English Dominican Congregation Trust

# St Mary's Nursing Home Margaret Street Stone

## Inspection report

Margaret Street
Stone
Staffordshire
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Date of inspection visit:
05 April 2016

Date of publication:
24 May 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This inspection took place on 5 April 2016 and was unannounced. At our last inspection in June 2013 we found that the service was meeting the required standards in the areas we looked at.

St Mary's Nursing Home provides support and care for up to 58 people. At the time of this inspection 57 people used the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was insufficient staff available to meet people's individual needs. People experienced delays when staff were needed to provide them with the care and support they required.

The provider did not have effective systems in place to assess, monitor and improve the quality of care.

The principles of the MCA were not consistently followed. People were at risk of unlawful deprivation as referrals for a DoLS assessment had not been made for some people who lacked capacity to consent to their care and treatment within the service.

Risks to people's health and wellbeing were identified and assessed but not always reviewed to ensure the action needed to mitigate the risks was recorded.

Staff did not always receive the training they needed to be able to support people in a safe way. This meant some people's specialist needs were not met safely or effectively.

People generally told us they enjoyed the food and were provided with suitable amounts of food and drink of their choice. Not all records for the purpose of monitoring people's fluid intake had been fully completed to ensure people's needs were fully met.

People had access to a range of health care professionals but follow up consultations were not always arranged.

Staff were kind and caring, however low staffing levels had a detrimental effect on meeting the care and support needs of all people.

There was a range of daily activities arranged for people to enjoy.

Staff were aware of the safeguarding procedures and knew where and to whom they could raise concerns.

The provider had a complaints procedure and people knew how and who to complain to.

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  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 consistently safe. Risks to people's health and wellbeing were identified and assessed but not always reviewed or managed in a safe or consistent way. There were not enough staff to support people in a safe and timely way. People's medicines were not always managed safely. Staff were able to recognise abusive situations and when necessary action was taken.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective. Staff had not been provided with appropriate training to fully meet people's needs and promote people's safety, health and wellbeing. The principles of the MCA and DoLS were not consistently followed to ensure that people's rights were respected. People's healthcare needs were met.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring as we saw some people did not receive the care and support they required in a person centred and individualised way. People's dignity, privacy and modesty was upheld.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive. Care plans were not always person centred and some information was not in a suitable format for some people. People told us they enjoyed the activities that were available. People knew how to complain if they needed to.

### Is the service well-led?

**Inadequate**

The service was not well led. The provider did not ensure there were sufficient staff to meet people's needs. Systems the provider had in place to monitor the service were ineffective. People and staff liked the registered manager and found them approachable and supportive.

# St Mary's Nursing Home Margaret Street Stone

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 5 April 2016 and was unannounced. The inspection team consisted of two inspectors.

We looked at the information we held about the service. The provider completed a Provider Information Return (PIR). This is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We spoke with 10 people who used the service; they were able to tell us their experiences with the service. We spoke with other people but due to their communication needs they were unable to provide us with detailed information about their care. We therefore spoke with five relatives of people who used the service to gain feedback about the quality of care. We observed the care and support people received. We spoke with the registered manager, the deputy manager, a nurse and four care staff. We looked at eight people's care records, staff rosters, two staff recruitment files and the quality monitoring audits. We did this to gain people's views about the care and to check that standards of care were being met.

Inadequate

# Is the service safe?

## Our findings

People without exception told us the service was short staffed. One person who used the service told us that at times they had to wait for support from the staff. A relative told us the staff were very good but if they needed a nurse they usually had to wait. Staff told us and we saw people experienced delays in receiving support. One person waited 25 minutes to be supported with the toilet, and two people were left in bed. They had been provided with basic care but staff told us they 'had run out of time' to support the two people with washing and dressing so they remained in bed. The people were not particularly concerned about this but they had been denied the choice of whether to get up or remain in bed. One member of staff told us that many people who lived at the service were very dependent on staff to support them with daily living. Many people required two staff to support them with personal care and mobilising . A staff member told us: "There is not enough staff and we could do with extra, today has been hectic". Another staff member told us: "People's needs have changed but the staffing levels haven't".

The registered manager told us that staffing levels were constant and not based on the dependency needs of people who used the service. Two nurses were rostered to be at the service at all times, they told us that 55 of the 57 people who used the service had been assessed as requiring nursing care. This meant that one nurse provided care, treatment and support to up to 28 people on any given shift in addition to supervising and overseeing the team of care staff. A nurse told us they had very little time to update any care records or supervise care staff as their time was spent administering medication and attending to people's nursing care needs. The manager told us that they were currently recruiting for nursing staff but this was proving difficult. In the meantime any gaps in the nursing staff rota and availability of permanent nursing staff, agency nurses were utilised.

