St Bernards Residential Care Home Limited

# St Bernards Residential Care Home Limited

## 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 Bernards Residential Care Home Limited is a care home providing personal care to a maximum of 43 older people. At the time of our inspection 36 people lived at the home and one person was in hospital. Some people lived with dementia.

People's experience of using this service and what we found
Managerial oversight of the service required improvement. Some of provider's systems and processes to monitor the quality and safety of the service remained ineffective and had not identified the shortfalls we found. Policies and procedures were not always followed. The management team needed to increase their knowledge of some requirements to ensure all regulations were complied with.

Risk management required improvement. Information staff needed to help them provide safe care was not always available to them and timely action had not been taken to ensure all fire safety risks had been mitigated to keep people safe.

That meant opportunities to make improvements had been missed. Whilst people told us they received their medicines we found they were not consistently managed in line with the provider's expectations or best practice guidance.

The provider understood their responsibility to be open and honest when things went wrong. Responsive remedial action was taken following our visit to make improvements which demonstrated lessons had been learned. Two weeks after our visit the nominated individual told us actions taken including strengthening auditing systems had improved safety.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People felt happy and safe living at the home. The culture of the service was inclusive, and people felt listened to and involved in the running of their home. Relatives shared that viewpoint. Staff felt supported and appreciated and spoke highly of their managers. The nominated individual was proud of the staff.

Staff had been recruited safely and there was enough of them on duty to meet people's needs. The home was clean, and visitors were welcomed. Staff worked in partnership with health professionals which supported people's health and wellbeing.

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 21 June 2019).

At the inspection in 2019 we recommended the provider reviewed their quality assurance systems to ensure they were fully effective. The recommendation had not been acted up. We also recommended people's consent to their care and support was recorded. That had happened which meant improvement in that area had been made.

Why we inspected
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.

We received concerns in relation to staffing levels and medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. The provider has taken action to mitigate the risks we identified.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Bernards Residential Care Home Limited on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safety and good governance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## 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 are in our well-led findings below.

# St Bernards Residential Care Home Limited

**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 Health and Social Care Act 2008.

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 was undertaken by 3 inspectors. Two inspectors visited the home and the third inspector gathered feedback from people's relatives via the telephone.

Service and service type
St Bernards Residential Care Home Limited is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Bernard's Residential Care Home Limited is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed the information we had received about the service since the last inspection, and we gathered feedback from local authority commissioners who work with the service. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with 7 people and 5 people's relatives to gather their experiences of the service and to find out what it was like to live at the home. We observed the care and support provided to people in communal areas.

We spoke with 11 members of staff including the deputy manager, the receptionist, team leaders, care assistants, a laundry assistant, the compliance manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed seven people's care records and multiple people's medication records. We looked at a range of records relating to the management of the service, staff training data, fire safety records, some policies and procedures and the recruitment records of three staff members to check they had been recruited safely. We shared our inspection findings with one local authority and our findings about fire safety with West Midlands Fire Service.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Known fire safety risks had not been mitigated in a timely way. A fire safety risk assessment had identified 12 immediate actions were required in August 2022 to improve fire safety at the home. Some of those actions had not been completed at the time of our visit.
- Five staff members could not recall attending fire drills and records of completed drills did not evidence which staff had attended. One staff member said, "I've never been shown the fire drill at night. I have worked nights." In addition, staff gave differing accounts when we asked them what they needed do to keep people safe in event of a fire.
- Information staff needed to help them provide safe care was not always available to them. One person was at risk of choking on food and another person was at risk of choking on drinks. Guidance was not in place to help staff manage a choking emergency. The deputy manager took action to address this.

Systems and processes did not demonstrate risks were always assessed and mitigated. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection visit action was taken to improve fire safety. This included adding an extra hinge to fire doors which meant the doors could withhold fire for at least 30 minutes in line with requirements.
- Risk assessments for other aspects of peoples care such as falls contained guidance to help staff care for people safely. Discussions with staff confirmed they knew how to manage and prevent people falling.
- Staff had reported accidents and incidents to their managers in line with the providers expectations. Incidents including falls were analysed to learn lessons and prevent recurrence.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

At our last inspection we recommended the provider ensured people's consent to their care and support

was recorded. The provider had made improvements.

● The provider worked within the principles of the MCA. When required people's capacity had been assessed and their care records documented whether or not they had capacity to consent to specific aspects of their care. Where needed, appropriate legal authorisations were in place to deprive a person of their liberty to keep them safe.

Using medicines safely
● Some aspects of medicines management required improvement. Previously demonstrated standards of medicines safety had deteriorated since our inspection in 2019.
● Protocols to inform staff when and where 'as required' prescribed creams needed to be applied to people's skin were not in place. That meant the creams might not have been administered in line with prescribing instructions to effectively treat and prevent sore skin.
● Some emollient creams in use contained flammable ingredients. Risks associated with their use had not been assessed. This is important as the build-up of cream residue on bedding and clothing makes those fabrics more flammable which can result in serious or fatal injuries from fire.
● More than 10 tubs of prescribed thickening powder were located in an unlocked cupboard in the dining room. The powders were stored alongside other drinking powders such as hot chocolate and were accessible to people which was unsafe. Thickening powders are added to fluids for people who have been assessed at risk of choking when eating and drinking. In 2015 NHS England issued a storage safety alert following the death of a care home resident who died after accidentally ingesting a thickening powder.
● The provider was not consistently working in line with their medicines management policy. For example, GP authorisation letters to support safe administration of 'homely remedies' had not been sought and the homely remedy system operated was not in line with best practice.
● Audits of medicines did not include all the medicines administered. For example, medicines administered through patches. Therefore, if errors associated with those medicines had occurred, they could have been missed.

