Complete Care Homes Limited

St Bernadettes Nursing Home

Inspection report

25-27 Trinity Road
Scarborough
North Yorkshire
YO11 2TD

Tel: 01723366522
Website: www.completecarehomes.net

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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 caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

About the service: St Bernadettes is a care home, which provided personal and nursing care to 20 people aged 55 and over at the time of the inspection. The home is registered to accommodate a maximum of 27 people.

People's experience of using this service: Since our last inspection the provider had failed to maintain high quality standards of practice within the service. The provider demonstrated their motivation to improve by working with us during and after the inspection.

Families told us that levels of communication between themselves, staff and management were poor. Despite them repeatedly asking for updates of their relative's wellbeing three families said their requests for information had been ignored. They also had little input to their relative's care and were not involved in care reviews.

Medicines were not always managed safely within the service and the registered manager had raised safeguarding alerts about these with the local authority.

People were looked after by staff who had not always received sufficient induction, training and support to ensure they could fulfil their role safely. Adequate checks of agency staff skills and identities had not been carried out. This put people at risk of avoidable harm.

Care plans and risk assessments were not reviewed on a regular basis or when people's care needs had altered. The quality of the record keeping varied and some care records we looked at did not have the full information in them to manage people's care safely.

People did not always have an opportunity to take part in stimulating and enjoyable activities. There was a lack of social events within the service.

People were able to talk to health care professionals about their care and treatment. People could see a GP when they needed to and they received care and treatment when necessary from external health care professionals such as the district nursing team and speech and language therapists (SALT).

More information is in detailed findings below.

Rating at last inspection: Good (report published on 4 October 2017). The rating has deteriorated to requires improvement at this inspection.

Why we inspected: We were notified about a serious incident in which a person using the service died. We also received information about medicine errors in the service. We looked at risks associated with these concerns.

Enforcement: We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 around person-centred care, safe care and treatment, good governance, staffing and fit and proper persons employed. Details of action we have asked the provider to take can be found at the end of this report.

Follow up: We will work with the provider following this report being published to understand and monitor how they will make changes to ensure the service improves their rating to at least Good.

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 caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

St Bernadettes 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 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by an incident which resulted in the death of a person using the service and this indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, which may be subject to criminal investigation, we did look at associated risks. The incident has been brought to the attention of the Local Authority and the Coroner.

Inspection team: Two inspectors carried out the inspection on the first day. One inspector completed day two and three of the inspection.

Service and service type: The service is a 'care home'. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (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: The inspection was unannounced on day one. The provider was notified of our return visits on days two and three.

What we did: Before the inspection we reviewed information available to us about this service. This included details about incidents the provider must notify us about, such as abuse; and we sought feedback from the local authority and professionals who work with the service. The provider was not asked to send us an up-

to-date provider information return prior to the inspection. This is information we require providers to send us at least once annually 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.

During the inspection we spoke with the provider, general manager, the management team - registered manager and deputy manager, a nurse and four care staff. We also spoke with three people and four families and spent time observing the environment and the dining experience. We chatted to people as we looked around the service. As the majority of people remained in their own bedrooms we did not use the Short Observational Framework for Inspection (SOFI) as it would have been too intrusive. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at four people's care records including medication administration records (MARs) and a selection of documentation about the management and running of the service. This included recruitment information for three members of staff, staff training records, policies and procedures, complaints and staff rotas.

Requires Improvement

Is the service safe?

Our findings

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

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. Regulations have not been met.

Using medicines safely.
•Medicines were not managed safely.
•People were at risk because nurses did not administer medicines safely or people did not receive them as prescribed. For example, nurses were not correctly signing when they had administered medicines to people, including medicines to reduce anxiety and agitation. For one person the impact was they were so sleepy the following day due to poor spacing of doses, they were unable to function properly.

The evidence above shows there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – safe care and treatment.

•Despite nurses completing medicine competency checks and attending meetings following their medicine errors, poor practice around medicines continued. The general manager told us the next step would be to start disciplinary action where staff continued to demonstrate poor practice.

