St. Mary's (Dover) Limited

St Mary's

Inspection report

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04 October 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 03 and 04 October 2017 and was unannounced.

St. Mary's is a large detached property providing residential and dementia care for up to 36 older people. The service is located within the town of Dover, with limited parking. Residential accommodation is situated over four floors which includes a separate dementia unit. The service also has its own chapel and a well maintained garden to the rear of the property. At the time of the inspection there were 15 people living at the service.

The service had not had a registered manager in post since April 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We last inspected this service in July 2017. We found significant shortfalls and the service had an overall rating of Inadequate. CQC took urgent enforcement action to prevent the provider admitting any new people and to request regular action plans and updates about the required improvements. The provider failed to comply with this action and did not send action plans as requested. CQC has taken further action that we will publish in due course.

We received a number of concerns from whistle-blowers and others about people's safety, care and well-being. As a result we undertook this focused inspection to look into those concerns.

Staff did not have a full awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards as they had not recognised when people's liberty had been restricted. Action had not been taken since the last inspection to make sure people were not unlawfully restricted.

People's health care needs were not consistently and effectively monitored to make sure they received specialist support when they needed it. When people had lost a large amount of weight they were not consistently referred to the relevant healthcare professionals to ensure people were receiving the professional advice they needed.

Staff had not received regular effective training, supervision and appraisals to support them in their role. The induction was not modelled on current recommended guidance. Agency staff who were used to cover shifts at short notice did not receive an induction into the service. Staff competency was not checked to make sure they were providing safe and effective care.

People were not always supported to have enough to eat and drink and to maintain a balanced diet. People were not involved in deciding what foods were on the menu. There was a lack of basic provisions to enable people to have choices about their meals. There was a lack of fresh vegetables. The stock of

produce and ingredients in the stores, fridges and freezers was very low.

The provider had not appointed a registered manager to improve the leadership of the service. A consultant had been employed since August 2017 and they were supporting a trainee manager and a deputy manager. There was a lack of leadership and poor governance systems placing people at continued risk of receiving poor care.

The provider had not taken appropriate action to ensure the service was compliant with the regulations. The provider had not notified the local authority or CQC about two safeguarding incidents which had occurred.

Staff raised concerns with the management team throughout the inspection that they had not been paid correctly. Some staff had not turned up for their shift because they had not been paid. People, their relatives and staff views were not taken into account to continuously improve the service.

The systems for monitoring and checking the quality of care provided were not effective as the shortfalls found at this inspection had not been identified and actioned. Records were not consistently accurate or up to date. The service had not improved since the last inspection despite CQC meeting with the provider on several occasions and signposting the provider to help and support.

We identified a number of continued breaches of regulations and additional breaches. The service was placed into 'special measures' following the last inspection and remains in special measures as it continues to be rated 'Inadequate'.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have a full awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff had not recognised when people's liberty had been restricted unlawfully.

People had access to health care professionals. However, referrals had not been consistently made to ensure people were receiving the professional advice they needed.

Staff had not received training, supervision and appraisals to support them in their role.

People were not always supported to have enough to eat and drink and to maintain a balanced diet.

Is the service well-led?

Inadequate

The service was not well led.

The provider failed to comply with recent enforcement action.

The provider failed to appoint a registered manager to improve the leadership of the service.

The provider failed to take appropriate action to ensure the service was compliant with the regulations.

The systems for monitoring and checking the quality of care provided were not effective and the service had not improved.

People/relatives and staff views were not taken into account to continuously improve the service.

Records were not consistently accurate or up to date.

St Mary's

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.

We carried out an unannounced comprehensive inspection of this service on 27 July 2017. After that inspection we received concerns in relation to the service not having sufficient food, the kitchen being dirty, people losing weight, staff not being trained and paid and staff leaving. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Mary's (Dover) Ltd on our website at www.cqc.org.uk.

The inspection took place on 03 and 04 October 2017 and was unannounced. It was carried out by two inspectors.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) as we carried out this inspection at short notice. This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law, like a death or serious injury.

During the inspection we reviewed people's care records and a variety of documents. These included four people's care plans and associated risk assessments staff rotas, staff training records and quality assurance documents. We spoke with four people, two relatives, nine staff, the deputy manager, the trainee manager, a management consultant, employed by the provider and the provider. We looked at how people were being supported with their daily routines and assessed if people's needs were being met.

The service was last inspected in July 2017 and was rated inadequate.

Inadequate

Is the service effective?

Our findings

Some people and relatives told us that the staff contacted health care professionals when they were not well, they said, "If I am not well [the staff] get the doctor for me". A relative commented, "My relative often gets urine infections and they always get the doctor in and they have seen a dentist". However, people did not receive effective care, based on best practice, from staff who had the knowledge and skills to carry out their roles.

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 people 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The provider had not followed the principles of the MCA.

At our previous inspection we identified that one person, who lacked capacity, was being restricted unlawfully and staff had not recognised this. They were aware that the person did not have full access to the service as there were two locked doors outside of their bedroom preventing their access. When we highlighted to staff that the person was locked in this area, they said, "Technically I guess they are. They broke the door by yanking it", "Yes the doors are locked but they can kick one of the doors open" and "This person does their own thing". The provider had not taken advice from the DoLS service at the local authority or applied for a DoLS authorisation for this person.

At this inspection no action had been taken regarding this issue and the provider had made no changes to the person's support.

The provider has failed to ensure that staff were working within the principles of the Mental Capacity Act (2005). This was a continued breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

At our previous inspection people's health care needs were not always monitored to ensure they received specialist support in a timely way from healthcare professionals. Staff did not always seek advice from healthcare professionals when people's health needs changed or deteriorated.

