Barker Care Limited

St Teresa's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
St Teresa's Nursing Home is a nursing home providing personal and nursing care for up to 70 people. At the time of the inspection 44 people were living at the home.

The home is laid out over three floors and areas within the home have been separated into three 'wings': Gainsborough Wing, Bartlet Wing and Austen Wing. People are placed on wings according to their needs, for example nursing or dementia care.

People's experience of using this service and what we found
People and their relatives told us they felt safe at St Teresa's Nursing home. Safeguarding incidents were reported to the appropriate agencies. Staff felt confident to raise safeguarding concerns with the registered manager and were aware of external agencies where they could report concerns.

Risks to people were identified and guidance was in place for staff to reduce the level of risk to people. Checks were in place to ensure the environment and equipment was safe. Infection control procedures were in place. Medicines were managed safely.

There were enough staff available to support people safely and meet their needs. Staff were recruited safely.

Governance systems were in place to monitor the quality of service and the health, safety and welfare of people. There were systems in place to communicate with people and relatives. We received some mixed feedback from relatives regarding the recent communication with the home.

Staff commented positively about the leadership and management of the home. Staff told us their morale was good.

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 inadequate (published 10 October 2019) and there were multiple breaches of regulation. At the last inspection we served a warning notice on the provider in relation to Regulation 12, Safe care and treatment. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of Regulation 12 (Safe care and treatment), Regulation 13 (Safeguarding service users from abuse and improper treatment) and Regulation 18 (Registration Regulations 2009) (Notification of other incidents).

At this inspection we only reviewed the safe and well led key questions. This is because of our current methodology and risks related to COVID-19 meant we were not reviewing the breaches of regulations in the

effective and responsive key questions.

This service has been in Special Measures since October 2019. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We undertook this focused inspection to check whether the service was meeting legal requirements relating to Regulation 12 (Safe care and treatment), Regulation 13 (Safeguarding service users from abuse) and Regulation 18 (Registration Regulations 2009) (Notification of incidents). This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. Our report is based on the findings in those areas at this inspection.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Inadequate to Requires Improvement. This is based on the findings at this inspection.

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 coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Teresa's Nursing home on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our current re-inspection methodology. 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?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

St Teresa's Nursing 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 specific 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 was made up of two inspectors, a specialist advisor who was a nurse and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
St Teresa's Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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
This inspection was announced. We announced the inspection before we visited to discuss the safety of people, staff and inspectors with reference to COVID-19.

What we did before the inspection
We reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is legally required to tell us about. We did not request a provider information

return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make.

During the inspection
As part of our inspection we spoke to two people and seven relatives on the phone about their experiences. We also spoke with 13 members of staff, including care staff, nurses, senior carers, maintenance and domestic staff and the activities coordinator. We spoke with the registered manager, area manager and clinical manager. We reviewed nine people's care and support records. We also looked at records relating to the management of the service such as incident and accident records, health and safety records, audits and staff recruitment records.

After the inspection
We spoke with five staff via telephone conferencing. We continued to seek clarification from the registered manager to validate evidence found.

Good

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 inadequate. At this inspection this key question has now improved to good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure people were protected from avoidable harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As part of this inspection we checked if the provider had met the requirements of the warning notice we served following our last inspection, relating to the Regulation 12 breach.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

- Risks to people were identified and staff had guidance to protect people from the risk of potential harm. Where people required support to transfer using equipment, detailed plans were in place to guide staff on the equipment they should be using and how to use it.
- We reviewed risk management in relation to falls, health related risks, nutrition and the risk of developing pressure sores.
- Some people required support to reposition themselves to prevent them developing pressure sores. We found there were some gaps in the recording for two people being repositioned in line with their care plan. Staff told us this was because one person refused the support. This was not documented in the records. We found no evidence of any impact on these people and all other records checked had been completed. We discussed this with the clinical lead who told us they would address this.
- Staff were aware of people's risk assessments.
- The environmental hazards we identified in our last inspection had been addressed.
- The service environment and equipment were maintained. Records were kept of regular health and safety and environmental checks. Fire alarms and other emergency aids were regularly tested and serviced.
- Individual and personalised emergency plans were in place to ensure people were supported to evacuate in an emergency.