Preventing and controlling infection.
•The service did not always meet current national guidance and standards in relation to infection control. For example, nurse practice around catheter care was not robust and had impacted on one person's health and wellbeing. There was evidence of poor practice and competency as nurses had not attended training on infection prevention and control until after the incident in October 2018.
•People were at risk of avoidable harm as staff who had relevant responsibilities for serving food (such as nurses and care staff), had not all undertaken food hygiene training and there was no evidence to indicate this was being followed up by the management team. Only the deputy manager, out of 28 staff including the cook, had done food hygiene training in the last three years.

The evidence above shows there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – safe care and treatment.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.
•Not all staff were up to date with safety related training such as fire safety and health and safety.
•Agency workers, including nurses who were 'in charge' of the service at night, had not received an induction before starting work. Therefore, agency staff may not have been aware of safety protocols and systems. This put people at risk of potential harm.
•Where accidents or incidents occurred, they were recorded by staff and reviewed by the management team. However, the management team did not demonstrate they were learning lessons following incidents and accidents because work to improve systems or staff competence was not always effective or followed up.

•Care plans and risk assessments were not up to date and did not reflect people's needs. The monitoring of risk was not effective as it failed to identify where documentation did not include full information to ensure people received the correct care and support. For example, one file lacked essential wound care documentation and the dressings being used were too small. This meant the person's wound was at risk of deteriorating.

The evidence above shows there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – safe care and treatment.

•The environment and equipment were safe and well maintained. The service was clean and tidy throughout.

Staffing and recruitment levels.
•Staff absence was not covered with appropriately skilled staff to meet people's needs. The provider did not have profiles to demonstrate they had checked that agency workers, including nurses and care staff, had the right qualifications, the right to work in the UK and were fit to practice before they worked in the service. This put people at risk of potential harm.
•We saw positive changes in the more recent recruitment files for permanent staff, but there remained some inconsistencies and issues with previous recruitment where these had not been fully explored. For example, one application form was dated after the interview date.

The evidence above shows there was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – staffing.

•The provider had ensured enough staff were on shift so that people received support in a timely way. A tool was used to monitor the number of staff needed, based on people's needs. People told us, "I feel there are enough staff" and "I don't have to wait."

Systems and processes.
•The provider had a safeguarding policy in place. Safeguarding concerns had been reported and acted upon, involving all relevant professionals when appropriate.
•Staff could explain what action to take to ensure people were safe and protected from harm and abuse.
•People who used the service said they felt safe, confident and happy when being supported by staff.

Requires Improvement

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations have not been met.

Staff skills, knowledge and experience.
•The provider had not ensured staff, including agency workers, were appropriately inducted and trained to support people safely. Where required the provider had not ensured staff competency was assessed, for example where nurses delivered clinical care. We wrote to the provider following this inspection to ensure action was taken immediately.
•There was a training programme in place, but the management team had not ensured nurses and care staff had completed mandatory training and nurses had appropriate clinical skills. For example, nurses had not received training in use of suction but were doing this in practice. Appropriate training was booked following our discussion with the general manager.
•Nurses had not received clinical supervision since May 2018. Clinical supervision is a formal process of professional support and learning that addresses practitioners' developmental needs in a non-judgemental way. Its aim is to help them increase both their competence and confidence through exchanges with experienced professionals and the use of reflective skills.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – staffing.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff providing consistent, effective, timely care within and across organisations.
•Assessments of people's needs were not always carried out thoroughly or robustly. This put people at risk of not having their needs met. For example, lack of appropriate assessment led to a person having to be quickly moved from the service because the registered manager realised they could not meet their needs safely.
•Care and support did not always reflect current evidence-based guidance, standards and best practice. The use of technology within the service was limited to moving and handling equipment and pressure relief equipment. We noted staff did use sensor mats, bed rails and bumpers to reduce risk of falls.
•People and families were not always enabled or supported to make decisions about care and support. Families who spoke with us did not realise that they could have access to and read their relative's care file where they had power of attorney for health and wellbeing or where their relative gave them consent to do so. There was little evidence in the files that people were able to input to their care plans.
•Communication between staff and families was poor. We received feedback from three families that staff had not contacted them when their relative had a fall or their wellbeing changed. On one occasion this was despite them having power of attorney for health and welfare. We discussed this with the registered manager who said they would keep families updated by email. Following our inspection families contacted

us again to say this had not happened.
•Staff told us they received handovers about people's care and support needs, but communication between the nurses and care staff was not effective. One member of staff said, "We need to be more responsive" and another told us, "The nurses do not always pick up on what care staff say about people not being well, they don't take it on board." We gave feedback to the general manager and registered manager during our inspection about this.

