

St Marks Care Home Limited

St Marks Residential Care Home

Inspection report

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13 November 2017
28 November 2017

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Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service effective?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

We undertook an unannounced focused inspection of St Mark's Residential Care Home over two days; 9 and 13 November 2017 and met with the provider on the 28 November 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection carried out on the 6 and 9 February 2017 which found it was not meeting some legal requirements. The team inspected the service against three of the five questions we ask about services: is the service well led, safe and effective.

No risks, concerns or significant improvement were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection.

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

St Marks Residential Care Home is an adapted building, located close to the town centre, GP surgery and public transport. The service provides personal care for up to 17 older people, some people living with dementia. There were 14 people living in the service when we inspected.

There was a registered manager in post, who was also a director of the company which owned the service. The registered manager was also registered to manage another care home for older people in Clacton which they owned. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found that sufficient action had not been taken and the provider remained in breach of the Regulations. We found that some parts of the service presented risks to people and there was a lack of robust assessments and controls in place to protect people and keep them safe. The environment was not always well maintained and we continued to find concerns with cleanliness and infection control.

We continued to have concerns about the numbers of staff their knowledge and skills. Staff did not always demonstrate adequate knowledge about how to support people safely. For example there were risks associated with aspiration and choking, moving and handling, infection control, unstable wardrobes, window restrictors, storage of hazardous fluids and trip hazards.

The quality of the training staff received was not effective enough to demonstrate they were able and competent to meet the needs of the people using the service. The provider did not have systems in place to

ensure they were up to date with best practice guidance and there was a lack of effective learning from safeguarding incidents to reduce the risks to people from reoccurring.

Improvements were needed in the medicines systems to ensure staff followed safe, person centred practice. The use and timing of 'as and when required' medicines, to ensure people received them safely in line with best practice, and their effectiveness monitored. This included staff being given clear guidance on the use of anti-anxiety medicines, to enable staff to demonstrate that non-medicines strategies had been tried first.

There were quality assurance systems in place but these were not robust or effective. They were not driving improvement and had not identified the issues that we found at the inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Risk to people's welfare were not managed effectively.

People were not being provided with a safe, well maintained environment, or protected from the risk of infection.

Improvements were needed in the safe management and administration of medicines.

There were not always sufficient skilled and knowledgeable staff deployed to meet the needs of people living in the service.

Is the service effective?

Inadequate ●

The service was not effective.

There had been no improvement to ensure people were consistently supported by trained and skilled staff.

Is the service well-led?

Inadequate ●

The service was not well-led.

Leadership at the service had not been effective in driving improvement.

The service was developing in line with good practice.

St Marks Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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. This inspection was unannounced and took place over two days: 9 and 13 November 2017. The inspection team consisted of two inspectors. We also met with the provider on the 28 November 2017, who provided further information.

This inspection was prompted in part by information we had received from people and their relatives since we inspected in February 2017, as well as checking to ensure sufficient action had been taken to address the breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified at that time.

Prior to the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send to us by law. We also looked at information sent to us from other stakeholders, for example the local authority and feedback we had received through the Care Quality Commission 'share your experience' website.

We used information the provider sent us in the Provider Information Return completed in February 2017. This is 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 also used the information the provider had sent us in their action plan following our last inspection. This included what action they had taken to address shortfalls identified during our last inspection, and how these improvements were being maintained and monitored.

We spoke with the registered manager who is also a director of St Mark's Care Home Limited, and six members of staff including catering, domestic, care and management staff.

We spoke with six people living in the service, two relatives of people who had used the service and the safeguarding and quality team at Essex County Council about their visits to the service. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care needs were being met we reviewed four people's care records and other information, for example their risk assessments, diet and fluid intake charts and medicines records.

We looked at three staff member's recruitment paperwork and records relating to the management of the service. This included training, staff duty rosters, fire evacuation plans and systems for assessing and monitoring the quality of the service.

Is the service safe?

