

Qualia Care Limited

St Marys Nursing Home

Inspection report

St Marys Road
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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

St Mary's is a residential care home providing personal and nursing care for 56 people aged 65 and over at the time of the inspection.

The care home can accommodate up to 74 people on three separate units, namely St Mary's, St Alexius and St Joseph's, each of which has separate adapted facilities and communal areas. Two of the units specialise in providing care to people living with dementia. There are additional kitchen and laundry facilities in the home, a small church and surrounding garden space outside.

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

At this inspection we found improvements were still required in areas such as infection prevention and control and with the home's auditing and quality monitoring processes. The service did not have a manager registered with the Care Quality Commission (CQC) at the time of this inspection. A previous manager had left the service shortly before this inspection; they had not been registered with the CQC. Management and oversight was being provided by a clinical lead, supported by a member of senior management. We identified two regulatory breaches and have made a recommendation regarding the premises. We identified improvements had been made in the management of medicines.

People were not always protected against the risk of infection. Policies and procedures in place were not always adhered to by staff and housekeeping staff were not always effectively deployed.

People's needs were met safely with appropriate staffing levels; previously furloughed staff had returned to work and the use of agency staff was minimal. People were supported by staff who understood how to identify and report potential abuse. Checks were carried out on new staff to ensure they were suitable to work in the home. Handovers ensured information was communicated to all staff to ensure people received safe support however, one person had some clinical information missing from the handover record. We made the nurse and manager aware of this.

The concerns we identified at the last inspection in relation to medicines had been addressed. The provider was investigating concerns raised about medicines at the time of this inspection and had taken appropriate action. When accidents or incidents occurred, learning was identified to reduce the risk of them happening again.

There was evidence of monitoring and review of care. We identified some recording issues and brought these to the manager's attention. There had been some improvements made to the building since our last inspection, however further work was needed.

Contact with health professionals had been maintained during the COVID-19 pandemic; some guidance and advice had been received over the telephone. People's specific dietary needs were communicated to staff employed in the kitchen, who were aware of recommendations made by health professionals. The manager

was aware of their responsibilities in respect of consent and involving people as much as possible in day-to-day decisions.

Systems and processes to monitor the quality of the service had been introduced recently by the manager but these were in their infancy. Support for the manager was available from nurses and unit leaders and the Deputy Lead of Nursing was based in the home during the week to offer help and guidance.

Relatives we spoke with told us communication during the pandemic had not been consistent. The manager outlined how the service planned to improve how it engaged with people, relatives and staff. Plans were in place to improve the meal time experience for people and a 'resident of the day' audit had been adopted to ensure regular reviews of people's care and experiences.

The provider needs to build on the progress made, ensuring this is fully embedded into practice and also make the required improvements identified in this report.

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 requires improvement (published 8 August 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

We received concerns and complaints in relation to the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

After the inspection our findings identified a specific incident. This incident is potentially subject to a criminal investigation. Our enquiries are on-going and therefore this inspection does not examine the circumstances of the incident.

We carried out an unannounced comprehensive inspection of this service on 26 and 27 June 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions of Safe, Effective and Well led which contain those requirements.

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. We were not assured that the provider was effectively managing infection prevention and control and brought this to the manager's attention. Following the inspection, the manager was able to demonstrate the actions taken to mitigate the risks.

Please see the safe sections of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating 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 remains requires improvement. This is based on the findings at this inspection.

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

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 infection prevention and control and management of the service at this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

St Marys Nursing Home

Detailed findings

Background to this inspection

The inspection

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notices in relation to Safe care and treatment and Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had also received information of specific concern regarding medicine errors, the home requiring repairs and a lack of consistent management of the home.

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 carried out by three inspectors 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 Mary's 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 did not have a manager registered with the Care Quality Commission. A manager had left the service shortly before this inspection. The clinical lead was managing the service at the time of this inspection. In the absence of a registered manager the provider is 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 gave the service 24 hours' notice of the inspection given the current COVID-19 situation.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with six people who used the service and seven relatives about their experience of the care provided. We spoke with 14 members of staff including the clinical lead, Deputy Head of Nursing Care, three unit managers, one nurse, seven care workers and a chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three 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 more care notes, training data and quality assurance records.

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 requires improvement. At this inspection this key question has remained the same. 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.

