County Healthcare Limited

St Mary's Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
St Mary's Care Home is a residential care home providing personal care to 31 people aged 65 and over, some living with dementia, at the time of the inspection. The service can support up to 44 people. It is a purpose-built home all on one floor.

People's experience of using this service and what we found
People received care and support that was not consistently safe or appropriate. The risks they were exposed to had not been fully identified, assessed or mitigated. During a global pandemic, the provider had failed to train all their staff in infection prevention and control and ensure they used personal protective equipment (PPE) as per government guidance. The premises and equipment were unhygienic and visibly soiled. This put people at risk of infection, including COVID-19.

We could not be assured that people received care to keep them healthy and well. People had not received their medicines as prescribed and the monitoring of people's health had been ineffective resulting in some people being exposed to harm and risk. We saw people had lost weight and did not receive the support they needed from staff to eat and drink.

Staff told us they had been scared to raise concerns or, if they had, their worries had not been actioned appropriately or promptly. This left people at risk. Staff had not received consistent support, training or had their competency checked; this left them feeling devalued and posed a risk to the people they supported. Communication was poor and relatives told us they had not been kept regularly informed about their family members, particularly during the pandemic lockdown when they needed extra reassurance.

The Care Quality Commission (CCQ) acknowledges that the current climate is one of global pandemic, and that providers have had to adapt their methods of oversight accordingly. However, the management within the service had been ineffective and the oversight from the provider had not been robust enough to promptly identify and rectify the concerns found at this inspection. Quality monitoring systems that were in place to drive improvement had failed and the lack of provider oversight compounded this. During our inspection we found staff lacked direction resulting in a chaotic approach.

The provider had installed a senior management team in the home as a result of the concerns raised prior to the inspection and had the support of other health and social care professionals, yet whilst some improvements were being made, we found the quality of the service was still poor. Regulatory requirements had not been met and we found the provider to be uncooperative during this inspection, failing to meet deadlines and providing information fully or promptly.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published 23 July 2018).

Why we inspected
We received multiple concerns in relation to medicines management, the premises, risk management, infection prevention and control and governance. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to inadequate. This is based on the seriousness of findings at this inspection.
We have found evidence that the provider needs to make significant improvement. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this report.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Mary's Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

At this inspection, we have identified breaches of regulation in relation to safe care and treatment, safeguarding people from the risk of abuse, governance and notifying CQC of reportable events.

Please see the action we have told the provider to take at the end of this report.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety and we will meet with them on a monthly basis to discuss their plans. We will work alongside the provider and local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

St Mary's Care 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 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was carried out by three inspectors, one working remotely with two on site, and one pharmacist inspector.

Service and service type
St Mary's Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means the provider is solely legally responsible for how the service is run and for the quality and safety of the care provided. There was, however, a covering manager in place and they are referred to as the manager throughout this report.

Notice of inspection
This inspection was unannounced although checks were completed prior to entry to ascertain COVID-19 status.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We spoke with one relative of a person who uses the service.

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

We used all of this information to plan our inspection.

During the inspection
Due to the COVID-19 pandemic the visit to the service was carried out by two inspectors and a pharmacist inspector over a shorter period; this was to manage the associated risks. The rest of the inspection was carried out remotely by the lead inspector who reviewed documents related to the care provided and the management of the service. The inspection activity took place between 6 August 2020 and 19 August 2020.

During the inspection site visit we spoke with two people who used the service. We also spoke with two members of staff and observed the care and support people received. An additional two agency staff were also spoken with. Following the site visit we spoke with a further seven staff members and one relative. Staff members included the manager, chef, senior care assistants, domestic assistants and care assistants.

We reviewed a range of records. This included 10 people's care records and the medication records for 21 people. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures, incidents, training records, quality monitoring audits and premises maintenance records, were reviewed.

After the inspection
We had further contact with the manager and provider's representatives to assess and validate evidence found. We also spoke with one social care professional for their feedback on the service. We asked the provider for contact details of the relatives of people who used the service so we could seek their feedback however this information was not provided.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- People were not protected against the risk of infection. Current national guidance and the provider's own policies and procedures were not followed, and the environment was unclean and unhygienic.
- The inspection team was not screened for symptoms of COVID-19 on arrival at the home. The provider's COVID-19 risk assessment stated all visitors should have this completed to mitigate the risk of infection.
- We saw staff using personal protective equipment (PPE) inappropriately which put people at risk. For example, we saw one staff member served food to people with their face mask under their chin failing to cover their nose and mouth in line with government guidance. In addition, we saw a kitchen staff member prepare food in the same manner.
- PPE was stored uncovered in some bathrooms and other areas of the home. This meant it was exposed to cross contamination.
- We found dirty and rusty equipment throughout the home including contaminated safety equipment and furniture such as safety mats, pressure cushions, hand rails and easy chairs. Some furniture was damaged, and paintwork was chipped in places, making it difficult to clean and decontaminate.
- The provider's own infection control audit completed on 28 July 2020 showed a poor compliance rate with the en-suite bathroom assessed as failing for every check completed.
- Due to concerns, the local clinical commissioning group had completed an infection prevention and control audit the day before our inspection site visit; this confirmed the service had failed to fully comply with good infection prevention and control practice.
- Staff had not received training in COVID-19 and, during a global pandemic, only 79% of staff had completed training in infection control.