Our findings

Our inspection of 6 and 9 February 2017 found that improvements were needed to ensure people were supported in a safe manner, in a clean and well maintained environment which met their needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager / director wrote to us and told us about the improvements they had made. They also met with us on the 23 May 2017, which enabled them to discuss further the action they had taken to address the issues we had identified.

At this inspection we found that although some actions had been taken, it was not effective and placed people at continued potential or actual risk of harm. Continued shortfalls in the understanding of the management team to ensure oversight of staff training, infection control, environment, medicine management and staffing levels impacted on the service's ability to identify and manage risk. Lessons had not been learnt from to minimise reoccurrences to ensure risks associated with individual people's safety, support and health needs were being identified and / or acted on.

This included areas such as monitoring skin viability, supporting people to move / transfer, nutrition, dementia, diabetes, choking and management of anxiety and behaviours.

New admissions were not managed well. The pre-assessment did not take into account people's compatibility with others. There were no strategies in place to support new people with anxieties and mental health needs moving into the service.

One person spoke about incidents where people living in the service raised voices and had confrontation with others. Incident records showed there had been confrontations between different people, whose needs and abilities were very different. No assessments or analysis had taken place to consider any impact or changes that might be needed to mitigate risks. For example, specific training linked to people's complex needs, increasing staffing levels to ensure a visible presence, and where required one to one support.

The staffing levels did not ensure people were continuously supported to keep safe, whilst promoting their independence, and meeting their individual needs. The registered manager used a dependency tool to support them in setting the staffing levels and we saw copies of these tools on people's care records. We found it was not effective, as it did not take into account where staff were expected to undertake duties which impacted on their availability to provide direct personal care. For example, food preparation, cleaning and interacting with visitors and health professionals. Or the risks associated with the layout of the building to ensure all people were safe and comfortable including those who remained in their bedroom.

Visitors to the service told us there were not always staff around to monitor people's safety during meal times. An incident record showed that a relative alerted staff that a person was choking on their food.

Visitors provided examples where they had found rooms' cold during the winter as staff had not checked to ensure windows were closed or explored people's choices in this area.

These factors along with insufficient guidance for staff meant that opportunities to limit risk were not understood or recognised. There was a lack of information to demonstrate how staff would monitor people's needs, recognise signs and symptoms of changing needs and know the actions to take when further intervention or guidance was required. We observed this to be the case for a person who was at potential risk of injury when leaving the service in an unsafe manner. No effective action had been taken to ensure the person's safety and well-being, whilst supporting them to retain their independence. This put the person at continued risk. When this was discussed with the senior leadership team they lacked understanding of what they could do to explore this situation, seek advice or escalate to other professionals.

Where there was a risk management plan, staff were not always able to demonstrate they were following it, or that they had the skills and knowledge required. We observed a member of staff assist a person to move using an underarm lift. This is not a recommended technique as it places people at risk of shoulder injuries. We also received information of concern about this from members of the public expressing concern that staff were manually lifting, rather than using the hoist to safely move people. Although we did not witness this happening during the inspection, we had raised the same issue in our February 2017 inspection. Therefore we were not confident that this was not happening. The senior management team said they had not witnessed this, but additionally did not have robust systems in place to ensure staff were competent to meet the requirements of risk management plans.

Staff's awareness of potential risks to people was not embedded in their day to day practice. As a result throughout the inspection we identified multiple areas which posed a risk, but had not been identified.

Environmental risk assessments and checks in place were not always comprehensive enough, and were not based on nationally recognised health and safety requirements. In some cases the provider could not demonstrate that the staff member undertaking them was competent and experienced to do so. Examples included hazardous cleaning agents unsecured and accessible, leaving a wet floor with no signage to alert people, trip hazards in the garden, poor maintenance generally, people's wardrobes not being secured to the wall to prevent them falling. The management of the risk of legionella had not been monitored effectively to safeguard people living and working in the service coming into contact. The provider could not demonstrate that a suitably qualified and competent person had completed required testing and monitoring. The Registered Manager and Director told us they did it, but could not provide us with any documentation to say that they were competent.