A visitor told us their relative who used the service had been left alone on the commode because staff had been called away to answer a call bell. This person's care plan recorded they were at high risk of falling, needed two people at all times for support and should not be left alone. This meant that the person was at risk of harm because staff were unavailable to meet this person's specific needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not enough suitable staff available to meet people's individual needs.

Risks to people were assessed and plans were put in place when risks were identified. However we found that people did not always receive their care as planned to manage their risk of falling. A nurse told us: "[Person's name] is on the floor most days". They went on to say the person was very regularly found on the floor and most times they were unsure whether the person had fallen or 'placed themselves' on the floor. No record was made of these falls in the care plan, risk assessments or accident forms. We saw that to reduce the risk to this person a sensor mat had been positioned on their chair to alert staff when the person was on the move. We observed that the sensor mat did not activate when the person moved out of their chair. Staff told us there were occasions when the person deactivated the sensor mat by unplugging the appliance. The actions needed to mitigate the risks to this person were in place but were ineffective. The person's risk assessment had not been reviewed and action to further reduce the risks had not been considered.

Some people required specialist equipment to support them. For example, air flow mattresses were needed to support people with reducing the risk of them developing sore skin. There was no information recorded for the most appropriate setting of the mattress to offer the most effective support. The deputy manager told us that staff were aware of the individual settings for each appliance but confirmed this had not been recorded.

We saw one person had sustained bruising to their arms and they were unable to tell us how this had occurred. There was no record of how and when the injury had occurred in their care plan or the daily notes. We spoke with the deputy manager about this injury, they told us this person was susceptible to bruising because of an underlying physical condition. The person's care plan included information about the underlying condition and the risk of skin damage. However the deputy manager was unaware of this particular injury to the person's arm. It had not been reported to the nursing staff by the care staff. The deputy manager completed the necessary paperwork, after we had spoken with them and informed them of the injury, to ensure staff would be able to monitor the injury and identify any possible trends so that the risk could be reduced.

We looked at the way the service managed people's medication. Some people had been prescribed external creams and ointments to help manage their risk of skin damage. Care staff told us they applied these creams when they provided support to people. There were no body charts to inform care staff where the creams were to be applied. There were no topical medications administration records to record when the person had received the prescribed treatment. The skin integrity care plan for one person recorded 'creams to be applied'. The registered manager and deputy manager told us they had identified that guidance was required but were waiting for advice from us (CQC) before introducing and implementing any records. This meant we could not be assured that people received their creams as prescribed because of the lack of documented guidance for staff.

These issues were in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not consistently protected from risks to their health and wellbeing.

Staff told us they knew how to identify and report abuse, and if they suspected someone was being abused they would report it straight away to either the registered manager or the nurse in charge. Where concerns had been raised with the registered manager we saw that action had been taken to refer the concerns to the safeguarding team at the Local Authority.

Requires Improvement

# Is the service effective?

## Our findings

Staff told us that on occasions some people would be resistive to receiving the support they needed with their personal care. They told us how they would support people by walking away and returning later, and when necessary holding the person's hands. Staff said: "We are gentle and try to be as quick as we can be, sometimes we hold the person's hands and arms and at other times we use a towel to wrap around the person's arms". Staff told us they had not received training in how to support people who may at times be resistive and they would not record this intervention. We saw the training planner for 2015 which recorded it was compulsory for nurses and carers to have restraint training and the dates were to be confirmed. This training had not been arranged. This meant that people were not always supported by staff who had received effective training to carry out their role.

Care staff told us they had not received formal one to one supervision with their line managers recently. One care staff told us it was over 12 months since they had the opportunity to discuss their work performance or their training and development needs with their line manager. The registered manager confirmed that staffs' annual appraisals were now due. This meant that staff had not had the opportunity to discuss their performance and identify any further training they may require.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The registered manager told us they had made referrals for some people to be legally deprived of their liberty and they were waiting for the authorisations to be granted. We saw some people who were unable to consent to some restrictions we saw in place, for example mechanical restraints with the use of specialised chairs and lap straps and constant monitoring and observation. We saw some people were being restrained by staff when they were resistant to care, they were unable to consent to this course of action. The registered manager told us that in these instances referrals had not been made to the local authority. This meant that some people were being unlawfully restricted of their liberty, the provider had not followed the MCA and DoLS procedures correctly.

This was a breach of Regulation 13 of The Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staff told us and we saw that some people would be unable to make specific important decisions that affected their lives. We saw one person who used the service was unable to make a specific decision about their end of life care. We spoke with this person's relative who told us that another member of their family

had been appointed to act on their behalf.  The family member had been appointed as Lasting Power of Attorney (LPA) and had the authority to act in this person's best interests. An LPA has the legal authority to make decisions on a person's behalf if they lack mental capacity at some time in the future or no longer wish to make decisions for themselves. The LPA had discussed this person's end of life care with a doctor and staff and a best interest decision had been made on behalf of the person.

