A.G.E. Nursing Homes Limited

The Angela Grace Care Centre

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 23, 26 and 30 November 2015 and 10 February 2016. The Angela Grace Care Centre provides accommodation for up to 72 people who require nursing or residential care for a range of personal care needs. The home has four floors, one of which was not in use. One floor was dedicated to people requiring assessment following discharge from hospital. The other two floors had people who required nursing or residential care, for dementia or other enduring mental health conditions or they were admitted specifically for end of life care. At the time of our inspection there were 51 people living at the home.

The service had a registered manager. 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.

Systems to monitor the effectiveness of some aspects of care had not been implemented, leading to inconsistent staff practices of recording and sharing information about people's care. People did not always receive their planned care to prevent pressure ulcers.

Summary of findings

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse. Staff knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS) and had applied that knowledge appropriately. People had access to an advocacy service.

There were sufficient numbers of experienced staff that were supported to carry out their roles to meet the assessed needs of people living at the home. Recruitment procedures protected people from receiving unsafe care from care staff unsuited to the job. Staff received training in areas that enabled them to understand and meet the care needs of each person.

People's care and support needs were reviewed and updated as people's needs changed. People had been involved in planning and reviewing their care when they wanted to.

People were supported to have sufficient to eat and drink to maintain a balanced diet. Staff monitored people's health and well-being and ensured people had access to healthcare professionals when required. There were appropriate arrangements in place for the management of medicines.

Staff understood the importance of obtaining people's consent when supporting them with their daily living needs. People experienced caring relationships as staff had taken time to build therapeutic relationships with them. People's dignity and right to privacy was protected by staff.

People were supported to carry out their wishes about their care at the end of their life. Nursing staff were experienced in carrying out assessments and providing care that met people's end of life needs and accessed the community end of life care team for additional support.

The Registered Manager provided staff, residents and relatives with opportunities to discuss the improvements and changes in the home. People had provided positive feedback about their experiences in the home. People had their comments and complaints listened to and acted on.

We identified that the provider was in breach of two of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and you can see at the end of this report the action we have asked them to take.

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?

Requires improvement

The service was not always safe.

Staff did not always receive accurate information on handover of shifts.

People were not adequately monitored for injuries following incidents and accidents.

People's risks were not always reviewed using effective tools to measure their risks.

People had plans of care to mitigate their identified risks, but staff did not always follow the plans.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse.

People received their care and support from staff that had been appropriately recruited and had the skills and experience to provide safe care.

People's medicines were appropriately managed and safely stored.

Is the service effective?

Good

The service was effective.

Care staff knew and acted upon their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS).

People received care from staff that had the supervision and support to carry out their roles.

People received care from care staff that had the training and acquired skills they needed to meet people's needs.

People were supported to have sufficient to eat and drink to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People's care and support took into account their individuality and their diverse needs.

People's privacy and dignity were respected.

People were supported to make choices about their care and staff respected people's preferences.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

People's needs were assessed prior to admission and subsequently reviewed regularly so that they received the timely care they needed.

People's needs were met in line with their individual care plans and assessed needs.

Appropriate and timely action was taken to address people's complaints or dissatisfaction with the service provided.

Is the service well-led?

Requires improvement 

The service was not always well-led.

Systems and processes had not always been sufficiently established to monitor all aspects of care, records and information sharing.

The management promoted a positive culture that was open and inclusive.

The service worked well with other providers.

The Angela Grace Care Centre

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 unannounced inspection took place on the 23, 26 and 30 November 2015 by two inspectors and an expert by experience. A further inspection was undertaken by one inspector on 10 February 2016. An expert-by-experience is a person who has personal experience of using or caring for someone who uses dementia care.

We reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners that help place and monitor the care of people living in the home that have information about the quality of the service.

We undertook general observations in the communal areas of the home, including interactions between staff and people. We viewed observed people's care during their and medicines being dispensed.