The service had failed to protect people from, and manage the risk of, infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People had been exposed to risk and avoidable harm as care and treatment had been delivered in an unsafe manner. The risks to people had not been fully assessed, reviewed or mitigated. Furthermore, the service had failed to ensure the condition of premises and equipment were safe.
- For one person who experienced recurrent infections, the service had failed to implement a prompt or robust risk assessment to help keep the person free from discomfort. In addition, the service had administered a medicine the person was allergic to. No care plan had been in place to manage the risks

associated with the numerous drug allergies the person experienced.
● For a second person, the regional manager told us they had been 'overdosed' on a medicine that has potential sedative side effects. When we looked at the records, we saw that the medicine had been given regularly without recorded justification and not on an occasional basis as prescribed. No guidelines had been in place for staff to follow to ensure the medicine was administered in a safe and appropriate manner. The person had subsequently experienced a fall requiring medical assistance.
● Records showed several people had lost weight. We saw that people received small portions of food and did not get assistance to support them to eat. One staff member told us, "People get food left in front of them and they aren't assisted." They went on to say of one person, "[Person] sits in their room, and the food is brought to them and left in front of them. They won't eat the food if not prompted, so it's taken away." Following the inspection, we made a safeguarding referral due to our level of concern regarding people's weight.
● We found accessible toiletries throughout the home that posed a risk of ingestion, particularly to those people living with dementia.
● The risk of fire had not been fully mitigated. Oxygen was used in the home and no signage was in place to alert the fire service to this in the event of a fire. In addition, regular maintenance checks had not been completed on the fire system including the alarm, emergency lighting and fire doors. The fire risk assessment had not been reviewed in the specified timescale.
● The provider had failed to keep people safe from the risk and spread of COVID-19. No risk assessment had been implemented until 18 July 2020 and the infection prevention and control policy had not been reviewed during the pandemic. The individual risks to people relating to the virus had not been assessed.

The service had failed to do all that is reasonably practicable to mitigate risk. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Records confirmed that people did not always receive their medicines as scheduled by prescribers because they had not been obtained. Safeguarding referrals had been made in relation to specific incidents around this prior to our visit.
● During the inspection visit we identified further recent instances when people living at the service did not receive some of their medicines and there were also gaps on Medicine Administration Record (MAR) charts that were unexplained including for medicines prescribed for topical application such as for creams and emollients. On the day of the inspection visit we asked the manager to take immediate action to obtain a medicine for a person who had not been given it as scheduled that morning. This was completed by the service as a result of our request.
● Daily stock checks of people's medicines were carried out by staff and monthly audits of people's medicines were completed by the manager, but incident forms had not recorded recent medicine incidents that we identified. Therefore, we concluded that the medicine checks in place were not sufficiently effective in promptly identifying concerns with people's medicines.
● The service confirmed that members of staff that were until recently authorised to handle and give people their medicines had not received training or had their competence assessed.

The service had failed to ensure proper and safe management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The service had ineffective systems in place to protect people from abuse or the risk of abuse.
● Some people had experienced harm in the service whilst others had been the subject of near miss

incidents. For example, the service had failed to promptly seek medical assistance for one person who was described by a professional as being in pain and distress when finally admitted to hospital.
● For another person, the service had failed to identify, assess and manage the risk posed by an abusive family member. Whilst this did not result in harm, the risk was present and had not been mitigated.
● At a time when services are at higher risk of forming closed cultures due to the pressures surrounding the pandemic, not all staff had received training in safeguarding adults.
● Staff told us they were either too scared to raise concerns or that they had, and no action had been taken. One staff member said, "I raised several safeguarding issues with previous management, but nothing was done. Whistle-blowing needs to be explained and discussed more as staff are scared they will get in trouble." Another staff member told us, "I have repeatedly raised concerns about staff and been told I don't need to as it's not a near miss. I have also raised concerns about the quality of care with new management and nothing is done. There needs to be more guidance and communication; staff are scared to speak up."
● One professional who had requested the service complete an investigation following a safeguarding concern told us they felt the scrutiny by the service had been poor.

People had not been protected from abuse and the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) 4014.