Using medicines safely

At our last inspection the provider had failed to ensure 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

● When people required 'as required medicines' there was guidance available for staff such as why the person should have the medicine and potential side effects. However, there was no information to guide staff about how much time there should be between doses.
● The systems in place to manage medicines safely had improved and there were appropriate policies and procedures in place.
● At our last inspection we found medicines records were not being fully completed and medicines were not always given as prescribed. At this inspection people's Medicine Administration Record (MAR) charts were completed when doses of medicines were given and people received their medicines as prescribed.
● At our last inspection we found there was a lack of information on how much time there should be between doses of 'when required' (PRN) medicines. At this inspection we saw detailed protocols had been written to guide staff when it would be appropriate to give doses of these medicines and the time required between doses.
● There were systems in place to record the application of creams and other external preparations.
● Medicines were stored securely, including drinks thickeners and nutritional supplements. Suitable arrangements were in place for medicines needing extra security.
● There were suitable systems in place for the ordering, administering, monitoring and disposal of medicines.
● Staff received medicines training and their competency was assessed.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure potential safeguarding concerns were identified and referred to appropriate agencies, putting people at risk from potential abuse. This was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 13.
● Safeguarding concerns were identified, recorded and referred to the appropriate agencies, such as the local authority safeguarding team.
● Each incident form was reviewed to consider if a safeguarding alert was required.
● People and their relatives told us they felt safe living at St Teresa's. Comments from people included, "Yes I do" and, "They look after me well." One relative commented, "Safe, yes I do, and [name] is completely satisfied with staff, they [staff] are absolutely marvellous."
● There were safeguarding systems in place. Staff understood the possible types of abuse people could be subjected to, and how to report it both internally and externally. One staff member told us, "There are no problems here, we report to the [registered] manager they always respond. We know if the manager does nothing we can report to the area manager, owner, police, local authority and the CQC."

Staffing and recruitment
● People told us there were enough staff available to support them. One person told us, "They come reasonably quickly, yes."
● Staff told us there were enough staff to meet people's needs. One staff member told us, "We have enough staff and they adjust staffing if we are short, all the time we are covered. We use agency to cover sickness." Another staff member commented, "Yes we have enough staff we get help from the agency if needed."
● Safe recruitment systems were in place to ensure only suitable staff were employed.

Preventing and controlling infection

● 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 using PPE effectively and safely.
● 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.
● We were assured that the provider was making sure infection outbreaks would be effectively prevented or managed.
● We were assured staff knew how to care for people who were at an increased risk of spreading infection. One person had been isolated as a precaution and staff had commenced in barrier nursing. Barrier nursing is where additional precautions are implemented to prevent the spread of infection. Whilst staff were clear on how they provided support to the person, there was a lack of specific written instruction of how the care was carried out. Staff confirmed they had also received training. The clinical manager confirmed they would record this information in the person's care plan.
● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● There were systems in place to ensure accidents, safeguarding and incidents were recorded, investigated and action was taken to reduce the likelihood of a reoccurrence.
● Incidents and accidents were analysed for themes and trends. The management team shared any learning through daily meetings and handover records.

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 inadequate. At this inspection this key question has now improved to requires improvement. We are unable to rate this key question more than requires improvement because of our current methodology and risks related to COVID-19, we only reviewed the safe and well led key questions. This meant we were not reviewing the breaches of regulations in the effective and responsive key questions.

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

At our last inspection there were widespread and significant shortfalls in service leadership. Leaders and the culture they created had not assured the delivery of high-quality care. This was a breach of regulation 17, (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection whilst we identified improvements, however as a full review of the governance across each key question was not undertaken during this inspection, we were unable to sufficiently evidence full compliance with Regulation 17.