Because assessments were not detailed and people and families had little opportunity to talk with staff and discuss their care; people were at risk of not receiving person-centred care that reflected their preferences and met their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – person-centred care

Supporting people to eat and drink enough with choice in a balanced diet.
•People told us they received sufficient fluids on a regular basis and staff were always willing to make them a drink if needed. We observed people had fluids in their bedrooms. However, the recording of fluids, consumed by people where a risk of dehydration had been identified, was poor. The registered manager said she would speak with staff and ensure recording was improved.
•People's nutritional needs were met and choice was provided. Information on people's dietary needs and preferences was obtained on admission. People were given appropriate support with eating and drinking and were offered different options at mealtimes.

Supporting people to live healthier lives, access healthcare services and support.
•People had access to healthcare professionals such as their GP, district nurses and chiropody. Information was handed to other agencies if people needed to access other services such as hospitals.
•One family told us, "Our relative is thriving here and receives good care" and another said, "[Name of relative] is really well and happy. Their mobility has improved lately."

Adapting service, design, decoration to meet people's needs.
•The service was clean and well maintained. There was an on-going refurbishment plan which included replacing chairs, tables and flooring as needed.

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

•We found authorisations were appropriate and monitored by the registered manager.
•People with capacity had signed their care plans and there was evidence of best interests meetings being

held where people lacked capacity to make choices and decisions around their care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People felt well-supported, cared for and treated with respect and dignity. However, families felt the lack of communication from staff about their relative's care, especially where people lacked capacity to communicate with their families, left them feeling isolated and excluded.

Supporting people to express their views and be involved in making decisions about their care.
•Staff did not always recognise when people needed or wanted help and support from family, friends and others. It was not always recognised that people's or their family's preferences were not being taken on board or properly respected. For example, staff did not keep families up to date with their relative's progress. One family told us, "We get quite upset. There is a loss when someone goes into care and the lack of communication does not ease that loss."
•Where people had lost the ability to use social media, telephone's and the internet to keep in touch with their family their relatives said, "We feel cut off from their care" and "We only get half a story." The general manager said they would ensure families received care updates on a regular basis going forward.
•There was no-one using an external advocate, but information on local services was available from the registered manager. An advocate is someone who supports a person to express their opinions and views.

Respecting and promoting people's privacy, dignity and independence.
•People said they were treated with compassion and dignity. They told us staff addressed them by their preferred name, gave them eye contact when conversing with them and were always polite and respectful when in their company.
•People said staff were supportive in helping them to remain as independent as possible. There were only five people in the communal areas as many were either on bed rest or remained in their own bedroom through choice. People said they were, "Comfortable", "Nice and warm" and "Well looked after."

Ensuring people are well treated and supported.
•People were pleased with the care and support offered within the service. Two people said, "The staff are lovely" and "Kindness itself."
•The majority of people appeared comfortable and their personal care needs were met. Staff demonstrated a friendly approach which showed consideration for their individual needs.
•Staff communicated with people in a caring and compassionate way. They gave time for people to respond.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs

People's needs were not always met. Regulations have not been met.

Personalised care.
•Care plans were not person-centred or well written, and did not reflect the care being given. For example, the care plan for one person said they needed support from two staff for mobilising. However, we observed that they were walking independently with one staff supervising them. Staff told us the person's abilities were improving and they were much more mobile than before. One member of staff said, "I found [Name] at the top of the stairs. I didn't realise they could get up there." The general manager agreed with our feedback and said the plan required more detail and updating and would ensure this was done immediately.
•People's care and support was not well documented. One person's care file had missing documentation around wound care. The dressing was inadequate and did not seal effectively around the wound causing leakage, skin irritation and a high risk of infection as the person constantly touched the wound. The general manager agreed with our assessment and immediately organised a better dressing from the GP. They told us the paperwork would be put in place immediately.