The fire evacuation plan did not provide accurate information for emergency services on the number of people living in the service, and which bedrooms they were in. The front door fire exit was kept locked. The door was not connected to the fire system, as part of following safe fire procedures, all staff were required to carry a key on their person. However, on both days of this inspection there were staff who did not carry a key. Also we observed where the front door key was held on a 'bunch' with others, not all staff were able to identify the right key. This impacted on their ability to open the door quickly in an emergency.

The system in place to protect people from infection and promote good hygiene practice was not safe and effective.

Staff were not clear about their responsibilities and the service did not follow national guidance. For example, staff were not following safe procedures in the handling of bodily fluids. In an open container in the laundry, we found a person's underwear soaking, with faecal matter still attached. We also noted that there were no disposable gloves, aprons, liquid soap, paper towels or specialist bags to transport soiled linen, which go straight into the washing machine; all supportive of promoting good infection control. The

laundry area did not provide a clean area for staff to wash their hands and follow good hand hygiene. Shortfalls in infection control procedures, put people at potential risk of germs being passed from person to person, which placed people at risk of harm.

During meal time, we saw staff were wearing disposable blue gloves. They told us it was part of their infection control measure. However, we observed the use of the gloves impacted on their ability to ensure good hand hygiene. This is because they kept the same gloves on as they handed people their dinner plate, assisted people to eat and drink, to walk, and were touching furniture, without changing their gloves or washing their hands.

Improvements were needed to ensure people were consistently supported in a clean and hygienic environment. Our last inspection in February 2017, we found shortfalls where some areas in the service we looked at showed a lack of thorough cleaning. Although action was taken at the time by the registered manager to address it, the improvements we had seen at the time had not been sustained. During this inspection we found items used by people which were in need of a thorough clean, and where they couldn't be, needed replacement such as a toilet seat surround with rusted legs and peeling paintwork which was corroded, and therefore presented risks of harbouring bacteria. Toilet light cords were dirty and in need of replacement, because they were a risk of cross infection.

Improvements were needed in the management of people's medicines to ensure they were effectively administered, and supported people's individual needs. We observed a staff member assisting a person to use their inhaler. We noted that the person wasn't encouraged, in line with best practice to have a drink straight after to prevent the risk of residue coating the tongue. Or, consideration given as the person required assistance, the use of an aid to support independence and ensure the full benefit of the medicine.

We heard the staff member ask another person if they required any pain relief, "No I don't want any pain killers." Where people were provided with 'as and when required' known as PRN medicines, we found staff were not always being given clear guidance in their use to support people's individual needs and ensure their safety. For example, with pain relief medicines, instructions just stated, 'four times a day PRN'. There was no guidance to staff to ensure they were not given too close together to ensure their safety, or in monitoring the effectiveness of them.

A person was prescribed a 'thickening' agent to prevent the risk of aspiration when drinking. There was no clear guidance with the product, linked to the person's needs. When we asked a staff member how much thickener they put into drinks, they showed us a normal spoon they used, rather than the measure supplied with the carton to ensure the right amount was given.

Despite action being taken following our previous inspections to address safety shortfalls, repeated shortfalls in the same areas including fire safety, unsecured wardrobes, further demonstrated that lessons had not been learnt. This was because issues were not being fully addressed, and where they had been, the monitoring, training and risk management in place were not robust enough to mitigate people from the risk of harm.

We asked the registered manager to ensure that a number of safety concerns we identified to be addressed as a matter of urgency.

This demonstrated an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The staff and leadership were unable to demonstrate that they had safe systems in place to identify and act on potential safeguarding 'triggers'. Records showed where unexplained bruising / injury, use of restraint, and unsafe behaviours had not been effectively reported, investigated and acted on. We were concerned that these had not been acted on; therefore the potential risk remained. To ensure people's safety and welfare, following this inspection we made a referral to the local safeguarding team, who are responsible for investigating safeguarding concerns.

This demonstrated an ongoing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were so concerned about all of the above information we imposed conditions on the provider's registration to require them to take urgent action to mitigate the risks to people in respect of their care and welfare and quality of life. We considered that if we did not do this people would remain at risk. We also restricted any new admissions to the service until improvements were made

Is the service effective?

