St Martins Care Home LTD

St Martins Care Home Ltd

Inspection report

22 Feckenham Road
Headless Cross
Redditch
Worcestershire
B97 5AR

Tel: 01527544592

Date of inspection visit:
28 November 2018
30 November 2018

Date of publication:
17 January 2019

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?	**Requires Improvement**

Summary of findings

Overall summary

We inspected this service on 28 and 30 November2018, the inspection was unannounced. The inspection was carried out by one inspector.

St Martins provides accommodation with personal care and support for up to 15 older people who may needs due to physical disabilities. Some people were living with dementia and other associated illnesses.

A requirement of the services' registration with us is that they have a registered manager. 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. There was a registered manager in place.

This was the first inspection under a new provider of the service. It was previously registered with us under a different provider and was registered as St Martins Care Home for the Elderly.

At this inspection, we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service requires improvement in safe, effective, caring, responsive and well led. The overall rating for the service is Requires Improvement.

The provider had systems in place to monitor the quality and safety of the service people received, but these were not always effective. Actions to mitigate risks to people had not always been taken by the provider. There were areas of the home that posed potential risks to people's safety and welfare. There were insufficient numbers of staff to ensure that people were given the appropriate support to keep safe. Medicines were not always administered in line with the person's prescriptions. Some medicine recording errors had occurred and it was not clear when rescue medicines had been given.

Some people felt that staff understood and responded to their health needs. Some aspects of diabetes care were not monitored appropriately and information for health professionals was not always accurate.

Staff felt supported by the manager and received training in their roles. Staff on shift met some people's individual needs. People could take part in some activities, however some people were at risk of becoming isolated.

People told us they felt safe with staff. Staff understood their responsibilities in keeping people safe from abuse. There were systems and processes in place to support this. People felt staff were kind and caring and enjoyed the food that they were offered.

Further information is in the detailed findings below.

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.

There were not enough staff to meet people's health needs and keep people safe.

People did not always receive their medicines safely.

The environment did not always protect people from the risk of injury.

People were supported by staff who knew how to keep them safe. Staff knew what abuse was and how to respond if they suspected abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always have the necessary monitoring of their health to keep them safe.

Staff understood the principles of the mental capacity act.

People enjoyed the food available to them.

Staff had training relevant to their roles.

Is the service caring?

Requires Improvement

The service was not always caring.

People received care that treated them with dignity and respect. However some people had care that was isolated.

Staff understood and demonstrated non discriminatory practices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have activities and access to the community when they wanted.

There was a complaints procedure in place but some relatives felt improvement was needed in how concerns were dealt with,

Is the service well-led?

Requires Improvement

The service was not well-led.

There were governance systems in place however they had failed to identify the concerns identified during the inspection.

Staff felt supported by the manager.

St Martins Care Home Ltd

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 unannounced inspection took place on 28 and 30 November 2018 and was conducted by one inspector.

Before the inspection visit the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law. We also asked the local authority for any concerns or information relating to service. We did not receive any information of concern.

During the visit we spoke with seven people who lived at the home, six members of staff who consisted of four care assistants, the cook, the deputy manager and the registered manager. We also spoke with a district nurse, social worker and a doctor.

We observed staff supporting people throughout the home. We also 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 looked at a care plans and risk assessments relating to people's care.

We reviewed records relating to the management of the service, this included the quality checks made by the provider and the registered manager.

Requires Improvement

Is the service safe?

Our findings

The manager told us that they used a dependency tool to assess what staffing levels were required based on the needs of the people that lived there. However, this dependency tool was not accurate as staffing levels did not always allow for people's risks to be managed safely. During the afternoon there were two staff on duty. We looked at people's care plans and discussed with the manager about the needs of the people that remained in their rooms and would need two staff to move and to meet their personal care needs. We identified five people that required two staff to meet their personal care needs. While we found that some people could be turned by one staff, the manager could not explain to us how they would ensure staff could respond to other people'. This meant that during this time where people had been identified as requiring two staff to move safely, other people were left in communal areas unsupervised. We asked staff how they managed this. One staff member said they asked visitors to "keep an eye out". This meant that people other than staff in the home were asked to accept responsibility for people's safety. The manager acknowledged that some people were at risk of falling and people required supervision in the open kitchen area. Following our visit they have increased their staffing, levels in the afternoon.

