

St Mary's Nursing Home Ltd

# St Mary's Nursing Home

## Inspection report

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Date of inspection visit:  
20 May 2019

Date of publication:  
20 January 2020

## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

About the service:

St Mary's is a care home, providing nursing, personal care and accommodation for up to 56 people. It provides care to older frail people, some of whom are living with dementia. The care home offers short respite nursing care stays and short stays for people discharged from local hospitals on a 'Discharge to Assess' basis. Care is provided over two floors. Each floor has communal lounges, dining areas and a kitchenette. At the time of our inspection visit 47 people lived at the home.

What life is like for people using this service:

People's risks to safety and well-being were assessed, recorded and reviewed. Actions were taken to mitigate risks of harm and injury to people.

There were sufficient staff on during the day shift. A few staff felt the first-floor night time staffing was low and the registered manager told us they would review this.

People had their prescribed medicines available to them and were supported with these by nursing staff. Staff received an induction, training and support from within the staff team and managers.

The home was clean and tidy, and staff understood how to prevent risks of cross infection.

People had their needs assessed before they moved into the home. However, people's individual oral care needs were not always assessed.

Staff were suitably skilled to meet people's day to day needs and protect people from the risks of abuse.

People had opportunities to engage in one to one activities, which reduced risks of social isolation.

People had access to healthcare when required.

Overall, people were offered enough food and drink to meet their dietary requirements. However, the lack of staff's organisation at lunchtime meant two people did not receive their meals as intended.

People's dignity was promoted by staff, who showed respect and valued people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The provider's policies and systems in the service supported this practice.

Staff did not consistently complete important records related to people's care and support. The registered manager and provider had not checked these records were completed by staff as required.

Overall, the provider's quality assurance system identified where improvements were needed, but this was inconsistent and did not always ensure quality and safety.

We reported that the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:

Regulation 17 Regulated Activities Regulations 2014 – Good Governance

Rating at last inspection: At the last inspection the area of Well Led required some improvements and other areas were rated good. This gave the service an overall rating of Good. (The last report was published on 29 November 2016).

Why we inspected: This was a planned inspection based on the rating of the last inspection. The service is

now rated as 'Requires Improvement' overall.

Enforcement: Action provider needs to take (refer to end of report).

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe

Details are in our Safe findings below.

### Is the service effective?

Requires Improvement ●

The service was not consistently effective

Details are in our Effective findings below.

### Is the service caring?

Good ●

The service was caring

Details are in our Caring findings below.

### Is the service responsive?

Good ●

The service was responsive

Details are in our Responsive findings below.

### Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

Details are in our Well Led findings below.

# St Mary's Nursing Home

## Detailed findings

### Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection Team: Two inspectors, a specialist advisor and an expert by experience carried out this inspection on 20 May 2019. A specialist advisor is a qualified health professional. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: St Mary's Nursing Home is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did have a manager registered with the Care Quality Commission (CQC). A registered manager, as well as the owner and provider, are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection visit took place on 20 May 2019 and was unannounced.

What we did when preparing for and carrying out this inspection:

We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We also sought feedback from the local authority and professionals who work with the service. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During our inspection we spoke with six people and four relatives. We spent time with people, who due to living with dementia could not give us their feedback, to see how staff supported them. We spoke with a nurse, four care staff, two activities co-ordinators, the cook, a housekeeper and the registered manager and the provider. We provided our contact details for night staff to give us feedback about the service, which

they did.

We reviewed a range of records. This included six people's care records, multiple medication records, food and drink and repositioning recording charts. We also looked at records relating to the management of the home. These included systems for managing complaints, checks undertaken in relation to health and safety and staff training records.

# Is the service safe?

## Our findings

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

Good: People were safe and protected from risks of avoidable harm. Regulations were met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong:

- People's needs had been assessed to identify any risks to their health and wellbeing, and staff knew people well and how to safely meet their care needs.
- One person was at risk of choking and staff followed the person's risk management plan, to ensure the person's fluids were thickened and their food was pureed. They sat the person upright to eat and observed them closely to identify if they were struggling to swallow.
- The registered manager had recognised potential risks of electrocution to one person who liked to hold their cutlery after meals, so had ensured electrical sockets were covered with safety covers, when not in use.
- Some people had been identified as at risk of having or developing sore skin. There was a low incidence of people's skin becoming damaged because staff took action to reposition people and used special equipment, such as airflow mattresses to relieve pressure.
- Where people were at risk of falls, actions had been taken to reduce those risks. The registered manager and provider were responsible for the analysis of accidents and incidents to identify patterns and trends, so actions were taken to prevent risks of reoccurrence.
- People had Personal Emergency Evacuation Plans (PEEPS) so staff and emergency services knew what level of support people required in the event of an emergency evacuation.

