Carewell (Health Care) Limited

St Mary's Care Home

Inspection report

St Mary's Care Home
Church Chare
Chester-le-Street
County Durham
DH3 3PZ
Tel: 0191 3890566
Website:

Date of inspection visit: 1 and 2 September 2015
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service effective?	Inadequate
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection tool place on 1 and 2 September 2015 and was focussed and unannounced. Following the inspection we asked the manager to provide us with further information and we collected this from the service on 11 September 2015.

At the last comprehensive inspection carried out in January 2015 we found there were regulatory breaches. The provider failed to ensure there was a registered manager at the home. The provider had not appropriately implemented the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) in respect of people living at the home. The provider had failed to ensure that care and welfare of service users was accurately planned.

In July 2015 concerns were raised with CQC by the local safeguarding team, the commissioning team and the Clinical Commissioning Group about the service given to people. The concerns were about the care given to people and the records kept by the service. The provider had an action plan in place to improve the service. We undertook this focused inspection to consider those concerns. This report covers our findings in relation to the

Summary of findings

concerns and any further issues we found during our focussed inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

We carried out the unannounced focused inspection of this service on 1 and 2 September 2015. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

St Marys provides accommodation, personal and nursing care for up to 54 older people. The home is set in its own gardens in a residential area near to Chester le Street town centre, public transport routes and local community facilities.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection a manager was employed by the service and had submitted an application to register to the Care Quality Commission.

People told us they felt safe in the home. Their relatives also thought people were safe in the home.

The provider did not have in place arrangements to ensure people received their topical medicines safely.

Accidents and incidents were recorded in the home but the manager was unable to find the records for July 2015.

We observed staff in the dining room supporting people to eat and a member of staff sitting feeding a person at a pace that was unhurried.

Notifications were given to kitchen staff about people's dietary needs; we found these were not always clear.

Suitable arrangements were not in place to manage and monitor people's hydration needs. We found volunteers gave out drinks to people and staff who collected the cups recorded the person's consumption by the cup nearest to the person.

We found staff were carrying out health checks for which they had not been trained. Staff had not been supported to carry out their duties through training and supervision. The provider had devised a plan to train staff.

The provider had brought into the service a manager to oversee the improvement of people's care planning. However at the time of inspection people had not given their permission to involve their relatives.

We found plans which were in place for people were not always being carried out. This meant people were not always receiving person centred care.

People told us they knew how to make a complaint and we found the provider had in place a complaints procedure. We saw the manager had followed this procedure to investigate a complaint.

We found the provider had failed to keep accurate and contemporaneous records about people's care. Records were not stored in a secure manner and some records were not made available to us.

We saw the provider had carried out a relatives survey in July 2015, the provider had recorded out of 48 questionnaires sent out one survey had been returned by a relative. During the same month 47 questionnaires were sent out to staff and five staff responded. These responses indicated staff did not feel supported by the manager and the staff did not see a manager whilst working night shifts

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 safe not always safe.

Repairs to emergency lighting had not been carried out in a timely way.

The provider did not have in place arrangements to ensure people received their topical medicines safely.

People told us they felt safe in the home. Their relatives also thought people were safe at St Mary's Care Home.

Is the service effective?

Inadequate

The service was not effective.

Kitchen staff had not been given clear instructions on people's nutritional needs.

Suitable arrangements were not in place to manage and monitor people's hydration needs.

We found staff were carrying out health checks for which they had not been trained.

Is the service responsive?

Requires improvement

The service was not always responsive.

The provider had brought into the service a manager to oversee the improvement of people's care planning. However at the time of inspection people had not given their permission to involve their relatives.

We found plans which were in place for some people were not being carried out.

People told us they knew how to make a complaint and we found the provider had in place a complaints procedure. We saw the manager had followed this procedure to investigate a complaint.

Is the service well-led?

Inadequate

The service was not well led.

We found the provider had failed to keep accurate and contemporaneous records about people's care. The manager was unable to make available to us some of the records we requested. Records were not stored securely.

Audits of the administration of people's medicines were out of date.

The provider had carried out quality audits in July 2015 and had received a poor response from relatives and staff. This meant the manager was unable to assess the quality of the service.

St Mary's Care Home

Detailed findings

Background to this 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 was planned to check 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.