Medicines were stored and disposed of safely. All staff had received training prior to being able to administer medicines to people. However, the safe administration and management of medicines was not always followed by staff. Some people received their medicines in line with their prescriptions, however some people's medicines records were incomplete, so we could not tell accurately what medicines people had been given and at what times.

Some people were prescribed 'as required medicines' (PRN). For PRN medicines to be administered safely there needs to be a protocol that provides clear instructions on the circumstances when the medicine should be given. Whilst there was a protocol in place this did not provide the level of detail required to describe how the person's anxiety presented. For example, the manager told us that one medicine was not to be used at times the person was 'screaming' as this was not necessarily a sign of distress. Twelve entries on the behaviour monitoring form (ABC, which records antecedent, behaviour and consequence) showed the reason as administering medicine to the person was for 'screaming'. Times of when this occurred and when the medicine was administered were also missing from these records, this meant that the person had received medicines at times when potentially they should not have been administered and other interactions and interventions should have been considered by staff. The amount of medicine remaining was also not monitored so it was not possible to be assured that this was just a recoding issue.

The medicine was to be reviewed by health professionals after a month with the information gathered on its use. The manager told us this information was also to be used by health commissioners to decide future funding and care for the person. The manager acknowledged that this information had not been gathered accurately and would now lead to a delay in an assessment of the treatments effectiveness.

This was a breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe in the service. One person said, "Staff look after us and keep us safe here." Staff understood their responsibilities around safeguarding people from abuse and how to report any allegations of abuse. There were a range of risk assessments in place where risks were identified and mitigated. We found procedures had been set out for safely moving a person and reducing the risk of falls.

There were safeguarding procedures in place to protect people from abuse. All staff had attended safeguarding training and staff were confident that any concerns raised with the manager would be dealt with straight away. We found examples where the manager had made safeguarding referrals to the local authority safeguarding team where concerns had been identified.

There were adequate checks in place to ensure that only suitable staff were employed. This included references from previous employers and a satisfactory Disclosure and Baring Service (DBS) check. This check helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable people.

There was a process for reporting and recording any incidents and a system to analyse any factors that could reduce the risk of reoccurrence. Where any concerns had been identified we found that action was taken to contact the relevant professionals for guidance. For example, falls were regularly reviewed, and we could see where action such as contacting the doctor had been taken.

There was guidance in place to promote infection control and staff had access to appropriate PPE (Personal Protective Equipment) such as gloves and aprons when they needed them. All staff that we spoke with told us the importance of maintaining effective infection control in the service.

People did have personal emergency evacuation plans (PeePs) which provided instruction to staff on how to keep people safe in the event of a fire and there were regular checks of fire alarms.

Requires Improvement

Is the service effective?

Our findings

Some people told us that they felt the staff looked after them well and responded appropriately to any changes in their health. One person said, "They [staff] have really helped with my thinking." Another person told us that staff understood people's needs.

People told us they enjoyed the food and drinks available at the home. One person we spoke with told us they thought the food was good and they enjoyed the choices on offer. We found that where people needed their food softening this was done with care to ensure that the food looked presentable.

People's own rooms were personalised with pictures and photographs and the new provider had started to make improvements to the décor of the home. The manager acknowledged there was more work to be done before the environment could be considered as being conducive to the needs of people living with dementia. There was some signage to help people including pictures of people's key workers on their bedroom doors. Staff told us that the role of key worker was to take that additional interest in the person and to understand their needs. Whilst some people were able to tell us who their key workers were, some people were unable to due to the level of their needs.

We spoke with a visiting health professional who told us that they felt that staff listened to guidance and were happy with the care provided. We also briefly spoke with a visiting doctor who felt that people's different care needs were responded to and they felt they were contacted at the appropriate time. We could see an example where the doctor had been involved in improving a person's sleep, following a request from the manager.

There were comprehensive assessments and care plans that detailed people's needs. However, we also found that some aspects of people's health were not always treated in line with current best practice. For example, there were three people living with type 2 diabetes. The manager or provider had not sought information on current guidance of effective management of diabetes. This had meant that people did not have regular monitoring of their blood glucose records and no records were kept of any readings ever being obtained in relation to blood glucose levels.

There were no special adjustments to the food offered to people who had diabetes and this meant that people may at times be having more than the recommended sugar intake.