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

Preventing and controlling infection

- Staff did not always wear personal protective equipment (PPE) in line with current guidance. Staff are required to wear a fluid repellent surgical mask within two metres of people. During the inspection, staff were observed not wearing masks, wearing masks incorrectly and wearing a mask that was not a fluid repellent surgical mask.
- We were not assured that the provider was using PPE effectively and safely. Correct PPE should be worn appropriately to reduce the risk of transmission of coronavirus.
- People were not always protected against the risk of infection. Policies and procedures in place were not always adhered to by staff. Housekeeping staff were not always effectively deployed.

Infection control guidelines were not consistently followed by staff. Systems were not robust enough to demonstrate the service was effectively controlling the spread of infection. People were at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection and evidenced that staff not following guidelines had received a supervision. Recruitment of additional housekeeping staff was made a priority.

- Laundry facilities in the home had recently been improved. The layout of the laundry helped to minimise the potential of cross-infection.
- Visitors to the home were limited but effective measures were in place to prevent any visitors from catching and spreading infections. There were sanitising stations in the home.

Using medicines safely

- Concerns identified at our previous inspection had been addressed. The provider had made improvements in the safe handling of medicines, helped by a successful change to an alternative pharmacy.
- Paper records were now accurately maintained and evidenced the application of creams and pain relief

patches were safe.

- PRN protocols were now sufficiently detailed and personalised to ensure that medicines prescribed in this way were managed safely.

Staffing and recruitment

- Observations we made and rotas we saw on inspection indicated there were enough staff to meet people's needs. Rotas were not always accurate however, as we spoke with two people on duty on one unit who were not included on the rota for Tuesday 3 November.
- Changes in staffing due to annual leave, sickness or other reasons were not always reflected on rotas. We brought this to the manager's attention and received revised rotas for the home.
- Staff were working in specific areas of the home and were not providing care on different units. Measures were in place to try and limit the spread of COVID-19.
- There were enough staff to manage the dependency needs of the people currently living in the home. People were supported in a timely manner to keep them safe.

Assessing risk, safety monitoring and management

- Processes to reduce the risk of harm were in place. However, one person had not received all the required clinical care since their admission. We brought this to the nurse's attention and discussed it with the manager.
- Prescribed regimes were in place for people deemed high risk of developing pressure ulcers. The provider demonstrated that people received regular repositioning to help ensure their safety and well-being.
- The provider had identified through a fire risk assessment and with fire drills that in the unlikely event of a fire, additional measures were needed to try to prevent the spread. This work was being done on the day of our inspection, with the installation of new fire doors around the home.
- Staff understood where people required support to reduce the risk of avoidable harm. Care plans contained explanations of the control measures for staff to follow to keep people safe.

Systems and processes to safeguard people from the risk of abuse.

- There were systems in place to safeguard people from the risk of abuse.
- Staff were aware of safeguarding responsibilities. Staff understood where people required support to reduce the risk of avoidable harm. One person we spoke with said, "I do feel very safe and they (staff) always know if I feel a bit off."
- The manager kept the Care Quality Commission (CQC) up-to-date with incidents that warranted reporting to the local authority as a potential safeguarding investigation.

Learning lessons when things go wrong.

- The clinical lead was acting as the new manager. They communicated important and relevant information to heads of departments in short, regular meetings. These were termed 'huddles' and were held daily.
- Heads of departments were formally updated about what was happening in the home. They were in a better position to direct their own staff teams.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

- There had been some improvements made to the building since our last inspection however further work was needed. Some work to electrical sockets was required in people's bedrooms.
- The flooring on the main corridor of the first- floor unit, St Alexis unit, required a more professional repair or replacing. Two inspectors noted the flooring was bubbling up and rising in places. Some ad-hoc repairs had been done to the flooring with the use of heavy -duty sticking tape. Despite the repairs the condition of this flooring in a wide, communal corridor posed a trip hazard.

We recommend that the service ensures that the flooring in the main corridor on St Alexis unit is made safe and does not pose a trip hazard to people and that other required repairs are addressed.

- The church attached to the home was not used at the time of this inspection due to the COVID-19 pandemic. The home had pleasant gardens which were popular during the summer months.
- Toilets and bathrooms were adapted to the needs of people with limited mobility.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed prior to their admission to the home.
- Staff did not always complete actions in line with people's care plans.
- One person had not had their blood sugar levels tested in line with clinical advice. There was a risk that staff were not able to fully monitor the person's health effectively. We have addressed this in the well led domain.

Staff support: induction, training, skills and experience

- Staff received the induction and training they required to carry out their job roles.
- Training included care related topics, such as safeguarding, people handling, dementia awareness as well as health and safety training.
- Training records showed staff had completed up to date training in a range of subjects. This was monitored by the management team on a matrix to ensure staff training was current.
- Some refresher training remained outstanding for some staff. The recent pandemic had contributed to some of the delays. The manager was aware from the matrix of the outstanding training and we were assured this would be addressed.