People who were able to, consented to their care and support. One person who used the service told us: "The carers are very good at helping me with the things I cannot do myself, they always ask if it is alright for them to help me". We observed how staff approached people when people required support and saw that staff always advised them of the course of action they were to take.

People told us they enjoyed the food and they had sufficient to eat. One person we spoke with told us they preferred to have breakfast in their room they 'could take their time getting up'. Most people had breakfast in their rooms and at lunch time people were encouraged to use the dining room. People considered to be nutritionally at risk were provided with fortified diets and food supplements to support them with adequate daily nutrition. Some people had fluid and diet charts to monitor their daily intake. We saw not all of the charts had been sufficiently completed so we could not be assured that people received sufficient daily nutrition and fluids to fully meet their needs. Staff told us they offered drinks to people but sometimes did not have the time to complete the charts.

Staff supported people to access health care services should they become unwell or require specialist interventions. People had access to regular consultations with their doctor if this was requested and required. Referrals for advice and support were made and guidance from health professionals was being followed. However, we saw one instance where a person continued to experience health issues following treatment from their doctor. The nurses had not followed up on these continuing health concerns by either contacting the doctor again or referring to other health care professionals. The deputy manager told us this was on their list to do.

Requires Improvement

# Is the service caring?

## Our findings

People told us all the staff were kind, caring and gentle. One visitor said: "The staff are golden they all go the extra mile to make sure everything is okay for my relative". A person who used the service commented: "The staff are kind and thoughtful, they know what they are doing and do it well". We observed that staff were patient and kind when interacting with people. We saw some good interactions and some examples where staff were kind and caring, but they were working within a system that meant they did not always have the time to provide person centred and individualised safe and effective care.

Staff were aware of people's individual preferences, likes and dislikes. We saw staff were attentive to ensure people's comfort and provided additional cushions and pillows to support people with their well-being. However, due to the high dependency needs of people and the current staffing levels, some people experienced delays in being provided with the support they required. We spoke with two people who were unable to fully comment on their experience of the service. But both people told us they were 'okay and comfortable' when we asked after their welfare.

A visitor told us they were involved with planning the care and support for their relative when they first started to use the service. They confirmed they had regular conversations with the nurses regarding the care and support that was provided. We saw that each person had a care plan that was based on an assessment of their needs but there was little evidence in the documentation to show that the person or their representative had been fully involved.

We observed people's privacy and dignity was upheld. We saw staff supported a person to transfer using the hoist, their dignity and modesty was preserved as staff offered and provided a covering for the person's legs whilst they were in the sling. Dignity signs had been positioned on people's bedroom doors to ensure they were not disturbed whilst they were being supported with their personal care and hygiene needs.

Relatives were free to visit at any time and we saw frequent visitors throughout the day. One visitor commented: "I visit often each week and have always been made to feel welcome. They [the staff] look after my relative very well in fact it is perfect and we are very satisfied". Another visitor said: "I visit often, nothing is too much trouble, and it's great".

Requires Improvement

# Is the service responsive?

## Our findings

Some information within the service was not in a format for some people to comprehend. One person was unable to read the menu on the dining table as the print was too small. There was no pictorial information to assist people who may have cognitive problems. The registered manager told us a white board was used to display the daily menu to aid people with the information. We saw staff and people interacting with each other, they discussed the menu and what was on offer.

All people who used the service had an individual plan of care based on an assessment of their needs. The plans were task specific and did not fully give an overview to ensure information was recorded in a person centred way. Plans were comprehensive and clear for supporting people with for example maintaining a safe environment. However, life biographies and advanced care planning had not been completed. Staff we spoke with had a good knowledge of people's individual care and support needs. Staff told us that communication between the teams was very good and details of people's needs and preferences were discussed at the regular hand over meetings.

People told us they liked the activities that were provided each day. One person told us they liked the exercise session that they had recently attended and they were looking forward to a game of bingo. A visitor told us there was 'always something going on' and if their relative did not wish to join in then this was respected.

People's religious and spiritual needs were met with regular services and Mass held within the service. Staff told us they had good links with the various religious denominations within the local area. One person told us they looked forward to participating in Mass which was something they had done all their life.

The provider had a complaints procedure. People we spoke with and their relatives told us they would speak with the registered manager or the nursing staff if they had any concerns. One visitor told us they planned to see the registered manager as they had a concern which they wished to discuss. They felt that they would be listened to and the registered manager would respond to their concerns. The registered manager told us no formal complaints had been raised with them since the last inspection. There were many thank you cards on display acknowledging the good care and support that had been provided when people used the service.