Our findings

Our inspection of 6 and 9 February 2017 found that improvements were needed to ensure people were supported by staff who were skilled and competent to fulfil the requirements of their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager / director wrote to us and told us about the improvements they had made. The providers information return (PIR) informed us that the service trained and developed their staff and, 'make sure they put their learning into practice to deliver outstanding care that meets people's individual needs'. This inspection showed that competency checks of staff practice were being carried out, and the Care Certificate had been implemented to support staff in gaining an understanding of the fundamentals of care. The Care Certificate is a nationally recognised set of standards that staff working in the health and social care industry should be working to.

Despite this we found people were not always receiving quality care and support, which promoted their health, well-being and quality of life. We observed shortfalls in staff's practice; moving people safely, dementia care, infection control, monitoring nutrition, medicines, care planning, record keeping and health and safety.

This reflected the feedback we had received from relatives and social care professionals, and on our 'share you experience' web form. They raised concerns around some staff's ability to support people with their communication, dementia, mobility, nutritional, physical, medical, emotional and mental health needs.

The registered manager spoke about the improvements they had made as part of supporting staff to develop the required skills and knowledge. For example, staff had undertaken 'virtual dementia' training to support them in understanding dementia from a person's point of view, so they could change their practice and improve the quality of people's lives. However, staff did not demonstrate how this was being put into practice to improve the experience of people in the service. For example, we heard a person living with dementia shouting out from their bedroom, "Please put my light on." Although the light was already on staff had not explored what could be done to improve the lighting for the person, or assess the impact poor lighting might have. As a result the person was anxious.

Visitors to the service also raised concerns about staff where English was not their first language. They were concerned about their ability to communicate effectively with people. Especially for people living with dementia, and / or had communication needs, where they were at risk of being socially isolated, or their needs not being understood. The Alzheimer's Society 'This is me' guidance describes the importance of being able to start conversations and communicate effectively to enhance the quality of the person's wellbeing and make them feel valued. Ineffective communication and understanding, could also impact on a person's frustrations and behaviours. We found that staff's understanding of English and communication skills varied. Where staff were not as confident, we observed they focused on tasks and were not seen to instigate conversation.

The registered manager told us they felt the majority of staff demonstrated good communication skills.

Where they had identified staff that needed to develop their language skills, they were in the process of accessing external help. In the meantime, training was translated to ensure staff understood. However in general, we saw that regardless of training, not all staff had embedded good practice and communication into their role. This meant that the service people received, was not consistent in supporting people's individual assessed care needs.

This demonstrated an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

Our last inspection of 6 and 9 February 2017 found a breach of Regulation 17 (Good governance) this was because we found the processes to monitor the quality of the service, were not effective enough to identify and address areas that needed improvement. The registered manager / director wrote to us and told us about the improvements they had made. They told us that they had made changes at the service which included strengthening the management team through the appointment of a support manager, and had introduced auditing.

The registered manager is also the director of the company which owns the service and was supported by the management team; support manager and deputy manager.

At this inspection we found that the registered manager was still unable to demonstrate that they had effective understanding of what was required to ensure safe and good quality care. This meant that they could not ensure adequate or effective oversight. They did not have a clear understanding of the risks and issues facing the service. Although they had been working in the care sector for many years, their practice and knowledge was not up to date. We found that systems were not in place to ensure where responsibility was delegated to others, that they could demonstrate those employees were competent and up to date with their practice. For example demonstrating competency of those checking staff practice, embedding staff training into practice, completing effective pre assessments prior to people coming to live in the service and environmental risk assessments.

Because of our concerns about the service, we met with the registered manager/director as part of this inspection. They did not have any overall strategy for the service or business plan. They talked about their options for improving the service but none of these had been explored fully at that time. We asked if they and staff knew what the aims and objectives are of the service and what was, and the overall ethos in the service. The registered manager was clear that their intentions were to run a safe service where staff and people using the service cared and worked together to ensure people had a 'home for life'. They acknowledged they needed to work with others to avoid isolation and help them to improve standards.

