St Dominic's Limited

St Dominic's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires Improvement

Summary of findings

Overall summary

The comprehensive inspection in November 2014 rated this service as inadequate. At this time we took enforcement action. Breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. We found significant risks due to people not receiving appropriate person centred care. Where people's health needs had changed considerably, care plans had not been updated. Staff did not have the most up to date information about people's health. This meant there was a risk that people's health could deteriorate and go unnoticed. Risk assessments did not reflect people's changing needs in respect of wounds and pressure damage. Accidents and incidents had not been recorded appropriately and steps had not been taken by the staff to minimise the risk of similar events happening in the future. People had not been protected against unsafe treatment by the quality assurance systems. We also found that training had not been delivered where identified and administrative processes to support training, staff supervision and appraisal were inaccurate and incomplete. Following the inspection, we received an action plan which set out what actions were to be taken to achieve compliance by January 2015. During our inspection in February and March 2015, we looked to see if improvements had been made. The inspection found that improvements had been made and breaches in regulation had been met. Due to a high number of concerns raised about the safety of people, the meal service and staffing levels we brought the scheduled inspection forward, so we could ensure that people were safe.

We carried out an unannounced comprehensive inspection of this service on 9,12 and 14 September 2016. The inspection showed that improvements had not been sustained and we found seven breaches of Regulation. The appropriate regulatory response is being considered.

After that inspection we received new information of concerns in relation to people's health needs not being met and lack of suitably qualified and experienced staff. As a result we undertook a focused inspection 5 December 2016 to look into those concerns and ensure people's immediate safety. This report only covers our findings in relation to the Safe question. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Dominic's Nursing Home on our website at www.cqc.org.uk

A registered manager was in post. 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 and associated regulations about how the service is run.

We found improvements in managing people's health needs, such as wound care, diabetes management and promotion of skin integrity had been made. However we found that some elements of Regulation 12 (safe care and treatment) were not yet embedded in to everyday practice to ensure consistent safe care and treatment. For example, the safe use of pressure relieving equipment.

The staffing levels were consistent but we saw that at times the deployment of staff had impacted on care

delivery. For example call bell response times meant people had to wait for assistance. People were not always appropriately supervised in a communal area that had electrical kitchen items left out with trailing wires and hot water. .

The use of agency staff had reduced as new staff had been employed. We were told that experienced clinical leads were due to start full time employment in December 2016.

We met some new staff that had recently been employed and were impressed with their enthusiasm and their commitment to the people they supported. We also found that staff that had worked at St Dominic's Nursing Home over the past year (and more) were committed to the improvements.

It was clear that the organisation was committed to improve the service and more time was needed to fully embed the improvements to care delivery and build up the staff team. This will be reviewed at our next comprehensive inspection which will be in the New Year.

The overall rating for this provider remains 'Inadequate'. This means that it continues to be placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

St Dominic's Nursing Home was not consistently safe and whilst improvements had been made, was not fully meeting the legal requirements that were previously in breach.

Care plans and risk assessments to maintain and promote peoples health were devised and reviewed monthly. However, the day to day management of people's individual risk assessments to maintain their health, safety and well-being were not always followed and therefore placed people at risk.

There was not always enough suitably qualified and experienced staff to meet people's needs. Staff recruitment was on-going and new experienced and qualified staff were coming in to post.

St Dominic's Nursing 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 was an unannounced focussed inspection on 05 December 2016. It was undertaken by four inspectors and they were focussed on the nursing and staffing concerns raised with us.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and the action plan sent to us by the provider. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records five staff files including staff recruitment, training and supervision records, medicine records accidents and incidents along with information in regards to the upkeep of the premises.

We looked at eight care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with 10 people who lived at the home, four relatives, and ten staff members. We also spoke with the provider who was present throughout the inspection.

We observed the care which was delivered in communal areas to get a view of care and support provided across all areas. This included the lunchtime meals. As some people had difficulties in verbal communication the inspection team spent time sitting and observing people in areas throughout the home

and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us. 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

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at St Dominic's Nursing Home. One person told us, "I have no worries about my safety." Another said "I think things have improved and I feel safe." A relative told us, "I have had concerns but I think it seems better, more staff and happier staff." Another relative said, "I can see a difference, we see familiar faces now which really helps." A visitor told us, "Staff seem more confident and more relaxed." A relative told us, "I have sat and spoken to staff about care for my relative and I feel that the care is right."