These people did not have any special diets and the manager and staff had no way of identifying if people were suffering from hyperglycaemia (high blood glucose) or hypoglycaemia (low blood glucose) both of which can pose serious risks to a person's wellbeing. The British Diabetic Association state, "Knowing your blood sugar levels helps you manage your diabetes and reduces your risk of having serious complications – now and in the future."

We asked the manager about a person who told us that their blood glucose monitoring machine was not working. This was their own machine that they had brought into the home when they moved in. The

manager told us that they considered that this person had capacity to measure their own blood glucose levels. However, this person was reliant upon staff to move them from their bed, and they spent all their time in their room with little staff interaction except during meal times and when personal care was given. We also found that the monitor was out of reach and not in working order. The manager could not tell us how they were assured that people's diabetes was being managed on a day to day basis. The manager assured us that they would seek guidance on how to manage people's diabetes more effectively in the future.

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 the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider 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.

We found that for some people their mental capacity to make decisions had been assessed and appropriate DoLS applications had been made. The provider had invited people, for example social workers and family members, to be involved in meetings to discuss decisions to be made in the person's 'best interests'. However, there was a person who had expressed a wish to move to a location closer to their family. The family told us this wish had been expressed for a number of months to both the family, staff and the manager and they had been told by the manager that this could not happen. The reason the person and their family were given was that the DoLS in place prevented this. We looked at the reason why the DoLS had been authorised and found that it did not prevent the person from moving home. The only restriction it provided was to allow the person to be escorted back to the home if they left unaccompanied. The manager acknowledged that the restriction had been misinterpreted and that they did not have the legal authority to prevent the person from moving. This was further reinforced by a visiting social care professional who also examined the DoLS during our visit. The manager assured us and the family that they understood there were no restrictions in place to prevent the person from moving home. However, since the inspection visit a DoLS application has been made to further restrict the person from moving. This is currently under review with the local authority.

Staff had some knowledge of the principles of the mental capacity act and we found consent was sought before care was given. Staff could tell us about situations where best interest decisions may need to be made. Staff also told us that they had received training on the MCA.

Staff had access to training that was appropriate for their roles. This included areas such as medicines, safeguarding and moving and handling. New staff had a period of induction before working alone with people. This included comprehensive training and shadowing more experienced staff until they felt confident in their role. One staff member said, "The training here at St Martins is good. You feel well supported by everyone."

Requires Improvement

Is the service caring?

Our findings

Staff were kind and caring and treated people with dignity and respect. One person said, "They are very kind to me here." Another person said," They are all kind and friendly. Everyone tries their best." People were positive about the approaches of the staff, calling them friendly and kind. Staff spoke fondly of the people they supported, and staff attitudes showed a motivation to care. We could see that where people were provided with personal care their privacy was respected.

Staff were able to tell us about people's preferences. We could see that where required reviews of people's care had involved the person themselves and where this had not been possible people important to them including relatives had been involved. For people that did not spend their time in visible areas of the home, we were not assured that the they received the same level of involvement in their care.

For example, there was a person who had recently had a change to their health needs which meant that they could no longer be supported to come out of their room into the communal areas of the home. We found the person did not have access to fresh water for drinking. The person and their family told us that on occasions they found the drinking water in the jug was not refreshed often enough and was frequently left out of reach. The manager told us they were not aware of this and would ensure that this did not happen again.

This person told us they missed having company and would spend long periods of the day without staff interaction. This was reinforced by our observations. The manager told us they were aware of the possible isolation of people who were in their rooms and were waiting for a downstairs room to become available for the person to move into. However, without a change to how staff were deployed we could not be assured that there would be an adequate reduction in the isolation of some people.

There was training for staff in equality, diversity and human rights. Staff demonstrated an approach that was non-discriminatory, and we were assured that regardless of people's abilities, race, culture or sexuality, they would all be treated equally.

We could see that there was engagement from the manager with the people that used the service on areas of the service that they wanted improving. For example, people had identified that they wanted increased access to the garden area that was currently inaccessible to some people due to mobility needs. There were plans in place to start work on the garden area, although this had not yet started.

Requires Improvement

Is the service responsive?

Our findings

People's care had been planned to incorporate their individual life histories to make it more personal to them. For example, one person had been a member of a successful music band and had a guitar, and memorabilia in their room. They also liked to discuss these times with the staff and visitors. Staff knew this and encouraged them in conversation and reminiscence. This person told us that they felt valued and important to the staff.