Supporting people to eat and drink enough to maintain a balanced diet

- People we spoke with were complimentary about the food choices on offer. One person told us, "The food we have is so good and I always get offered cups of tea."
- People had nutritional care plans which informed staff about people's dietary needs and any support required. People at high risk, for example of weight loss or choking, were provided with appropriate diets. This information was communicated to kitchen staff.
- We observed lunch and saw some people were supported by staff with their meals.
- Diet and fluid charts were used for some people to monitor their nutritional intake. Staff recorded when a person had had a drink or food to show how much fluid or diet they had taken.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People were regularly seen by health professionals or when required. These visits had been recorded.
- There was evidence of staff noting a change to a person's physical health. For example, a chesty cough or possible urine infection, and then contacting the General Practitioner (GP). This had mainly been a consultation or advice over the telephone due to the COVID-19 pandemic.
- People's had been weighed weekly or monthly, depending on the level of need. Action was taken if there were any concerns about people being particularly underweight or overweight. However, these records were not always accurate. We have addressed this in the well led domain.

Ensuring consent to care and treatment in line with law and guidance

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.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Capacity assessments were carried out and best interest's decisions were made, with input from people's relatives and health professionals.
- People were asked for their consent by staff. One relative we spoke with told us "Staff accept it when it's a 'no' but they know how to deal with it."
- DoLS authorisations had been completed for those people with specific restrictions in place to keep them safe.

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 Requires Improvement. At this inspection this key question has remained the same. 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.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Prior to this inspection the service had gone through more changes in management. The registered manager, in post at the last inspection had deregistered from the service in December 2019. A subsequent manager had applied to register with the Care Quality Commission but had then left the service shortly before this inspection. The Clinical Lead was managing the home at the time of this inspection.
- The provider had not acted to promptly address all the issues identified in the warning notice issued in 2019. The provider had not had oversight of the home, and staff culture was a concern.
- Oversight of the home by the provider had not been consistent. There was no evidence of quality audits being carried out by a manager prior to June 2020.
- Roles and responsibilities were not defined on the two units of the home where nurses and care workers worked together. It was difficult to see where responsibilities in relation to management of the service lay on those units.
- Managers did not ensure care plans were easily available. Care workers we spoke to on one unit told us access to care plans was limited.
- Whilst audits of the service were now in place, the infection control audit had not identified the non-compliance by some staff in this aspect.

Systems were either not in place or robust enough to demonstrate the service was effectively managed. People were at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Systems and processes to monitor the quality of the service had been introduced recently by the Clinical Lead, but these were in their infancy.
- Support for the manager was available from nurses and unit leaders. In the absence of a deputy manager the Deputy Lead of Nursing was based in the home during the week to offer help and guidance.

Continuous learning and improving care

- Records demonstrated that audits were carried out, however, they were not always effective as they did not identify the issues we found at this inspection.
- The manager planned to improve the quality of care by being reactive.

- The manager was open to engaging with relatives and external health professionals with concerns or complaints to try to resolve these.

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

- Feedback about how successful the home engaged with people's relatives was mixed.
- Relatives we spoke with told us communication during the pandemic had not been consistent. One relative told us, "I would really like more email updates from the home to let me know what has happened generally and what my relative has been like in the last week or so."
- The clinical lead outlined how the service planned to improve how it engaged with people, relatives and staff.
- Meal time service was changing so that people could engage with the chefs and give feedback about the food. There were plans in place to develop a visiting booth in one of the ground floor lounges so that visitors could access the home safely and see their relatives.
- Daily walk rounds were undertaken by the manager to check on elements of the service, such as people, staff, the kitchen and the environment. The manager used this time to engage with people and staff to see if they had any informal concerns or complaints.
- Meetings with staff took place. Daily 'huddles' occurred with unit leaders so that the manager could share important information and actions. Staff meetings provided staff with the opportunity to share their views and to discuss any concerns.

Working in partnership with others

- The service worked in partnership with key organisations, including the local authority and health and social care professionals.
- Weekly meetings were in place with the local authority to track progress and outline improvements to the service. A CQC representative also attended these meetings.
- We saw the current inspection rating for the service was clearly displayed.
- The manager understood their regulatory responsibilities and had reported accidents and incidents to the Commission, including any potential incidents of abuse referred to the local authority.

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 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate the service was effectively managed. People were at risk of harm.