- There were systems in place to monitor the standard of care provided at the service. The registered manager and provider had a range of audits and action plans in place to identify shortfalls and areas of improvement. Systems to monitor safeguarding, medicines and safe care and treatment had improved.
- People's confidential information, such as information about their care and corresponding personal details, was stored securely.
- The management structure had been changed to support effective oversight of the service. A clinical lead was now in post to enable delegation and management of the service when the registered manager was not available.
- Relatives were complimentary about the care their family members received and the management of the home. One relative told us, "I certainly seem to have a good relationship with [registered manager]". Another commented, "I went to visit with management as I had a few questions, I wasn't rushed at all."

At our last inspection we identified statutory notifications were not always submitted to the Commission as required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- Statutory notifications had been submitted by the registered manager in line with their legal responsibilities.

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

● People and their relatives told us they thought the service was well led and they commented positively about the registered manager. One relative told us, "[Name of person] is being well looked after. Carers have been excellent, and [name of person] is happy there." Another relative said, "I've been impressed with the way they care for [relative], their attitude is respectful, and they understand their needs."

● Visits were being arranged for people's relatives to meet with them in a safe way. One relative told us, "We had a regular weekly spot on a Wednesday afternoon, we would sit outside on the terrace and a member of staff would sit with us. If it's raining it's possible to sit under the terrace." Inside visits were also arranged in a designated area with a Perspex shield between the person and their relative.

● Staff told us the registered manager was available and approachable. One staff member told us, "[Name of registered manager] is approachable and very supportive." Another commented, "They are fine, we can speak with them and they will listen to us."

● Staff told us there was a positive culture in the service. One staff member told us, "We are happy and work well as a team, we are like a big family."

● Staff told us they were committed to providing person centred care and positive outcomes for people. One staff member told us, "We want to empower them [people] to do as much as possible and continue their life, bring meaning to their life and support them to make decisions."

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

● The registered manager understood their responsibility to let others know if something went wrong in response to their duty of candour.

● There were systems in place to ensure the duty of candour was followed. When incidents occurred in the home the registered manager considered the duty of candour and recorded on the incident form where relevant parties, such as people's relatives, were informed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We received some mixed comments from relatives about the recent communication with the home. Some felt the communication had been good, whilst others stated they thought it could be better. One relative told us, "I can phone every day and get an update, I get a good picture of [relative] through the staff." Another relative commented, "I sometimes wish we had a bit more contact, sometimes I ring and can't get through." We discussed this with the registered manager who told us since visits had stopped in March 2020 the increase in calls had gone up considerably. They also stated they would look into the comments raised.

● Staff confirmed they attended staff meetings. One staff member said, "We have weekly meetings and if we have any concerns we can talk to the [registered] manager. We also have monthly staff meetings, they communicate any information from head office. We are listened to, if we have concerns they listen to us."

● Staff briefings were also held to discuss current topics and guidance to ensure staff were kept up to date.

● An annual survey was carried out to seek feedback from people and their relatives. We saw the results of the survey carried out in March 2020. Action points had been created from the feedback where required.

Continuous learning and improving care; Working in partnership with others

● The service worked in partnership with other organisations to support care provision. For example, a range of health professionals.

● The service maintained a record of accidents and incidents showing the details, action taken and outcomes. This supported any future learning from such 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care This is a continuing breach from our previous inspection in August 2019. The breach was not reviewed at part of this inspection. Assessments of peoples' needs did not always contain current relevant information and guidance for staff. People were not always supported to avoid social isolation through the development of relationships and access to activities that were meaningful to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent This is a continuing breach from our previous inspection in August 2019. The breach was not reviewed at part of this inspection. Capacity assessments and best interest decisions were not always completed in line with the principles of the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This is a continuing breach from our previous inspection in August 2019. At this inspection whilst we identified improvements, a full review

of the governance across each key question was not undertaken during this inspection, we were unable to sufficiently evidence full compliance with Regulation 17.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing This is a continuing breach from our previous inspection in August 2019. The breach was not reviewed at part of this inspection. Staff did not always receive training relevant to their roles and to the people they were supporting.