Whilst we could see that some activities happened such as arts and crafts, there were periods of inactivity in the home, particularly at times when staff were busy with people's personal care needs. We asked how they catered for people that wanted to go out, Staff told us that when staffing levels allowed they would try to take people out to the local shops but acknowledged this was not always possible. The manager told us they had a staff member allocated to activities for ten hours per week. The manager told us that they use these hours to offer as much as they can in relation to activities and felt that this arrangement worked well. However, we had mixed views from people and relatives regarding the provision of activities. One person said, "I just sit here, no staff at all." A relative said, "I never find much going on and I visit at all times of the week." Another relative said, "They try hard and sometimes there is someone in just to help with activities."

The provider's complaints procedure included a system to provide a response to the complainant if complaints were made. There had been no formal complaints made since the new provider. The manger told us that they tried to respond quickly to any concerns raised. The manager assured us that they were open and transparent to concerns and complaints and strived to work with people to get the care right.

However, we had received mixed reviews about the way that the manager engaged with some relatives. Some relatives had made positive comments such as, "The manager is always there for [person]", "The manager is good at what they do." Some relatives told us that they felt at times action had not been taken appropriately. For example, one relative told us how they felt "disengaged" in trying to improve aspects of the care for their relative. We informed the manager of the feedback we had received, and they told us they would take steps to address any issues that people had.

The manager and staff engaged with a variety of health and social care professionals in trying to ensure care and treatment remained personal to the individual. Whilst we received some positive feedback from visiting health and social care professionals we had concerns that some people's important health information was not gathered and that this could have a detrimental effect on the individual. For example, the lack of monitoring of the use and efficiency of a medicine meant a delay in key decisions regarding a person's care, and information regarding peoples' diabetes was not available.

Staff had training in supporting people who were receiving end of life care. We could see that where people had instructions regarding their wishes about resuscitation (DNACPR) these were signed and in people's care records. The manager told us about how they had reviewed a DNCPR with an individual as they had concerns it had not been discussed fully with the individual.

Requires Improvement

Is the service well-led?

Our findings

At the time of inspection there was a registered manager in post. They had been the registered manager of the service since 2017, having managed the service under a different provider since 2014.

The manager did work in partnership with other agencies to meet people's needs and we saw engagement with district nurses, social workers and a doctor during our visit. However, where specific information had been requested by health professionals to measure effectiveness of a treatment intervention to help a person with their anxiety, this information had not been gathered effectively. This meant there would be a delay in decisions being made about funding and future care for that person.

The current systems used to monitor and improve the quality of the service, had not identified the areas of concern we found during our inspection visit. The manager told us that they had a dependency tool that identified how many staff were required on shift to provide safe care, however the levels that had been allocated did not enable safe care. Medicines audits had failed to identify that rescue medication was not being given in line with the prescriptions instruction. Important aspects of people's health were not being monitored on a routine basis, and environmental risks to people's safety had not been considered.

This was a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had told us about the aims to be a person-centred service however our experience during the inspection highlighted that not everyone was receiving a service that was person centred. The manager told us that there were improvements planned in the care that people received and that they felt the provider was supportive of any ideas or suggestions relating to the home. The manager gave the example of being able to shop for food without worrying about tight budgetary constraints. This was also demonstrated by the speed that staffing levels were increased by the provider following our findings.

Staff spoke positively about the management of the home. They told us that they felt valued and supported. We could see that the manager had a good rapport with the staff and had an open-door policy to be accessible to staff when they needed support or supervision.

The manager told us that they occasionally had local school children visit people in the home and that they were expecting them soon to sing carols. There were also links with a local church who came in to officiate worship for people that wanted to. People told us that they enjoyed these times with the children singing.

There were regular meetings for people that used the service and for their relatives. The manager told us that they provided the opportunity for people and their relatives to be involved in the care that people received. For example some relatives were now going to help with renovating the garden area in the new year with the involvement of some of the people living at the home,

The provider had notified us of events that occurred at the service as required and had also liaised with the

local authority and commissioners to ensure they shared important information in order to better support people.

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 Care and treatment was not always provided in a safe way for people that used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not effective systems to govern the service and ensure the safety of people that used the service.