This inspection took place on 1 and 2 September and was unannounced. Following the inspection we asked the manager to provide us with further information and we collected this from the service on 11 September 2015.

The inspection team consisted of two adult social care inspectors, a specialist advisor and an expert by experience. The specialist advisor on the inspection team had a background in nursing care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on the inspection team had a background in working with older people.

Prior to the inspection we reviewed all the information we had on the service including notifications and safeguarding information. We spoke with professionals in the local safeguarding team, the local authority commissioning team and the Clinical Commissioning Group.

During the inspection we spoke with twelve people who used the service and nine family members. We spoke with eleven staff including the manager, the quality manager, a support manager who was reviewing care plans, nurses, senior carers, carers, ancillary staff and volunteers.

We reviewed four care records, and looked at bathing, food and fluid records.

Before the inspection we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during the inspection.

Requires improvement

Is the service safe?

Our findings

We asked people if they felt safe living in the home. One person said, "Yes, I feel safe in here. The staff are quite nice but there are not enough of them." Another person said "I am alright. Staff are good. I feel safe when I get a bath because they help me to get out of the bath. I can manage to help myself getting in the bath but getting out is difficult." Another person said "The staff keep me safe by giving me my medicine. I would forget about it if they did not remember." One family member confirmed their relative was safe and said, "Yes, she is safe enough in here".

We reviewed accidents and incidents in the home and found accidents had been recorded by staff and these had been reviewed by the manager. However during the inspection the manager was unable to find the accident records for June and July 2015. The manager later provided us with the accident records for June but not July.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had in place arrangements for carrying out the maintenance of the building. We saw the home had in place electrical safety checks. We found in July 2015 an independent company had been commissioned to carry out emergency lighting checks and found several of the emergency lights were not working. The company reported that there was not adequate illumination for safe movement on the escape route and in the open areas. During our inspection we asked for arrangements to be put into place to reduce the risk to people. The manager provided information to show the lights had been fixed after our focussed inspection. We found the repairs had not been carried out in a timely manner in response to the level of risk.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke with people about the numbers of staff on duty. One person said, "I would think there is enough staff. Sometimes we have to wait a few minutes for attention, but that is normal." Another person said, "It is not so bad at the moment but there are times when you seem to wait a while – especially when you want the loo." One person told us, "Although the staff are quite good they can't take you out because it would leave them with less staff. It would be nice though – if they could." Relatives told us, "No I certainly don't think there is enough staff on at times. I have complained about how my [person] has to wait for attention. I make no bones about it." One relative said, "Some days there seem enough staff, other days there isn't. It is a good thing I can get in every day to help them." Staff told us there were insufficient staff on duty to meet people's needs. The management told us this was not the case as the home was not full. The manager explained the difficulties in recruiting nurses. Most people who used the service we spoke with told us they felt there was enough staff on duty to meet their needs. Some family visitors felt that there were times when staff appeared to be fully stretched and thus not enough staff.

We recommend the provider reviews the level of staffing deployed over the 24 hour period.

We looked at people's medicines and found the home was about to change their pharmacy supplier. Staff required to administer people's medicines had received training and had their competencies assessed. We looked at people's Medication Administration Records (MARs) and found these were up to date with few signatures missing. The manager attributed the missing signatures to agency staff. We random sampled people's medicines and found the recorded stock of medicines matched the actual stock. We looked at people's prescribed topical medicines and found these were kept in people's bedrooms. We found open tubes of prescribed topical medicines in drawers with no opening dates and no records to show staff had applied the creams. This meant people's medicines were not always being safely administered.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The DoLS aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Where that freedom

is restricted a good understanding of DoLS ensures that any restrictions are in the best interests of people who do not have the capacity to make such a decision at that time.

Eleven staff had received training in MCA and DoLS. The records showed applications for temporary DoLS applications had been made and these had expired. Following our visits to the home inspection we asked the manager for more information and they told us which applications had since been made. We checked with the local authority DoLS team who confirmed the applications had been sent to them. We found further work was required to meet the DoLS.