Preventing and controlling infection:

- Staff we observed wore Personal Protective Equipment (PPE) such as plastic aprons and gloves.
- The home was clean and odour free. Housekeeping staff had a good understanding of their role in infection control. They told us they were kept informed of any infections in the home, so they could follow the provider's policies and procedures to prevent the infection spreading. A visiting healthcare professional told us, "I have never come in and found any odour."

Using medicines safely:

- People had their prescribed medicines available to them and were supported to take them by nurses. Where people had topical creams applied to their skin by care staff, records had been signed.
- Overall, medicines were stored securely. However, we found one medicine fridge located in the first-floor communal lounge had been left unlocked. The registered manager took immediate action to address this and told us this was not accepted practice.

Staffing and recruitment:

- There were enough staff on shift to safely meet people's needs. Day shift staff spoken with confirmed this, telling us, there were "always enough staff on duty during the day" and they worked well as a team to ensure people's needs were met. One told us, "We have had a few residents join us recently and managers have

made sure there are enough staff to facilitate the care." Another staff member told us staffing levels ensured they were able to work safely and always follow good practice.

- One staff member told us it could be a challenge to meet people's needs at night because there was only one nurse and one care staff on duty on the first-floor. They told us, "It is not enough to look after the residents, we need an extra carer at night."
- Following our inspection feedback, the registered manager and provider told us they would immediately re-assess night-time staffing levels for the first-floor. The registered manager told us how this would be undertaken and assured us staffing levels would be adjusted if needed.
- The provider's system for recruiting staff ensured staff's suitability to work there. A new member of staff confirmed they had to wait for their references and police check before they could start working at the home.

Systems and processes to safeguard people from the risk of abuse:

- Staff were trained and knew about different types of abuse. They knew how to protect people from abuse and poor practice and were confident to raise any concerns with the registered manager or the provider. One staff member said, "I would report it straightaway" and added that if no action was taken, "I would go outside the company and whistle-blow."
- The registered manager understood their responsibilities in reporting specific incidents to us and the local authority.



# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations were met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

- People had pre-admission assessments completed before they moved in, so the registered manager could be assured they could meet the needs of people who were new to the service. However, the assessment concentrated on people's physical and medical needs rather than a holistic overview of all their care needs.
- People had individual plans of care, which, overall gave staff the information they needed to meet people's care and support needs.
- However, people's oral care needs were not always assessed, and care plans did not inform staff of the support people required to maintain oral health. This included people who were not able to have nutrition orally. The National Institute for Clinical Excellence (NICE) gives guidance about people who received their nutrition through other means and may be susceptible to oral bacterial infections. The registered manager assured us oral health care plans would be implemented.

Staff support: induction, training, skills and experience:

- The provider had their own training facilitator to ensure staff received training appropriate to their roles. They told us, "In order to improve standards and the lives of the residents at St Mary's, the training of the staff is critical."
- Staff told us their training had enabled them to do their job confidently and competently. Staff told us they could highlight any areas where they felt they would benefit from further training and these requests would be actioned. "Training is good, they go through things in detail and come onto the floor as well and show you practically."
- New staff received an induction which included training and working alongside more experienced staff until they had been assessed as being competent to work alone. New staff had a mentor to support them during their probationary period.
- Staff had regular opportunities to meet with their managers and discuss their training and development needs.

Supporting people to eat and drink enough with choice in a balanced diet:

- People were offered choices about what they ate and drank.
- People were offered regular drinks and snacks including cakes, biscuits, chocolate bars and bananas. There were milkshakes available for those people who needed extra calories. Further plans to fortify milk to people's drinks and cereals meant increased opportunities would be taken to increase people's calorie intake when needed.
- People's lunchtime experience was not consistently relaxed or enjoyable. For people having their lunch in the ground and first-floor dining rooms, it was very busy with staff walking to and from the kitchenette to

collect meals to take to people in their bedrooms. The dining room was cramped and noisy.