During this inspection we spoke with 17 people who used the service and eight of their relatives. We spoke with external health professionals. We looked at the care records of seven people and the medicine records of 13 people. We spoke with the registered manager and 19 staff including four nurses, ten care and three support staff. We looked at six records in relation to staff recruitment and training as well as records related to quality monitoring of the service by the provider and registered manager.

Requires improvement

Is the service safe?

Our findings

Staff did not always follow guidelines that were designed to detect injury following a fall, putting people at risk of harm from potentially untreated injuries. Where people had sustained an injury from a fall, records showed that staff had assessed their condition and taken the appropriate immediate steps, such as calling for medical assistance. However, in November 2015 one person had a number of falls which had not been followed up by staff; they were taken to hospital with a serious injury two days after the falls. The manager implemented guidelines to check people's health and well-being for up to 24 hours after a fall, however, records showed that not all staff were not routinely recording that they had checked people at regular intervals for up to 24 hours after a fall. There were differences between the practice of following the guidelines between each floor of the home. There was no system in place to monitor the use of the guidelines; we brought this to the attention of the registered manager who had not taken any action as yet. People remained at risk of incurring injuries without this being detected as staff did not always follow the guidelines designed to detect this.

People's needs were not always reliably relayed to staff in handover meetings at the beginning of each shift. Nursing staff relied on the handover information sheets, care plans and white boards in their offices to provide key information about people in an emergency; however, the information did not always correlate with each other. The handover and the types of information varied between the different floors of the home. There had been two incidents in September 2015 where nursing staff had not been able to find all the relevant information for ambulance crew in an emergency. People's information, including information about their decision to be resuscitated in the event of a cardiac arrest, was not always accurately recorded. This was brought to the attention of the manager who had yet to implement a reliable system of recording people's care needs to staff in handover.

The falls risk assessment did not take into account all of the relevant risk factors such as the number of previous and recent falls a person had experienced. We saw that two people continued to have falls as staff had not been made fully aware of their risk of falls as the risk assessment had not identified them as at high risk. A high risk would have prompted staff to be more vigilant and provide more supervision. People continued to be at high risk of falls, where staff had not been made aware to be more vigilant due to the ineffectiveness of the falls risk assessment.

Although people's needs were regularly reviewed and their care plans were updated to reflect changes, staff did not always ensure that actions to mitigate the identified risks were carried out. People who had been identified as at high risk of acquiring pressure ulcers were provided with pressure relieving air mattresses, however staff did not always ensure that the mattress settings were set to a therapeutic level to relieve people's pressure areas. We brought this to the attention of the nurses and the manager who took steps to ensure people's pressure relieving mattresses were set to the correct settings and these were monitored regularly.

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

People felt confident that they could raise their concerns directly with staff and that these would be appropriately responded to. One person told us "I feel safe here, because the care is good", a relative also told us "[name] feels safe here". Staff understood their responsibilities to safeguard people and knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. They had received training and were supported by up to date guidance and procedures, including guidance on how to report concerns and the contact details for relevant authorities. Staff provided examples where they had identified concerns and alerted the manager. Records showed the manager had made timely referrals to the safeguarding authorities.

The manager calculated how many staff were required and ensured that enough staff were allocated on the rotas. There had been episodes up to the inspection in November 2015 where the rotas showed there were less staff, and people told us that they had to wait for care. We passed our concerns onto the registered manager and in February 2016 we saw that more staff had been recruited and staff told us that the situation had improved, one member of staff told us "there are more staff around at meal times."

Prior to commencing employment in the home, all staff underwent relevant pre-employment checks and interviews to ensure that people were protected from the

Requires improvement

Is the service safe?

risks associated with the recruitment of new staff. Nursing staff were required to prove their nursing registration and this was monitored to ensure they maintained their registration.

People were assured that regular maintenance checks were made on safety equipment, such as the hoist and the fire alarm. There was a business continuity plan in place which explained the actions that staff would take in the event of anything disrupting the service, such as a failure of the power supplies. Personal emergency evacuation plans for each person were available to staff in the event of an emergency. Staff had received fire awareness training and regular fire alarm checks were carried out. Staff were mindful of the need to ensure that the premises were kept appropriately maintained to keep people safe. There was a system in place for ensuring that the front door was secure to minimise the likelihood of uninvited visitors entering the premises without staff knowledge or people's agreement.

