Jasmine Healthcare Limited

St Andrew's Nursing and Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Andrew's Nursing and Care Home is situated in Ewerby near Sleaford, providing accommodation for people who require residential and nursing care. The service can support up to 45 older and younger adults, some of whom may experience memory loss. There were 36 people living in the service at the time of inspection.

People's experience of using this service and what we found

Staff had access to personal protective equipment. Although, national guidance around donning and doffing were not always followed. The provider had implemented systems and processes to protect people from COVID-19 however, these were not always adhered to.

There were quality assurance processes in place. However, audits did not identify shortfalls in the service and audits were not robust. People received their prescribed medicines, however, further improvements in practice were required. Documents were not in place to support staff to administer 'as and when required' medicines.

Falls and accidents were reviewed and monitored. However, there was not always evidence of positive actions and lessons learnt following these reviews. People using the service told us they felt safe.

Staff had received training in order to recognise how to protect people from abuse. However, the registered manager and staff did not recognise when their own practices were resulting in psychological harm to the people being cared for at the service.

We received mixed feedback from people using the service regarding receiving person-centred care. People using the service who lacked capacity to make their own decisions had care plans in place to ensure they were treated in the least restrictive way possible and in their best interest; Policies and systems in the service supported this practice.

The registered provider had carried out sufficient pre–employment checks. Staff were up to date with their mandatory training.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was Good (published 19th December 2019). At this inspection the service rating has deteriorated to requires improvement. Breaches of legal requirements were found.

Why we inspected

The inspection was prompted in part by notification of a specific incident. Following which a person using the service sustained a serious injury. Additionally, we received concerns relating to staffing levels in the service. We have found evidence that the provider needs to make improvements.

Please see the Safe and Well-led sections of this full report

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so

We have identified breaches in relation to The Safety of people's care, governance in the service and safeguarding at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always Well- Led.

Details in our Well-Led findings below.

St Andrew's Nursing and Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of four inspectors, two inspectors carried out the onsite visit while two inspectors supported off site.

Service and service type
St Andrew's Nursing and Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to ensure risks relating to Covid-19 could be reduced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used information the provider sent us. We used all of this information to plan out inspection.

During the inspection
We spoke with three people who used the service and two relatives about their experience of the care provided. We spoke with eight members of staff including the provider, registered manager, senior care workers, care workers and the kitchen assistant.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

● The provider had systems in place to safeguard people from the risk of abuse and knew how to follow local safeguarding protocols if required. However, the service did not always recognise when their practice was having a psychological impact on people.

●People were not always protected from derogatory treatment, which meant was is a risk people could be at risk of psychological harm. For example, one person's care plan stated they required assistance with continence care. There was an evaluation of this care plan stating the person was limited to a set amount of incontinence aids a day. The person told us, and records showed that when they went over the allocated amount of continence aids pads, they were left in an undignified situation. This was derogatory treatment which may have had a negative impact upon the person's wellbeing.

The provider failed to ensure people were safeguarded from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Most people said they were cared for and felt safe living at the service. This was confirmed in feedback from people and their relatives. One person said "I feel safe. We are like a big family."

Assessing risk, safety monitoring and management

●Risks associated with contracting COVID-19 were not always assessed. Where staff had chosen not to have the COVID-19 vaccination the provider had not conducted a risk assessment to mitigate any risks to them or people who used the service.

●Risks associated with people's care were not always identified, mitigated, recorded or monitored effectively. Prescribed power used to thicken drinks was left accessible to people who used the service. This posed a risk of people ingesting the power which could cause them to choke.

●Another person's care plan stated that they had been assessed by the Speech and Language Therapist team (SALT) as needing a modified diet, however, the care plan contained conflicting information about the consistency of the food. Staff knowledge was also inconsistent. This placed the person at risk of unsafe support.

Using medicines safely

●Medicines were not always managed safely. Information was not always available to staff to enable them to administer medicines to people in a safe way.

●Medicines were not stored in a secure way. The key to the clinic room was kept on a hook above the door.

This meant that there was a risk of unauthorised people accessing the clinic room. The registered manager informed us since the inspection that they have ordered a keypad lock to be fitted on the clinic room door.

The provider failed to ensure all risks associated with people's care had been assessed and medicines were managed safely. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The above findings were raised with the registered manager during the inspection. The container of thickener powder was removed, and the registered manager informed us that since the inspection the person has been re-referred to the SALT team for an assessment of their diet.
●Despite the above findings, we observed staff supporting people to take their medicines in their own time, without rushing them. One person said "They give me my medicines. I am happy with the way they do that."
●Personal emergency evacuations plans (PEEPs) were in place for people using the service. This meant, should people need to leave in case of an emergency such as a fire, then staff from the emergency services would be able to access information as to how best to evacuate people in an emergency.