The lack of appropriate and up to date care records meant 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

•People were not always involved in decisions about their care, treatment and support. Care reviews were not always taking place especially for privately funded people.
•People did not receive information in an accessible format because the provider had not fully implemented the Accessible Information Standard. They had not identified or recorded the communication needs of people with a disability or sensory loss. The general manager said this was being looked at and would be developed.
•During our inspection we did not see anyone taking part in activities. People said this did not bother them unduly, but families said their relatives were bored and lacked stimulation. There was an activity coordinator in the service but they were on leave. One family said, "[Name of activity coordinator] is supposed to do activities, but they are constantly asked to escort people to appointments or help out with care so nothing takes place." Observation of the service showed that people stayed in their bedrooms most of the time, watching television, listening to the radio or music and reading.

End of life care and support.
• No one was receiving end of life support at the time of our inspection.

Improving care quality in response to complaints or concerns.
•People and relatives knew how to make complaints and were confident of raising issues. However, we

found that some concerns raised by families during the inspection were not responded to immediately. These were followed up by us after the inspection and resolved by the general manager.

Inadequate

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Leadership and management; Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements; Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong; Engaging and involving people using the service, the public and staff; Continuous learning and improving care.

•At this inspection we found that the quality of the service had deteriorated. There was a lack of oversight and monitoring of the service. Audits were ineffective and failed to recognise the deficiencies in the service.
•We found evidence of poor communication between management and staff/staff and families which was impacting on people's health and wellbeing.
•Staff training was not up to date and staff lacked the knowledge and skills to recognise risks to people's health and safety. We found that agency staff did not receive a robust induction when they started work and nurses did not receive clinical supervision. We could not be certain that staff had the appropriate training and skills to meet people's needs. This had not been identified and acted upon by the registered manager or provider until after an incident in the service occurred.
•Medicines management was poor, with staff not correctly administering medicines to people. This had impacted on people's quality of life and placed them at risk of harm.
•The quality of record keeping was poor with a lack of up to date care plans and risk assessments to guide staff in delivering effective support and care to people who used the service. Monitoring charts for fluids were not well recorded. At least one person did not receive the wound care they required to keep them safe and well looked after. This impacted on their health and wellbeing.
•Methods used by the provider to seek feedback from people and families such as surveys and meetings were not effective. When survey feedback was received it was not acted upon to demonstrate the provider had attempted to make improvements. Comments made included, "Staff should take more notice on what has been said to them" and "Some [staff] are quite good and some are quite nasty."

Systems and processes were not established and operated effectively to ensure the service was assessed or monitored for quality and safety in relation to the fundamental standards. This led to multiple breaches of regulation in relation to person-centred care, safe care and treatment, good governance, staffing and employment of fit persons. People who used the service were at risk of avoidable harm. This was breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - good governance.

We wrote to the provider following our inspection to raise serious concerns with them and to require them

to tell us urgently what they intend to do to put these matters right and by when.

Working in partnership with others.
• There was little evidence that the service had established links with the local community, to give people an opportunity to take part in social activities outside of the service. However, we noted that staff worked in partnership with other agencies to access advice and support when they had concerns about people's wellbeing.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person-centred care and treatment that was appropriate, met their needs and reflected their personal preferences. Regulation 9 (1-3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people who used the service. Risks to people's health and safety and the mitigation of those risks were not sufficient to keep people safe from harm, including those around medicines management and competent staff. Regulation 12 (1) (2) (a-c) (g-h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and record keeping processes were ineffective in monitoring and improving quality and safety of the service, assessing and mitigating risks to people who used the service and maintaining an accurate, complete and contemporaneous record in respect of each person using the service. Regulation 17 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure persons employed for the purposes of carrying on a regulated activity had the qualifications, skills and experience which are necessary for the work to be performed by them. Recruitment procedures were not operated effectively and the provider failed to assure themselves that recruitment and / or checks on agency staff carried out by another party were complete and satisfactory before they worked in the service. Regulation 19 (1) (b) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate support, induction and training to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a)