- Some people received staff's support with their lunchtime meal. For example, one staff member offered encouraged one person, telling them, "You try and do some more yourself [Name], you are doing really well." This staff member offered support later asking the person, "[Name] are you struggling today, would you like a bit of help?"
- However, staff's lack of organisation during lunchtime, across both floors, posed risks to people not having their meal as intended. For example, one person living with dementia was given their meal by a staff member. Before eating this, the person stood up and moved away from their seat. Another staff member encouraged this person to sit down, but at another table, and gave them their pudding. The person's untouched meal was thrown away. Another person had their pudding given to them, and correctly informed staff they had not yet had their first-course.
- We discussed people's mealtime experience with the registered manager who told us immediate action would be taken to ensure a designated staff member co-ordinate serving meals to ensure people received their meal.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:

- A healthcare professional told us, "The providers have got a pretty good system so if somebody isn't looking well, staff will ask us (GP) to see them." They went on to say, "Staff know people well and are good at describing how a person has changed."
- People had a 'hospital grab sheet' but details about people were basic and contained very limited information for hospital staff in the event of a person's admission.

Ensuring consent to care and treatment in line with law and guidance:

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- People's capacity to make specific decisions had been assessed and where a person lacked capacity it was clear when staff needed to act in people's best interests.
- Staff told us they spoke to people's families so they knew people's likes and dislikes, and where necessary took decisions in a person's best interests. A staff member told us, "We make decisions based on our knowledge of people."
- Where restrictions were placed on people's care, the provider had made appropriate DoLS applications for authority.

Adapting service, design, decoration to meet people's needs:

- The home was purpose-built and was adapted to meet people's needs. The premises were spacious and enabled people to walk about if they wished to. However, there were limited objects to engage people living with dementia or to add purpose to their walks.
- There was a pleasant garden, but this was not readily accessible to people without staff support. We found

doors to the garden were kept locked and a staff member told us, "People can't go out alone because they might fall." We discussed NICE guidance and the importance of accessibility to fresh air with the provider and registered manager. They told us immediate action would be taken to assess and mitigate any potential risks, so people could freely and safely access outside space.

- There was some signage in words and pictures to help people on the ground floor find their way around, although this was not always at eye sight level.

# Is the service caring?

## Our findings

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

Good: People were well-supported, cared for and treated with dignity and respect. Regulations were met.

Ensuring people are well treated and supported; equality and diversity:

- Positive and caring interactions took place between people and staff at the home, where people were respected as individuals. Staff acknowledged people throughout the day. They spoke to them by name when passing them through the corridors and either spoke to people or gave physical signs of acknowledgement as they went about their duties in communal areas. For example, one member of staff gave a thumbs up to a person sitting on the other side of the room as they went to assist somebody else.
- One staff member told us how they used their knowledge of people to have meaningful conversations with them. "[Name], I know they used to like fishing. This morning when I was assisting them with breakfast I talked about fishing."
- Relatives made positive comments to us, one said, "They treat my relation very well, staff talk to them nicely and I've never heard staff talking badly about people."
- Staff used touch as well as their voice to provide reassurance and encouragement to people.
- Staff were observant of people's needs. One staff member asked, "[Name], can I put this cushion behind your back?" Another staff member recognised a person was feeling a bit low in their mood and said, "Would you like a walk in the garden after lunch, would that cheer you up." When the person declined the staff member asked, "Would you like me to read to you in bed?"

Supporting people to express their views and be involved in making decisions about their care:

- Relatives told us staff had involved them in their family member's initial assessment to inform their plan of care.
- Staff offered people every day choices, so they could make decisions about their day, such as where they spent their time.
- Staff understood their role to advocate on behalf of people. One staff member told us, "People here are very vulnerable and there are residents who can't talk so we have to speak up on their behalf if needed."

Respecting and promoting people's privacy, dignity and independence:

- Staff supported to maintain their appearance which promoted their dignity. For example, tabard aprons were offered to people at mealtimes to protect their clothing from spillages.
- Staff used language that was respectful toward people and showed they were valued.
- Staff knocked on people's bedroom doors and encouraged people to do what they could for themselves, promoting people to retain their skills.