Staffing and recruitment
● There were not enough trained, supported and competent staff on duty to meet people's needs.
● Some staff had been administering medicines without being trained to do so; this had resulted in widespread medicines errors, putting people at the risk of harm.
● Staff had not received regular support, supervision or training and their competency had not been assessed. One staff member told us, "My induction and training for my role just didn't happen." Another staff member said, "If we are a dementia home then we need to be trained in dementia care, and not all staff are. For example, some people refuse food, but if you try again later, they will eat it. Some staff just think they don't want it and take the food away."
● Prior to the inspection, the provider told us that, at times, staffing levels had been below the recommended levels.
● Most staff we spoke with told us staffing levels had recently improved but had been an issue in the recent past.
● Our observations during the inspection showed there were enough staff on duty however there was a lack of direction or oversight of staff meaning the shift was chaotic and unorganised.

Not enough suitably qualified, competent and experienced staff were deployed. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staffing had improved leading up to the inspection. Several agency staff were being employed to fill gaps in the rotas including qualified nurses to administer medicines.

Learning lessons when things go wrong
● Although staff understood their responsibility to raise concerns and report accordingly, management had failed to onward report and the lack of provider oversight meant opportunities to learn lessons had not always been taken.
● The service had undertaken several investigations into incidents that had occurred, but they lacked robustness that again missed opportunities to better improve the care people received.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in the service which had not been identified and rectified in a timely manner by the provider.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There had been a lack of effective management and provider oversight at the service which had resulted in people experiencing poor care. Whilst senior managers had been brought in to rectify the issues, the seriousness and widespread nature of the concerns had been allowed to escalate, prior to their input, putting people at significant risk.
- There was no manager in place that was registered with the Care Quality Commission (CQC) as required by the provider's registration. The previous manager had been dismissed early July 2020 after the provider became aware of serious concerns under their leadership. Whilst the provider took decisive and prompt action when concerns were identified, lack of oversight had meant concerns had been ongoing for some weeks prior to this.
- Both of the relatives we spoke with told us the service had failed to inform them of incidents involving their family members. They told us communication was poor and that the service had failed to be honest and transparent with them. One of these relatives told us they felt they had been, "Fobbed off with excuses." They went on to tell us that during the pandemic they had received only one letter and one phone call from the service to keep them updated and had not been told there had been a COVID-19 outbreak within the home.
- Throughout the inspection process, the provider was uncooperative and failed to meet deadlines that they themselves had set to demonstrate compliance with regulatory requirements; this did not provide us with assurances.

Processes were not in place to drive improvement and meet regulatory requirements. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service had failed to notify CQC of events that are required to be reported. This included safety events such as those relating to people's health and welfare.

This is a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Continuous learning and improving care

● Whilst a framework was in place to monitor quality and drive improvement, this had not been fully utilised. Audits had either not been completed or inaccurate information had been inputted meaning data to make improvements had not been captured and opportunities missed.
● The provider had initiated a service improvement plan when concerns were identified however, they had failed to complete some actions as planned. For example, an equipment audit had not been completed which would have identified the dirty equipment we observed on our inspection visit.
●The incident analysis completed by the service showed incidents were not always followed up.
● The service had failed to support staff and their competency had not been assessed or kept under review. Staff told us they were fearful to raise concerns. One staff member said, "Staff need routine and direction." This had resulted in staff feeling devalued and unmotivated.

The quality of the service had not been effectively assessed and monitored to mitigate risks. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Whilst the manager understood their responsibilities around the duty of candour, leading up to our inspection there had been several incidents involving people who use the service where their family members had not been informed promptly as required by the duty of candour requirement. In some instances, family members had been unaware of incidents regarding their loved ones until told by other stakeholders. This did not provide us with assurances that the provider acted in a transparent and open manner.

Failure to act in an open and transparent way is a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Both the relatives we spoke with told us the service had been poor at engaging them, seeking their feedback or involving them in the care of their family members. One relative described the service as having, "No thought" regarding how they engaged with them.
● Staff told us they had felt devalued and not listened to but that this had recently improved since the new management team had been in place. They told us they felt more able to raise concerns and more confident that they would be listened to and concerns acted upon.
● The manager told us they regularly engaged with people who used the service however the provider could not demonstrate any formal feedback had been requested or received from any person who used the service, their relative, staff member or stakeholder.

Working in partnership with others
● Since concerns had been identified within the service, the provider had worked, and engaged, with other stakeholders to drive improvement.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of incidents that had affected the health, safety and welfare of people who used the service. Regulation 18(1) and (2) of the CQC (Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to do all that is reasonably practicable to mitigate risks to people. Regulation 12(1)(2)(a)(b)(c)(d)(f)(g) and (h) of the HSCA

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Processes to protect people from abuse and improper treatment were ineffective and people had been exposed to risk of harm. Regulation 13(1)(2)(3) and (4)(d) of the HSCA

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance Systems to assess, monitor and improve the quality and safety of the service had failed resulting in people receiving poor care. Regulation 17(1)(2)(a)(b)(c)(e) and (f) of the HSCA

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to be open and transparent with family member in relation to care and treatment. Regulation 20(1)(2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not deploy enough suitably trained, supported, skilled or competent staff to meet the needs of the people who used the service. Regulation 18(1) and (2)(a)