of care practices and accompanying records, in order to ensure that all staff were aware of their role and responsibilities. Following this inspection, we concluded that the provider had met the legal requirements of the Warning Notice we had issued.

At this inspection we found that staffing levels had not been decreased, which was a potential concern expressed by staff at the previous inspection. The provider stated that ongoing recruitment was needed in order to reduce the use of agency staff, so that people using the service and the permanent staff team benefitted from better continuity and stability. We noted that improvements had been made since the

previous inspection in order to promote people's safety. There was a noticeable increase in staff compliance with wearing an identification badge, to enable people and visitors to identify who they were speaking with. The cleaning programme had addressed issues of clutter and dust within the premises.

We did not observe any concerns with the care and support provided for people living with dementia. Comments from relatives and external professionals indicated that people's needs were understood and met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found that action had been taken to improve safety.

People, and relatives where applicable, stated there were usually enough staff on duty. However, a negative impact on the quality of care was experienced on the occasions when insufficient staff were available.

Staff were clearly identifiable to people and visitors and the premises were free from unnecessary clutter.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

We found that action had been taken to improve responsive.

The provider had taken appropriate action to improve the quality of record keeping, in order to demonstrate that people's needs were properly assessed and met.

People were provided with appropriate support in the event of unintentional weight loss.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

St Vincents House

Detailed findings

Background to this inspection

We carried out a focused inspection of St Vincents House on 6 and 14 March 2017. The inspection was unannounced on the first day and we informed the provider of our intention to return on the second day. The inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our previous inspection on 26 and 27 October and 3 November 2016 had been implemented. We also looked into other concerns we received about the service.

We inspected the service against two out of five questions we ask about services: Is the service safe and is the service responsive? The inspection team consisted of two adult social care inspectors on the first day and one adult social care inspector on the second day. During the inspection we spoke with five people who used the service and one relative. Some of the people who used the service were living with dementia and were not fully able to tell us their views and experiences. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us. We also spoke with one visiting health and social care professional, three health care assistants, two staff nurses, three unit managers, the clinical lead, the registered manager and the regional manager. We looked at a range of records including eight care plans and associated records, staffing rotas and quality monitoring audits.

Following the inspection we spoke by telephone with four relatives, and contacted representatives from the local authority safeguarding team and the local clinical commissioning group for their comments about the service.

Requires Improvement

Is the service safe?

Our findings

Prior to carrying out this inspection we received information of concern alleging there were insufficient staff deployed at the service, which resulted in people not receiving safe care and support. At the time of the previous inspection we received mixed comments from people and relatives about the staffing levels; however, people had confirmed they noticed the impact on the quality of care and support when staffing numbers decreased, for example if a staff member was off sick and attempts to replace them were unsuccessful. Staff said at the previous inspection that they were worried that the provider might reduce the current staffing levels or not appropriately enhance staffing numbers in the event of higher occupancy rates and increased dependency levels. At the previous inspection we noted that there were 72 people using the service and at this inspection we found this had increased to 76 people. The provider informed us they were continuing to admit new residents in a planned manner, to ensure they could properly assess and address people's needs.

At this inspection people and relatives reported that they were pleased with how staff met their needs but they observed a negative impact when the provider booked agency staff. One relative told us, "I would say that the care is very good but falls down as soon as they use agency staff" and gave us an example of when their family member's care was not provided in line with their care plan as an agency worker did not know how to correctly offer support. The relative acknowledged that it was a difficult situation for the service as people's safety would be more compromised if the provider did not book agency staff. A second relative said, "I am happy with the care but when they are short of staff it is very busy. The staff will do everything [my family member] needs but you can see they are working so hard to make sure they get round to everybody." A third relative reported, "The staff are great and work their finger to the bone." We observed that staff interacted positively with people and saw that care was provided in a kind and patient manner. The staff we spoke with demonstrated a good knowledge of people's needs and confirmed to us that the staffing numbers and skill mix on both days of the inspection were in accordance with the rotas.

We received comments from some staff in regards to whether there were sufficient staff deployed. Comments indicated that episodes of short staffing occurred when the management team could not replace a staff member, for example if a colleague reported being unable to attend work close to the beginning of a shift. One staff member told us that there were now higher standards in place in relation to how health care assistants and staff nurses completed care records and this had created a sense of additional work until staff got used to these responsibilities.

We discussed the information of concern about staffing levels with the registered manager, the clinical lead and the regional manager. The registered manager told us that both himself and the clinical lead assisted staff if a unit did not have its full complement of staff and since the previous inspection they had been working alongside nursing and care staff during the week and at the weekend. This practice had been arranged in order to support staff to develop their skills and confidence to produce accurate record keeping. The regional manager stated that the service was continuing to recruit new staff so that the use of agency staff could be reduced.

At the previous inspection we noted that staff wore different uniforms according to their roles, which enabled easier identification by people and their visitors. However, we had also observed that a significant number of staff were not wearing name badges, which could have impacted on people's ability to accurately report any concerns about the conduct of individual staff. At this inspection we saw that staff wore their allocated identification and in exceptional circumstances had applied a temporary name badge.