There were appropriate arrangements in place for the management of medicines. Staff had received training in the safe administration of medicines and passed competency tests that demonstrated they were knowledgeable. People told us that they received their medicine when they needed it. We observed staff administering medicines to people and heard them explain what the medicines were for. Staff followed guidelines to give medications that were prescribed just in case of pain or other symptoms, such as Paracetamol. There was regular monitoring of the medicines where issues that had been identified had been addressed.

Good

Is the service effective?

Our findings

People received care and support from staff that had completed an induction that orientated staff to the service. Staff induction included training in moving and handling and infection control, where staff completed workbooks to demonstrate they had understood the training. Staff spent time with more experienced staff to get to know people and their care as part of their induction.

Staff received training in areas that enabled them to understand and meet the care needs of each person they cared for such as an overview of dementia. Care staff commenced the Care Certificate through an outside agency to gain and improve their skills. Nursing staff received training in areas such as catheterisation; the provider was in the process of developing a range of training for nurses to help develop their roles.

People were cared for by staff that received supervision to carry out their roles. Staff told us that they felt supported by the manager as they had regular meetings where they had the opportunity to bring up any issues and staff saw these issues were dealt with immediately.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment 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).

Nursing staff and the registered manager understood their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS) and had applied them appropriately. Where people had been assessed and found to not having capacity there were best interest meetings with the GP and family to make and record the decisions about their care.

Where people could not consent to their care, their next of kin or families were involved for example, relatives provided staff with information on people's likes and dislikes and staff provided relatives with updates of people's care. We saw that some relatives had signed to consent for photographs to be taken and records to be shared with health professionals.

People received enough to eat and drink to maintain their health and well-being. Staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). Staff referred people to the in-house nutritionist when people had been assessed as being at risk. People were referred to health professionals when they experienced difficulties in swallowing or continued to lose weight. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely, for example where people had difficulty in swallowing, staff followed the health professionals advice to provide food that had been pureed. People had access to drinks in their rooms and were offered hot drinks regularly and staff recorded what people drank on a daily basis.

People had been assessed for their needs to be able to eat independently and actions such as providing adapted cutlery and plate-guards were written in care plans. Care staff were seen to provide these at meal times and provide assistance for those people who needed it. We observed that some people were unable to sit at a table long enough to eat a meal, and staff accommodated them by providing food little and often to ensure they ate enough to maintain their well-being.

People were supported to have sufficient to eat to maintain a balanced diet. People told us they had a choice of meals and that there was always enough food. One person told us "the food is quite good, I don't like curry and pasta, so they do me a jacket potato. I get lots of vegetables". The chef had a good knowledge of people's dietary needs and had access to information at a glance which showed people's needs likes and dislikes and were able to adjust meals accordingly.

People's healthcare needs were met. Nursing staff monitored people's well-being by taking their clinical observations regularly, such as blood pressure. Where people required closer observations such as on return from hospital, the nurses carried out regular clinical observations and understood when to report any abnormal readings to the GP or hospital. People told us that if they

Good

Is the service effective?

needed to see the doctor they told a member of staff and this was arranged for them. People had access to other health professionals such as a chiropodist who visited the home regularly.

Good

Is the service caring?

Our findings

People told us that they were treated nicely. One person told us "the nurse is very kind and patient", a relative told us "the carers are kind and lovely". We observed one person living with dementia asking staff the same questions over and over again, and staff responding kindly and answered their questions properly. One relative told us "I am very happy with the care [name] receives."

Where people were admitted to the home for a short time, we saw that staff were mindful about getting to know their needs quickly. One of the care staff told us "the nurses tell us about new people at handover so we understand what people need and what they like."