Inadequate

# Is the service well-led?

## Our findings

The registered manager told us that audits and checks for the quality and safety of the service were completed at regular intervals throughout the year. These included infection control, medication, equipment and the environment. However we identified concerns in these areas which had not been identified through the auditing process.

People did not have their own slings when they needed the mechanical hoist to support them with moving. We saw the same sling being used for several different people. A member of care staff told us: "People share the toileting sling". We saw that soiled and dirty clothes were placed directly on the floor in a communal bathroom and not into bags for laundering. We saw a member of staff going into different people's bedrooms; they wore the same plastic apron and gloves. Another care staff confirmed this member of staff was supporting people with personal care. This meant there was a risk of the potential spread of infection and the safety of people was compromised.

We saw two rooms leading to fire exits had been used as a sluice room; it would be difficult to exit the rooms through these areas in the event of an emergency because the area was used to store cleaning equipment, for example buckets and mops. We saw bottles of chemicals on top of a cupboard and other chemicals stored in an unlocked cupboard in the sluice room. Hot water was provided in this area to wash the commodes pots. We saw people who used the service walked around the unit and were in the vicinity of this unsecured area. There was a potential risk of people having access to the chemicals and hot water.

We saw two other sluice areas that were used to dispose of bodily waste and to wash the commode pots. Staff told us that the majority of people used a commode. There was no mechanical device available for staff to dispose of or clean the commode pots so they were subject to cross infection risks and splash back incidents. There were no locks on these doors to reduce the risk of people who used the service coming into contact with very hot water and cleaning chemicals. This showed that the provider did not have effective systems to identify and promptly respond to risks to people's health, safety and wellbeing.

We had concerns with the way topical medications were administered and recorded and could not be assured that people received the creams and ointments correctly and to the prescribing instructions. There was no specific guidance, for example body maps, topical administration records, for staff to refer to or to record they had supported people with this treatment. The temperature of the medicine fridge was being recorded daily but did not record the minimum/maximum temperatures in line with current guidelines. The registered manager told us that each month the nursing staff completed an accuracy check and audit of the medicines in each unit. These were then used as part of the provider's six monthly medication audit. The issue with the use of topical medicines had been identified but no action taken. The registered manager told us they were waiting for advice from us (CQC) before introducing and implementing any records.

Staff supervisions and appraisals were outstanding with care staff telling us they had not received a one to one supervision for over 12 months. The registered manager told us they were due but at the time of this inspection there were no fixed arrangements in place. Staff told us they had not received training in

managing difficult situations and at times were restraining people who were resistant to care. The provider had not arranged for training in this area even though some of the people exhibited behaviours that challenged.

We looked at the way the provider recruited new staff. We saw that at the point of employing the person all relevant safety checks had been carried out. However, checks to ensure the continuing good character of staff and their registration to continue to work as a nurse had not been carried out. We saw that one person had not had a criminal check since 2002, the registered manager confirmed this had not been discussed with them since starting work at the service. We saw Nursing and Midwifery Council (NMC) registrations for current nursing staff were out of date. The registered manager acknowledged checks had not been made with the NMC the records in a personnel file we looked at were out of date. The provider did not have effective systems in place to ensure the continuing good character or current NMC registrations of staff.

People told us the service was short of staff, we saw that people experienced delays in receiving the care and support they required in a timely way. We were told and we saw that two nurses were on duty over the 24 hour period; this meant that each nurse had to provide care and treatment to up to 28 people and to supervise and guide a team of care staff. People told us the nurses were very good but they very often had to wait when they needed the attention of the nurse. The registered manager had identified a need for more staff including nurses and had spoke with the provider about this on many occasions. They informed us of a recent recruitment drive which resulted in the possible appointment of nursing staff, however in the meantime nurse staffing levels continued to be at a constant level and not based on the dependency or nursing needs of people who used the service.

The service had a registered manager and was supported by a deputy manager, team of nurses, care and ancillary staff. There were clear lines of accountability and staff knew who they were to report to. However, the registered manager told us that the deputy manager and the nurses were not allocated sufficient supernumerary time to support the registered manager with the running and management of the service. The deputy manager and nurses were not allocated sufficient time to supervise staff, review care plans and ensure records were up to date. In the absence of the registered manager, the deputy manager was not allocated supernumerary hours to fulfil the managerial role in the manager's absence.

The above evidence shows effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This constitutes a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff felt supported by and had confidence in the registered manager. Two members of care staff told us they worked well as a team and were supportive of each other. Another member of staff said: "We provide good quality care and we are kind and gentle with people, but we could do with a few more staff so that we can really help people and spend the time with them that they need".

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were not receiving care that was safe. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider did not sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of all people who used the service. |