At the previous inspection we had observed that although the parts of the premises used by people and their visitors were clean, there were thick layers of dust on high level pipes in the laundry room. On the first day of the previous inspection we found an unoccupied bedroom was being used for storage and a COSHH (Control of Substances Hazardous to Health) equipment room contained boxes stored on top of each other and items for disposal, including a television set, which sat next to new pillows. This cluttered room was next door to a utility that provided electricity, which might have caused a hazard. At this inspection we noted that the cleaning programme had addressed dusty areas and actions had been taken to remove clutter.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we found examples of inaccurate record keeping within people's care plans. These findings included an out of date and incorrect score for the Malnutrition Universal Screening Tool (MUST) assessment, no night time repositioning was recorded on a person's repositioning charts for two nights and the failure of staff to commence a daily fluid balance chart and a daily food chart in accordance with guidance given one day earlier by the clinical lead. We had also noted conflicting information in relation to how frequently a person needed to be repositioned and no written information as to the actions taken by staff when a person who had been identified as being at risk of dehydration did not attain their target daily fluid intake.
These issues in relation to record keeping resulted in us issuing a Warning Notice to the provider, which was due to be met by 31 January 2017.

At this inspection we found the provider had achieved significant improvements, which had also been noted by people and their relatives. One relative told us, "They are looking after [my family member] very well. He/she has been repositioned every few hours. They have managed to eliminate his/her bed sores. They explained to me why he/she is at risk of these sores and that's why they do the turns. I can't fault this place." Another relative told us, "[My family member] is very happy here and the care is good." They said they had read the most recent Care Quality Commission inspection report and thought that staff had worked hard to make real improvements, "I am over the moon about how they look after [my family member.] They are caring, full of compassion and keep this place spotlessly clean." A third relative commented on how the staff cared for his/her family member, "Staff are very nice and [the registered manager] is a very nice man who will do his best to sort things out. They have been putting [my family member] to bed for pressure sore care. They showed me the photos. I see them change his/her position."

Staff told us they had received training and support about how to complete care planning documents and other records that demonstrated how they met people's personal and health care needs. This was confirmed when we looked at a range of documents, which included training records and minutes for nursing and care staff meetings, one to one supervisions, individual and group coaching sessions, and focused clinical meetings. The clinical lead and the registered manager explained that in order to make sustainable improvements they had provided training and guidance for not only nursing and care staff but also housekeeping, catering and maintenance staff so that there was a wider understanding about the importance of making sure people had the right nutrition, hydration and equipment to meet their needs. We noted that spot checks and audits were conducted by management staff at the service and senior quality assurance staff from the provider's head office.

We looked at eight care plans for people with a range of complex needs that required careful record keeping. This included people with a pressure ulcer or identified as being at risk of developing pressure ulcers and/or people who needed close monitoring to ensure they received adequate nutrition and hydration. The records were accessible, arranged in an organised way and showed clear improvements, although we found a few examples of areas for further progress. For example, one person's care plan stated they were prescribed a medicated shampoo; however this item was no longer prescribed on their medicine

administration record. We discussed this with a staff nurse who confirmed this was a recent change to their personal cleansing and hygiene regime and assured us they would update the care plan. However, we saw a positive example where a member of staff had made an error when assessing the risk score for a person's Waterlow assessment. (This is a pressure ulcer risk assessment and prevention policy tool.) The staff member had noted their mistake when adding up the score and written out a new chart with the correct score.

We spoke with a visiting GP from the practice that attends to the medical needs of the vast majority of people who use the service. The GP told us that the registered manager and clinical lead had consulted with them and a senior partner about the improvements that needed to be achieved following the last inspection visit. The GP explained to us that they regularly reviewed the fluid intake targets for people, as sometimes the standard calculation tool did not take into account specific medical factors affecting an individual. On the first day of the inspection we found that one person had not achieved their target daily hydration level for over three days, which meant they needed to be referred to a GP for review in line with the provider's policy. We discussed this finding with the clinical lead as there was no evidence that a GP referral had been made. On the second day of the inspection we noted that the person had now been seen by a GP, who had confirmed that the person did not need daily monitoring of their fluid intake.

We received information of concern about the quality of care and support given to people living with dementia. The main concern was that people were unintentionally losing weight and the provider was not identifying and addressing the need to assist people to maintain a satisfactory nutritional intake. There were also concerns expressed that people's clothes and other laundry items were not properly looked after and people were not provided with social stimulation. Following the receipt of this concern, we had contacted the provider and requested information about people's safety, wellbeing and participation in social activities. The registered manager sent us a range of information which included audits and evidence that referrals were made to dietitians when people unintentionally lost weight. At this inspection we spoke with the GP about the health care of people living with dementia care needs. We were told that the staff were pro-active in identifying unintentional weight loss and they promptly reported their concerns to relevant health care professionals, along with any other clinical observations that could indicate people needed medical support. The GP said that people received build up drinks and fortified food items, for example porridge with added cream and mashed potato with added cream and butter, and their weight status was kept under review and discussed with nursing staff at subsequent GP rounds.

We spoke with relatives about the support given to their family members. One relative told us, "[My family member] has severe dementia. Nothing is too much trouble for the staff, it's a fantastic place and never smells of urine." During the inspection we observed that people were encouraged to take part in activities, which included a film afternoon on one of the units and a tea party in the ground floor café with a visiting musician performing audience participation songs from the 1950's and 1960's.