Systems and processes were not sufficient to demonstrate people's medicines were managed and administered safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our visit action was taken to improve the medicines safety. This included prescribed thickeners being removed from the dining room and some staff members completing further training to increase their skills and knowledge of safe practice.
● People told us they received their medicines when they needed them. Relatives shared that viewpoint. One relative explained staff had correctly administered a course of antibiotics to their family member which had successfully treated an infection.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding systems were not operated effectively. We had not been informed when 3 safeguarding referrals following medicine errors had been made to the local authority for further investigation. The compliance manager was not aware of the requirement. Notifications were submitted following our request.

● People felt safe living at the home. One person said, "I feel safe, if I fall, I have staff around me to help." Another told us, "I always feel safe. I am in good company, I am happy."
● Relatives spoke positively about safety. Comments included, "Staff have been brilliant around safety; [Name] can fall but they have crash mats next to their bed and a sensor on their wrist to summon help," and,

"[Name] broke their hip. Their mobility hasn't come back but staff put a sensor mat by the bed. Staff are aware of risks."

● Staff completed safeguarding training and understood their responsibilities to keep people safe. One staff member said, "Training helped me know about abuse and what I need to do. Report it to the manager. I report everything."

Staffing and recruitment

● We saw enough staff were on duty during our visit to keep people safe and meet their needs.

● Six out of 7 people thought enough staff were on duty. However, a seventh person explained on occasions they did have to wait for up to 30 minutes before staff responded to their requests for assistance when they pressed their nurse call bell. The nominated individual was aware of this issue and was taking action to address it. Action included locating misplaced electronic pagers that alerted staff to people's requests.

● Staff including night staff felt staffing levels were safe and relatives spoken with had no concerns about staffing levels. One relative said, "They have enough staff, and they are consistent; we are always seeing regular faces of staff which is important."

● Staff were recruited safely. The provider followed safe recruitment procedures to make sure staff were suitable to work at the home. The nominated individual told us the ongoing recruitment of staff was one of the biggest challenges the service faced.

Preventing and controlling infection

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. However, some staff wore nail varnish, watches and bracelets and one staff member had long fingernails which was an infection prevention and control risk.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● 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 responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The provider facilitated visits for people living at the home in accordance with guidance. People told us their visitors were always welcome.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.

At our last inspection we recommended the provider reviewed their quality assurance systems to ensure they were fully effective and identified areas needing improvement. Improvement had not been made.

● Governance systems continued to require improvement and the rating of this key question has not improved since 2019. The provider lacked clear oversight of the service provided because their auditing systems were not always operated effectively.
● Audits of people's medicines had not identified the concerns we found and not all aspects of medicines were checked. Audits of care records had not identified information staff needed to manage choking risks was not available to them. That put two people at risk of receiving unsafe care.
● Lack of oversight also meant opportunities to drive forward improvement had been missed. Timely action to improve fire safety had not been taken and the action taken to ensure staff worked in line with infection prevention and control best practice guidance had not been effective.
● The management team lacked knowledge of some regulatory requirements. We had not been notified of three safeguarding referrals until we bought this to the attention of the deputy manager.

The provider had failed to ensure systems and processes were established and operated effectively at all times to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Remedial action was taken in response to our inspection feedback. Two weeks after our visit the nominated individual informed us, they were confident all areas requiring improvement had been addressed. That demonstrated a commitment to continuously learning and improving.
● The latest CQC inspection rating was not displayed in the home to inform people and visitors of our judgements. Immediate action was taken to address this.
● The provider's statement of purpose (SOP) did not accurately reflect the type of service provided or the homes management arrangements. A SOP is a legally required document that must accurately reflect information about a provider's service. Action was taken to address this.
● The management team consisted of an experienced registered manager and the deputy manager. They were supported by the nominated individual. The nominated individual explained the COVID-19 pandemic

and recruitment challenges had contributed to some areas of the service falling below their expectations. They said, "We have had a terrible time, it has been very difficult." Some new staff had been recruited and were due to start work at the home shortly after our visit.

● Staff explained their work practices were observed by a member of the management team to ensure they were competent to carry out their roles. That made them feel supported.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People told us the culture at the home was inclusive. Their feedback was listened to and they were involved in running their home. One person told us, "Everything is centred around us. I enjoy the cheese and wine sessions. I am happy with how the home is run; I like the manager."

● Relatives had opportunities to attend 'family forums' and felt involved in their family member's care. They had been invited to celebrate birthdays and attend social events such as summer fetes.

● Staff felt valued and appreciated. One staff member said, "Management's good. I would tell them if I had problems. We get small thank you gifts, it's a family run home." The nominated individual was proud of the staff team. They commented, "They are amazing, they provide good care."

● St Bernards Residential Care Home limited had been awarded an overall score of 9.8 out of 10 on an independent care comparison website. On average people had rated their overall experience as 4.9 out of 5.

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; Working in partnership with others

● The management team were disappointed with our inspection findings. They were open and honest during our visit and told us how they had used our feedback to focus their improvement activities.

● The whole staff team worked with other organisations including GP's and district nurses to support people's health and wellbeing. Care records evidenced this approach had improved outcomes for people.

● St Bernard's Care Home took part in local community 'in bloom' celebrations. People from the local community were invited to view the homes well-maintained garden areas. One person said, "It's good to let people come and have a look at it, we are proud of it."

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<br><br>12(1)(2)(a)(b)(g) Systems and processes were not sufficient to demonstrate risks were identified, assessed and mitigated. Medicines were not always managed safely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 HSCA RA Regulations 2014 Good governance<br>17(1)(2)(a)(b)(c) Systems were not established or operated effectively to assess, monitor and improve the quality and safety of the service. Accurate and up to date records in respect of each service user were not maintained. |