At our inspection in September 2016 we found that people's health safety and welfare were not always safeguarded. The provider had not taken appropriate steps to ensure that there were measures in place to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had also found there were not sufficient, experienced staff deployed to keep people safe or assist them to receive appropriate care and support. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider submitted an action plan detailing how they would meet the legal requirements by 30 November 2016. Whilst we found that clinical staff had been recruited, staff deployment had improved and the risk to peoples' health and well-being had been mitigated, the provider was still not fully meeting all of the requirements of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that whilst individual health risk assessments were in place, they had not included sufficient guidance for care staff to provide safe care and others were not being followed. This inspection found that peoples care plans and risk assessments had been reviewed and where necessary added to or rewritten. However risk associated with the use of pressure relieving equipment had not always been assessed and used appropriately. For example, seven pressure relieving mattresses were found to be set on the wrong setting for individual people. One person's mattress was set on 7, staff had not checked that this setting was correct for their weight of 39.5 kgs as they did not know what the setting meant in respect of the person's weight. After a search of cupboards a conversion chart for that specific mattress was found and that told us that the setting of 7 was for a weight 170 kgs. Following a discussion with staff the pressure relieving mattress was re-set to the correct setting of 2. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. The risk of pressure mattresses being incorrect is that it could cause pressure damage.

We also saw that 8 people whose risk assessments stated they were at high risk of pressure damage were sat in one position without a pressure relieving cushion or a change of position. The care plan and risk assessment stated that these people should have their position changed two hourly to prevent pressure damage.

On Fern unit there were no staff visible and there were two people in the communal area. The environment was not safe for the people who lived there. There were trailing leads from a microwave, toaster and kettle which had been left on a bedside table that was not stable. These were in easy reach of people. The kettle

had recently been boiled which increased the risk to people. The maintenance person moved the electrical items identified as a risk to people once reported during the inspection.

The recording of food and fluids had improved considerably but this was not consistent throughout the service. There were fluid records that had only 200 mls documented in 24 hours and other records were completed retrospectively. We therefore could not be assured that the risk of dehydration had been mitigated.

Wound care management was an area that had been identified as a concern as there had been two safeguarding alerts raised in November 2016. Systems for the management of wounds had changed following the safeguarding meetings and all registered nurses now had an insight and overview in to the wound care treatment. Wound records identified that whilst improved, documentation needed to be further improved to ensure best practice. For example, one person had three separate pressure sores, but there was only one wound care plan for all three wounds. Best practice would include separate wound charts for each wound so they could be monitored.

Topical creams instructions lacked information where the cream should be applied and not all records were completed. Some people were receiving creams that were not prescribed for them. Records therefore were not informative or accurate.

The overall cleanliness in St Dominic's Nursing Home had improved but there was still improvements to be made in ensuring that all equipment used by people was clean and hygienic. For example there was excrement found on some bedrails and bumpers and not all commode pots were suitably clean. Whilst improvements had been made there were still improvements needed to embed safe care delivery and treatment to fully meet Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst the organisation has made staff training and recruitment a priority there was still a concern over the leadership of staff to lead care delivery on a day to day basis. This was confirmed by the variable care delivery seen on Fern Unit and Bluebell Unit. There were a number of people who remained in their bedrooms on Bluebell Unit and staff struggled to provide care in a timely manner. For example, fluid and turn records were completed retrospectively and were inaccurate when we visited them. We also observed people on Fern Unit left for long periods of time in the lounge area and in their bedrooms without staff presence or interaction from staff. At times people sat without any background music, the offer of the television or an activity." We asked staff about the staffing levels. Staff told us that they were "Always very busy" and this meant they "Had to rush to get people up and dressed before lunch." One staff member on the middle floor said "One extra staff member who has experience in managing challenging behaviour would make all the difference, that what is what causes us to rush." We noted that one person had to wait eight minutes for someone to answer their call bell because staff were busy elsewhere. Staff did not check to see if this was an urgent call.

The dependency of people who lived at St Dominic's Nursing Home was high as there were many people who lived with dementia as well as being physically frail. Staff were not always able to offer assistance to meet people's individual needs. Whilst improvements had been made there were still improvements needed to ensure that there were sufficient, suitably qualified and experienced staff deployed to meet peoples' needs to fully meet Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The organisation had worked extremely hard at recruiting new experienced and qualified staff. The amount

of agency care staff had decreased and the permanent staff team increased. We were told that two new clinical leads had been recruited and were due to start full time employment in December 2016. Three new registered nurses had started employment in November 2016, one of whom had previously worked in St Dominic's Nursing Home. This would provide a more consistent leadership in delivering care and treatment.

Diabetic management for people reflected their individual needs and the care directives were clear and contained the necessary information to guide staff in meeting their health needs appropriately. For example blood sugar levels were monitored against people's normal levels and action taken when identified as either low or high. There were records that detailed that contact had been made with the community diabetic nurse and GP.

Advice from an Infection control specialist had recently been received and we saw that an action was in place to address the shortfalls found. Throughout the inspection we observed staff using gloves and aprons appropriately. Staff were able to tell us the procedures in place when attending to catheters to mitigate cross infection risk. Sluice areas and continence aids were clean. Care plans for the staff to follow in respect of management of catheters were in place. Infection control policies and procedures evidenced that they had been updated in November 2016.