# Is the service responsive?

## Our findings

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

Good: People's needs were met. Regulations were met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- Care staff told us they referred to people's one-page summary of care needs, which outlined people's needs. One staff member told us, "This gives a useful overview for us, it's mainly the nurses who use the full care plan."
- Care plans provided sufficient detail to enable staff to meet people's needs. Although care plans were task orientated, staff gave personalised care. For example, people cared for in bed had their televisions and radios on which were tuned into different programmes that reflected their personal preferences.
- People's communication needs were met. For example, two people used a white board to communicate. For another person with limited hearing, we saw staff writing down what they wished to communicate. We observed one member of staff using visual prompts to help a person understand the choices they were being given.
- People's pastoral care needs were met. For example, a vicar from the local church visited regularly for those people who wished to follow their faith.
- Activities took place to reduce risks of social isolation. Due to people's frailty and complex health needs, the majority of activities were carried out on a one to one basis. An extra activity co-ordinator had been recruited to enable more one to one time. One activities co-ordinator explained, "I get a lot of positive results from one to one time." They described how they read poetry with one person who they described as 'coming alive' when they heard poetry. Other people enjoyed looking at photographs of their family and events in their lives and chatting about them. Activities staff explained how they carried out research, for example about a village where one person had been born, so they could have more meaningful conversations with people.

Improving care quality in response to complaints or concerns:

- People and relatives had no complaints about the services they received. They felt the registered manager was approachable and felt able to raise concerns following the provider's complaints policy which was displayed.
- The registered manager recognised they did not have an easy read pictorial complaints policy and assured us this would be put into place.

End of life care and support:

- End of life care was given at St Mary's and many people had decisions in place as to whether they should be resuscitated in the event of a cardiac arrest. 'Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records showed people's and their relative's involvement in decisions and end of life care planning.

# 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

Requires improvement: Service management and leadership was inconsistent. Management and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements:

- At our last inspection in November 2016, we found improvements had been made to records related to people's care, however, we told the provider and registered manager further improvements were required to ensure all important care records were accurate and consistently completed by staff.
- At this inspection we found the required improvements in records related to people's health care needs, medicine skin patch and injection site and fluid and food monitoring charts had either not been made, or not sustained or embedded into the managerial oversight of care delivery.
- The registered manager and staff assured us tasks were undertaken as needed, but they had not always completed records as required. This meant records were not always available for staff to refer back to and posed a risk of inconsistent or incorrect care being provided. For example, one person's insulin injection site was not consistently recorded. This is important because over-use of one area of skin can cause lipodystrophy (fatty deposits) to develop which affects the absorption of the insulin.
- One person was prescribed twice weekly catheter 'flushes', however, care records had only one entry in the period between 6 to 18 May 2019, which recorded nurses had completed these. Our specialist advisor was of the opinion the 'flushes' had likely been completed as there had been no complications in the person's catheter draining.
- Some people were at risk of developing sore skin and required staff to support them to reposition. Whilst staff told us people were repositioned, records were not consistently completed to record times when this happened, which posed risks of staff not knowing the time when a person should next be repositioned.
- One person was identified as 'at risk' of malnourishment and was described as 'underweight'. This person's food monitoring chart had numerous gaps where staff had not recorded what food was offered, declined or eaten.
- The registered manager oversight of some checks and audits they had delegated to staff was not always effective in identifying where improvements were needed. For example, visual checks designed to ensure people's airflow mattress pumps were set correctly failed to identify setting errors where, for example, one person's recorded weight was 40.2kg but their airflow pump was set on 150kg. This posed potential risks to people not receiving their optimal pressure relief.

The above concerns demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection feedback, the provider and registered manager took immediate action and sent us a plan detailing what changes they had implemented immediately to ensure staff completed care records as required. They also outlined how their oversight of these would take place to ensure improvements in completing records and daily checks were sustained.

- Staff told us the registered manager was visible and they felt able to approach them directly with any concerns or issues. One staff member told us, "If you have a problem you can always go to the manager."
- Staff also told us the provider was regularly in the home and commented, "He will always say hello just in passing," and, "The provider is around a lot. He comes on the floor and speaks to the residents." People and relatives knew who the provider and registered manager were and told us they were friendly and chatted to them.
- Staff felt proud of the standards of care in the home. One staff member told us, "The nursing care is a high standard in this home," and, "I think it is great. It is the best home I've worked in because of the quality of the care people receive and we all work well as a team."

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

- The registered manager attended local provider forums where learning was shared.
- The provider offered opportunities to people and their relatives to give feedback and positive feedback had been received from the March 2019 feedback survey.
- There was a suggestion box available for relatives to post their ideas about how the service could be improved.
- The rating from the provider's last inspection was displayed, as required, in the entrance area of the home.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider and registered manager did not ensure an accurate, complete and contemporaneous record was consistently made in relation to service user's care needs. The provider and registered manager did not have effective managerial oversight of care records.