People who lived at the home had their needs met by staff that had got to know their likes and dislikes. Staff were aware of people who responded well to music and to conversation. We saw that people received their hot drinks from staff that understood if they needed a beaker or the consistency of their drink made thicker.

People benefited from staff that had taken time to build therapeutic relationships with people. We observed that whenever people experienced anxiety they received reassurance from staff; we saw that people became more relaxed in the close proximity of staff. We observed staff taking time to talk to people and involving them in the daily life in the home, by holding their hand and taking part in activities. Staff were skilled in communicating with people even when people were unable to communicate verbally. We saw that staff responded to people's body language and took care to ensure that people could understand what they were communicating.

People's dignity and right to privacy was protected by staff. We observed that people were asked discreetly if they would like to use the bathroom and as people were assisted in moving from their chair the staff explained how they would be moved using a hoist. People's needs were met by staff in a dignified manner, for example we saw a member of staff helping someone to eat their meal at a pace that suited them. Staff gave examples of how people's privacy and dignity was respected, one member of staff told us "we make sure that people's bedroom doors are closed when we give personal care and people are dressed properly."

People had access to an advocacy service. Where people had no next of kin, we saw that an advocate had been appointed to represent them in times when they could not make decisions for themselves.

People were supported to carry out their wishes about their care at the end of their life. Where people had chosen to be admitted to the home for their end of life care, nursing staff from the home had visited people in hospital to assess their needs and speak with them and their families about their wishes. People and their relatives were involved in the care planning and decision making where they wanted to. Some people had decided not to be resuscitated in the event of a cardiac arrest, one person told us "just let me go as peacefully as possible", and another person told us "I've told my daughter ages ago that I don't want that [to be resuscitated]".

Records showed that where people had made specific decisions about their care that these had been carried out, for example receiving visits from their faith group. People received care that provided relief from their symptoms such as pain. Staff liaised with the community palliative care team to help manage symptoms and acquire equipment. One person showed us a special back rest that staff had resourced from the local hospice. We saw evidence of visits from Macmillan nurses and palliative care staff from the local hospice. Nursing staff were experienced in carrying out assessments and providing care that met people's end of life needs; they were aware that some people could have living wills, or advanced directives which they would carry out in line with people's wishes, although there had been no-one admitted with these yet.

Good

Is the service responsive?

Our findings

The home had three distinctive areas of care, assessment immediately after leaving hospital, where NHS physiotherapists and occupational therapists worked alongside staff to assess and monitor people for their suitability for going home or to another care setting (Castle Ashby Ward). Some people were admitted to the home for long term care (Boughton Ward), and others were identified by health professionals as requiring care at the end of their lives (Delapre Ward). Each person required different skills from staff and their suitability for admission to the home was assessed before they came to live at the home to determine if the service could meet their needs.

People receiving care on Castle Ashby Ward had regular assessments and evaluations of their care to establish their future long term care needs at home or other care settings. Staff worked closely with NHS therapists to promote people's independence and encourage people to regain skills to care for themselves. Staff were aware of the emotional needs of people in this transitional stage and the affects this can cause for people living with dementia. The NHS therapists were helping staff to work to a model of dementia care.

In all areas of the home people were assessed for their care needs, plans of care were devised with the involvement of people and their families where possible and updated regularly or as people's needs had changed. For example we saw people's care plans had been updated to reflect their changing mobility needs. Care staff had access to the care plans and took part in handover meetings at the beginning of their shift where changes in people's care were discussed.

People had opportunities to take part in activities that interested them, such as music. The dedicated activities staff aimed to meet individual needs, one person had received massages to their hands and feet, they told us it "helps my pain and movement a little."

People who were at risk of acquiring pressure ulcers relied on staff to assist them to move their position regularly; Where people had been identified as at risk of acquiring a pressure ulcer nursing staff had indicated how often people required help to change their position in order to prevent pressure ulcers. Staff recorded on daily care records where they had provided care which demonstrated that people had received their care as planned.