Preventing and controlling infection
●During the inspection we observed that kitchen staff were not always wearing PPE in line with government guidance. We have also signposted the provider to resources to develop their approach. The registered manager informed us that since the inspection the kitchen staff are always wearing masks.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

Staffing and recruitment; Learning lessons when things go wrong
● Accidents and incidence had been recorded by staff and there was a formal analysis of the falls people had experienced. However, actions taken to prevent further falls was not always completed on the analysis. Lessons learnt were often not recorded.
●Training records for staff showed staff had received mandatory training. However, we identified some gaps the competency of nurses in relation to specialised equipment which could increase the risk of infection spreading. Although no one was using this at the time of the inspection, clinical staff knowledge of this risk was important to mitigate any future risk.

●The registered provider carried out appropriate pre-employment checks on staff to ensure their suitability to work with people they supported. This included references and a criminal record check. However, the providers own policy of annually reviewing staff criminal record checks had not always been adhered too.
●There were enough staff on site to provide safe care to people. A dependency tool was used to calculate how many staff were needed according to the level of care and support required. However, staff told us that recently they had been struggling as staffing numbers had been low. During the inspection we observed people to be receiving their care in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider and registered manager did not always have oversight of the culture within the home, quality assurance audits did not pick up when a person's care was not being delivered in a person-centred way.
- We received mixed feedback from people and using the service their relatives on how they were treated with dignity and respect, by the staff at the service. One person told us they had been shouted at by a member of staff. We referred this concern to Safeguarding for further investigations. Another person said "Care staff are very good. Nothing too much trouble. Quite willing to help." We observe staff being kind and caring towards people during the inspection.
- One person's care plan stated the person had mental health issues. The care plan did not offer the staff any guidance as to how to best support the person with their mental health. One person said, "I do not feel they take my mental health issues into account." This meant people were at risk of a relapse in their mental health and were not being treated in an inclusive way.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems and processes to assess, monitor and reduce risks to people's health, safety and welfare were ineffective, which impacted or had the potential to impact on people's quality outcomes.
- Staff were not always following government guidance set out around preventing the spread of COVID-19. This included staff not always taking their own temperatures on arrival, No-longer taking residents temperatures twice weekly and risk assessments of staff who did not wish to be vaccinated not addressing the risks that this might pose to people living at the service.
- Quality assurance audits did not always identify areas of concern. For example, an evaluation of a care plan did not identify the use of undignified language. Medicines audits did not identify when staff had not completed checks correctly, some staff had been recording that a fridge to store medicines was running at temperatures much higher than recommend for the medicines stored there, this had not been addressed. Failure to identify and address these issues posed a risk to people's health and safety.
- Action was not always taken to address known issues. For example, a medicines audit documented that nurses and senior carers would have supervision to cover lessons that needed to be learnt following a drug error. This had not been completed and records showed errors continued.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

●We spoke with the registered manager about these concerns during the inspection. The registered manager Shared an action plan to address the concerns. We will assess the impact of this at our next inspection.
●There were resident's meetings at the service in order to gain feedback about the service. However, they were not always well attended.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●During the inspection the registered manager was able to tell us how they act on their duty of candour by being open and honest, informing family of any incident or accident, apologising when a person has needed to make a complaint. However, when we reviewed complaints, we found families were not always informed of incidents and apologises were not always recorded.
●We received mixed feedback as to how people at the service and their relatives felt the registered manager and senior team responded to complaints or feedback. One person told us they felt their complaint would be swept under the carpet. A relative told us their relative did not like the first room they were in. They were moved and are settled well in their new room.
●The provider had a complaints policy in place which was displayed in the home. However, one person said they felt if they were to complain it would not be dealt with.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
●Most people and relatives told us they were happy with the way in which the registered manager communicated with them. Relatives told us they were kept up to date and informed about their family members care. However, there had been complaints about how visits were organised and how families were informed about the process of booking to see their relative. The registered manager had sought to resolve these issues.
●Staff supervisions had not taken place in the last year due to the ongoing pandemic. The registered manager had plans in place for all staff to have supervision going forward
●The registered manager and staff at the service worked along side health care professionals to achieve outcomes for people. This included working with the GP practice, community nurses, mental health teams and social workers.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with the prevention of COVID-19 were not fully assessed and mitigated. Medicines were not stored securely or safely. As and when protocols were not always in place. Protocols that are in place do not give staff details of symptoms or behaviors that may require as and when medication

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from discrimination, which might amount to abuse or cause psychological harm

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Although there were quality audits in place they were not robust. The registered provider and the registered manager did have oversight and were not aware of the shortfalls found on inspection.

The enforcement action we took:

warning notice