We spoke with people about the food in the home. One relative said, "It could be better, a lot better. Hot food is sometimes cold when it arrives. They burn chips black. I have told them I will show them how to cook. I know what I am talking about." Another family member said, "My dad likes strong tea. All he gets is tea with a load of milk in it – he never complains, but I do." One person told us, "They have changed the times we get our meals. I preferred it the way it was, we were not asked, just changed it." Other people who lived in the home had variable experience of the food. One person said, "The food is good but there are off days when you get cold soup and we get lots and lots of sandwiches at tea time." Another relative said, "Sometimes food is very good but not always. Depends who is cooking. There are some good days and some off days."

We observed staff in the dining room supporting people to eat and a member of staff sitting feeding a person at a pace that was unhurried. They ensured the person was ready for the next spoonful of food. Relatives told us they visited the home every day to help support their relatives to eat. One relative explained their family member could not eat independently and said, "It makes it a bit easier for the staff."

We saw that notifications to the kitchen had been made about people's diets, however these were not completed. For example we saw a tick had been put in a box alongside 'weight reducing' or 'weight enhancing diet' with neither statement crossed out. This meant kitchen staff had not been given clear instructions on people's nutritional needs.

People's fluid charts did not have target levels of fluid in place for each person and fluid charts were not totalled. We saw fluid intakes fluctuated from day to day but there were no adjustments made to compensate any lack of hydration from one day to another. We observed volunteers giving people drinks and asked staff how did they know what to record on the fluid charts. Staff told us if the person had an empty cup beside them they know what people had drunk. We pointed out that some people moved around the room and would not be sitting next to the cup they had drunk from. This meant staff were unable to monitor people's fluid intake and people may have been put at risk of dehydration.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the care given to people to have a bath. One person said, "When I have a bath I need a lot of help. The girls use the hoist and make sure I am safe. There are always two of them and I have a bath a couple of times a week." Staff confirmed to us people normally have baths or showers twice a week, however we found that this was not always recorded and the provider was unable to demonstrate if people were offered regular baths.

One person said, "I suppose everyone has to learn. They tell me about courses and training they are going on. It must do some good; most of them know what they are doing." We reviewed staff training in the home and found some staff had attended some courses, but not all staff had received training pertinent to people's needs. For example we found there were people with diabetes in the home but only two members of staff had received training in diabetes. Three staff had received training in first aid. We found staff needed to have updated training and the provider showed us their training plan to ensure staff training was being updated.

One relative told us "We get told when mum is not feeling well and the staff feels she needs a doctor." We saw senior carers took people's blood pressure, monitored their blood glucose levels and oxygen saturation levels. Staff were

Inadequate

Is the service effective?

unsure about what high or low levels meant and told us they would like some training on this issue. We fed this back to the management team who assured us this practice would be stopped.

We looked at staff supervision records and found that staff had not received supervision and appraisals in line with the provider's policy. For example we found two staff members had not received supervision since February 2015.

There were two volunteers in the home who had Criminal Records Bureau (CRB), now the Disclosure and Barring Service checks in place. We observed the volunteers thickening people's fluid and giving them drinks. The volunteers assured us they had plenty of experience in carry out this task, however the provider had failed to support the volunteers with appropriate training and supervision.

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

Requires improvement

Is the service responsive?

Our findings

We spoke with people about the activities in the home. One person said, "It would be nice if they took us out to a few different places instead of being in here every day." Another person said "When we sit outside we are left for hours, it would be good if they had a staff member look out to see if we needed anything – I could not draw their attention when I needed to go to the toilet." Another person wanted, "More activities to keep us occupied." During our inspection the activities coordinator was working as member of the care staff due to a staffing shortage. We saw people were not engaged in any activities during the day and were at risk of social isolation. The activities coordinator was carrying out care tasks during the day and was unable to provide planned activities for people.

People who lived in the home told us they knew how to make a complaint. On person said, "I do know how to make a complaint. I made a complaint about them moving my possessions around the room – I did not like it. There is a message to that effect in my room." Another person said, "I would know how to make a complaint, but I have nothing I want to complain about. I think most of the staff does what they can for us." A family member confirmed they knew how to make a complaint; they said, "Yes I do know how to make a complaint. I have been to the Manager's door several times now. My dad won't complain, but I will on his behalf. I can't say they alter much, listen but don't act. I am not too pleased with the care in here."