People's beliefs and how they wished to practice their faiths were recorded in care plans. People were helped to maintain their faith, for example one person had regular visits from their faith group and carried out religious ceremonies with them in the home. Other faith groups visited the home regularly and were informed if any people new to the home wanted to receive a visit from them.

People had their comments and complaints listened to and acted on. Where there had been verbal and written complaints in the last year, the manager had responded in writing in a timely way in accordance with the services' complaints procedure. The manager demonstrated how actions had been taken to rectify situations to prevent them happening again, for example the supply of hot water to the upper floors had been rectified. A complaints procedure was available for people who used the service explaining how they could make a complaint. People said they were provided with the information they needed about what do if they had a complaint.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in post since November 2014, when the home first opened. The Registered Manager is dual qualified RGN and RMN and had 31 years experience of nursing and specialising in dementia care.

The home provided different types of services over three floors. Teams of staff worked mainly on specific floors which meant that each team of staff had their own culture and ways of working, for example the information they shared at handover and how staff followed people up after an accident. This had led to varying degrees of care as the registered manager had not fully established systems to ensure that the quality of care was consistent.

Systems designed to ensure that nurses had all the accurate information relating to people in an emergency were not fully established. We had brought this to the attention of the manager in November 2015, however, by February 2016 they had not monitored the consistency or quality of the information available to staff in care notes or handover. People continued to be at risk of having inaccurate information relayed to staff and outside agencies.

Systems designed to protect people from undetected injury were not fully implemented. We had brought this to the attention of the registered manager in November 2015. Where people had accidents including falls, the manager had implemented guidelines for staff to check people for injury and well-being at regular intervals for 24 hours after the accident. We saw that in most cases the system had been followed, however, there was no monitoring of the use of the guidelines which meant that the registered manager was unaware that staff were not always following up where people had had an accident. There was a risk that people could incur an injury which would remain undetected as staff did not always check up on people's health and well-being for 24 hours after their accidents.

We identified that people's air mattresses were not always set to a therapeutic setting that would provide pressure relief. We brought this to the attention of the registered manager in November 2015, but they had not yet implemented a system of recording what the settings of the mattress should be for each person and or that checks had been carried out regularly to ensure that people were receiving pressure relief from their mattresses.

Records relating to people were not always complete or accurate. Staff were not always clear about people's Lasting Powers of Attorney (LPA). Where people did not have the mental capacity to make decisions about their healthcare, staff had not recorded if people had an LPA, or if they had whether the LPA was for health and care decisions. We saw that some relatives had been consulted to make decisions on people's behalf regarding their daily routine or life-sustaining treatment, but there were no clear records whether these relatives had the lasting Power of Attorney to make these decisions. We brought this to the attention of the registered manager in November 2015 but there continued to be no consistent system in place for recording if people had a lasting power of attorney for health and care decisions.

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

We provided feedback during the inspection in November 2015 and saw that changes to staffing levels and recording people's daily care had been made. This had had a direct impact on the quality of people's care as people's experiences had improved greatly. People no longer had to wait for long periods to receive care and people were getting enough to drink. Systems had been put in place to improve care staff's knowledge of people's needs and the quality of the handover between staff.

The Registered Manager had met with staff, residents and relatives to discuss the improvements and changes in the home. People had provided positive feedback about their experiences in the home. A survey had been issued to relatives, and the initial replies were all very complimentary about the service.

The service worked well with other providers such as NHS and the community end of life care team. People had benefited from their expertise and on-going input for assessment and staff guidance.

Staff said the manager was approachable and provided valuable guidance and fed back to staff constructively about how to improve care. They said the manager or provider were always available if they needed advice. Staff told us they received a great deal of support from the

Requires improvement

Is the service well-led?

manager, who they described as having an open door policy. One member of staff told us “the manager is accessible and friendly, she comes round [the home] once a day”.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not ensure that they did all that was reasonable practicable to mitigate risks to the health and safety of service users. Regulation 12 (2b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes had not been established to effectively monitor and mitigate risks to the health, safety and welfare of service users. Regulation 17 (2b)