The registered manager / director had started a new business venture (day care) by making the service available for others during the day. They were unable to demonstrate that the new enterprise would not impact on the safety and wellbeing of people living in the service, or, how people had been consulted and asked their views, benefits or concerns about sharing areas of their environment.

Staffing rotas were not being managed well. Staff told us the registered manager completed the staffing rota on Sunday evenings, which they sent to the team leader on shift. It was then the responsibility of staff to contact them to find out what shifts they would be working. This meant that staff would not have confirmation of their shifts for Monday, until the night before. This could impact on staff's available to cover at such short notice, and / or the management's ability to cover unplanned absences. The registered manager had been covering nights as they had no cover.

Systems in place for identifying, capturing and managing organisational risks were ineffective. They had not identified the risk to people's health, welfare and safety which we had identified. They also failed to mitigate the risk of harm to people in relation to the environment. For example, during our inspections of February 2017, we reported on the shortfalls we had found in the cleanliness and maintenance of the service, and the actions taken by the registered manager to address them at the time. Because the checks put in place were not effective enough, this inspection identified that the service was failing to provide people with a clean environment which protected them from the potential risk to their health, through community acquired infections. Our inspection report of February 2016 identified unstable wardrobes in some people's bedrooms, which the provider took action to address by fixing them to the wall. At this inspection when we found unstable wardrobes in other people's bedrooms had not been risk assessed.

These inspections also identified the same emerging themes of not ensuring enough skilled staff were deployed across the service, improvements required in care planning, training, and in medicines management. Although acted on, shortfalls in regulatory knowledge, best practice health and safety, had impacted on the provider's ability to put in effective quality assurance systems to monitor, drive, and maintain improvements within a timely manner. This was also reflected in the reports the service had received from commissioners of the service, and the Essex Safeguarding team. For example, the registered manager confirmed they had a copy of the Health and Safety Executive: Health and safety in care homes publication. However, the shortfalls we found in risk assessment, fire safety and legionella, did not demonstrate that they were using this as an effective tool to drive improvements. Nor were they able to demonstrate where they had taken previous action to address health and safety concerns, to ensure they had effective checks and audits in place to prevent a reoccurrence. We found management were putting up signs to instruct staff, with no effective follow through and monitoring. For example, in the laundry there was a sign 'Room to be kept clean and tidy at all time'. The cobwebs, broken equipment and unclean state we found it in, showed that signs and monitoring systems were ineffective.

Information received from 'share your views', relatives of people who had used the service, and social care professionals, questioned the quality of the training and monitoring of practice. The registered manager told us that training was provided for staff and checks were undertaken on staff understanding and competency. We looked at a sample of these checks, and saw that staff practice had been observed and signed off as competent. The checks undertaken were not sufficiently robust and did not provide adequate performance management.

This demonstrated an ongoing breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider was not doing all that was reasonably practicable to mitigate the risks to people using the service.</p> <p>Medicines were not being managed in a proper and safe way.</p> <p>People were not always supported in a clean and hygienic environment. Safe infection control policies and guidelines were not always being followed to mitigate the risk of the spread of infections.</p> <p>Regulation 12 (1) (2) (a) (b) (c) (d) e) (g) (h)</p>

The enforcement action we took:

We took urgent action to restrict admissions and impose positive conditions to drive improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>Policies and procedures were not robust enough to identify and act on potential triggers which could impact on a person's safety and wellbeing. This put people at risk of potential harm.</p> <p>Regulation 13 (1) (2) (3)</p>

The enforcement action we took:

We took urgent action to restrict admissions and impose positive conditions to drive improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Quality assurance systems were not robust</p>

enough to independently identify shortfalls and take action to improve the service.

Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f)

The enforcement action we took:

We took urgent action to restrict admissions and impose positive conditions to drive improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably competent and skilled staff were not always available to support people. Regulation 18 (2) (a)

The enforcement action we took:

We took urgent action to restrict admissions and impose positive conditions to drive improvements.