During our inspection we found a manager had been brought into the service to oversee the review of care planning. When we first spoke to the manager they told us their DBS check had not yet come through and they were having no contact with people living in the home but were reviewing care plans by asking members of staff to complete sheets with information as they did not know the people concerned. At the same time we saw there were permission sheets in people's files intended for people to sign to say if they wanted their relatives to be involved in their care planning. We found these were incomplete; for example one person had signed the form but no section had been deleted to say if they did or did not want their relatives to be involved. This meant the relatives had not been included in the care planning.

Plans which had been put in place were not always adhered to. For example we found one person was expected to have a pressure sore risk assessment completed on a weekly basis. We found this had been carried out three times since April 2015. The same person required turning on a regular basis to avoid pressure sores. The manager and the staff on duty were unable to demonstrate they had carried out this task but one member of staff told us the person did not always want to be turned. Another person required snacks throughout the day and we observed no snacks were available. The quality manager told us the usual cook prepared cakes and scones for people. This meant people were not receiving person centred care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the provider had in place a complaints procedure and which showed one complaint had been made to the service in July 2015. The complaint had been investigated by the manager and an appropriate response had been made to the complainant. This meant there were procedures in place to manage complaints.

Inadequate

Is the service well-led?

Our findings

One staff member said, "I think we are working better together now as a team. Probably been better for about a year now. I have been on several training courses. If we identify something we feel will benefit us and the people in here, then I can go on it. I think the Manager helps us all they can." Another staff member said, "Our Manager is very approachable and she helps us when we need it. If we have a problem we know we can discuss it. It is a lot better in here now, there is not such a division between staff." All of the family members with whom we spoke were able to say who the Manager of the Home was. There were a few residents who were unable to recall her name, others did know her by sight and name. One person said, "Yes, she is a pleasant lady. She asks how I am and she knows my name. I would be able to talk to her if I had a problem." Another person said, "You always get a smile from her when she meets you. I think she is very nice." One family member told us, "The Manager is a nice person but is not good enough for the job."

At the time of our inspection there was not a registered manager in post. The manager employed by the service had submitted an application to become registered. The provider had brought in an additional manager to review people's care records and the home was supported by a quality manager and a regional manager.

Following concerns raised by the local safeguarding team and the Clinical Commissioning Group we found the provider had held a meeting to engage the staff and explain the concerns as well as what actions were needed to improve the service.

One relative told us, "No we are not involved in the running of the home. I would change a few things around if I was." One person said, "I don't think we have any say in the running of the home – that is why they have a manager isn't it." We saw the provider had carried out a relatives survey in July 2015, the provider had recorded out of 48 questionnaires sent out one survey had been returned by a relative. During the same month 47 questionnaires were sent out to staff and five staff responded. The responses from the staff indicated they did not feel supported by the manager and the staff did not see a manager whilst working night shifts. We found a relatives meeting had been set up on 28 August 2015 and no relative attended. This meant relatives and staff were not able to contribute to the running of the home and the manager was unable to use this method to assess the quality of the service.

We checked to see if the manager carried out audits to monitor the quality of the service. We found the audits were not routinely carried out. For example we found the last weekly medicines audit had been carried out on 7 July 2015 and there were no monthly medicines audits from April 2015.

During our inspection we looked at the records kept in the home. We found people's records were not stored securely. The manager was unable to provide us with accident records, weight records for people who lived downstairs and positional change records for one person who needed their resting position to be changed to avoid pressures sores from developing. We also found the provider had failed to keep an accurate and contemporaneous record in respect of people's bathing.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 People were not in receipt of person centred care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment of people was not provided in a safe way. Regulation 12(1) People's topical medicines were not being managed in a safe way. Regulation 12(2)(g)

The enforcement action we took:
We are taking enforcement action and will publish this when the inspection process is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services and others were not protected against the risks associated inadequate nutrition or hydration.

The enforcement action we took:
We are taking enforcement action and will publish this when the inspection process is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The manager had failed to assess, monitor and mitigate risks to people. Regulation 17(2)(b) Records were not accurate, complete or were contemporaneously kept. Regulation 17(2)(c)

The enforcement action we took:
We are taking enforcement action and will publish this when the inspection process is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Staff had not received appropriate support through training and supervision

The enforcement action we took:
We are taking enforcement action and will publish this when the inspection process is complete.