At this inspection some referrals had been made, however these were not always timely and others had not been completed at all. For example, when a person had lost 7lb 4oz between 01 and 30 May 2017 staff had noted that this was a 'large loss and the person's weight should be monitored'. This person's weight monitoring chart showed the next entry to be 11 September 2017 when a further small loss was noted and a

referral was then made to the dietician for advice and guidance. There were two separate weight charts for this person; both showed this person's weight had not been monitored and no referral made for support for over three months despite losing weight. Another person's weight chart noted the person's weight had dropped by almost 1 stone in ten months. There was no record to show what action staff had taken and that this person had been referred to a healthcare professional.

People did not always have regular dental check-ups to make sure their teeth remained as healthy as possible. One person's records noted their last check-up as 06 March 2012 with a follow up visit on 29 March 2012. It was noted that '[Person] needs help with their dental hygiene'. There were no further check-ups recorded. In August 2017 staff noted on the community nurse visits record, following a visit from a nurse, 'Need to ask for a dentist to visit as [person] has a loose tooth'. A referral was completed the following day; however there was no record of this appointment being followed up to make sure the person received the treatment they needed.

Health and social care professionals had been visiting people since our last inspection to carry out reviews of their needs. Professionals told us they were concerned that people's health needs were not being met. For example, one healthcare professional told us people's fluids were not being monitored consistently to make sure people had enough to drink. Another healthcare professional said that care plans had not been updated with treatment plans for a person's pressure area; there was no updated body map to ensure that staff had the guidance to help keep this person's skin as healthy as possible. In addition the person required half hourly checks at night and these checks had not been completed and reposition charts did not record if this person had been supported to move to reduce the pressure on their skin.

The provider had failed to ensure that people received safe support with their healthcare needs. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that staff completed an induction when they began working at the service but records did not confirm this. The induction training did not follow, and was not modelled on current guidance in line with the Care Certificate standards. The Care Certificate is an identified set of standards that social care workers adhere to in their daily working life. No checks were completed after the induction to check on staff knowledge and competency. We looked at three staff files and only two contained records relating to an induction. When the provider used agency staff to cover shifts there was no structured induction into the service. The trainee manager told us that agency staff were shown where the fire panel was. The provider relied on staff on duty to introduce agency staff to people and show them around the building. There was no record of this and we could not be confident that agency staff would know what to do in the case of an emergency.

The management team told us that, following the induction, staff completed the provider's training package. This consisted of information booklets and question papers. Once completed these were sent to an external company for marking and certificates were sent to the service. None of the three staff files we looked at contained information about any training they had completed.

There was no process for staff to complete practical training on how to move people safely using special equipment such as a hoist. The trainee manager told us, "Staff learn from an experienced and senior member of staff". Staff told us that night staff had not been trained in moving and handling people and one member of staff commented, "It is worrying because some people's skin is so thin you have to be really careful when you move them". There was a risk that people may not be moved safely.

Staff had not had their competency checked to make sure they were providing people with safe and effective care. The trainee manager told us they had worked at the service for a year and that no competency checks had been completed in that time. At the end of the first day of the inspection the trainee manager told us that the competency of the night staff would be checked by a manager that evening. On the second day of the inspection this had not happened.

A night shift leader had raised concerns with the trainee manager about the confidence and competence of a colleague. The trainee manager told us they had rostered the member of staff on a day shift and observed them and found them to be competent, however, there were no records to confirm this. We were also informed that this member of night staff had been left to work alone on the dementia unit whilst the two experienced night staff worked together in the main part of the service. The trainee manager told us they were meeting the night shift leader for one to one supervision about this but had not done so and were unable to tell us when it would take place.

Staff received the basic training they needed to support people's care needs, such as, infection control and safeguarding people. The training schedule monitored by the management team was not up to date with new staff members. They did not know if there were any shortfalls.
Staff knew people well and were able to tell us how they supported people. They told us the signs people showed when they were becoming anxious and what actions they took to reassure and calm people. During the inspection staff were observant and pre-empted situations. For example, when people were likely to invade another person's space, staff gently guided them to a different part of the room and supported them, chatting kindly to them. People were relaxed with the staff.

Staff told us they supported each other. However, they did not feel supported by the management team or the provider. The three staff files we looked at did not contain any records of one to one supervision with a senior staff member. A folder in the office contained staff supervision records for 15 members of staff. None of these staff had received one to one supervision from a senior member of staff since our previous inspection.

The provider has failed to ensure staff receive the appropriate support, training and supervision as is necessary to carry out the duties they are required to perform. This was a breach of regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to have enough to eat and drink and to maintain a balanced diet. Concerns had been raised to CQC about the lack of food and basic provisions like tea, bread and milk and about poor cleanliness of the kitchen. CQC made a referral to the local environmental health officer who visited the service. They found that there were no imminent risks but would be inspecting again in a few weeks to follow up on the shortfalls. A new cook had been employed at the service and had been working there for two days. Staff told us that food was not ordered in bulk and came in in "dribs and drabs". A member of staff told us, "People eat pretty well but there is a lack of choice".

On the first day of the inspection we looked in the food store rooms. The storage area for fresh vegetables contained two very old, sprouting leeks, a bag of potatoes, a bag of onions, one yellowing cabbage and a small amount of hard and wrinkled mushrooms. Fridges and freezers contained a small amount of produce. For example, one large chest freezer only contained one bag of peas, one bag of sweetcorn and a bag of sprouts. The trainee manager told us that a shopping order was to be delivered the following day and showed us what had been ordered. This was only enough for the next few days.

On the days of the inspection the cook had prepared home-cooked soup and food and offered people

choices. Staff offered people choices of toast or cereals at breakfast. We asked night staff if there were snacks available for people if they were hungry in the night. Staff commented, "We go to the kitchen and hope there is something there" and "I have brought food in from home before. I won't see these people go without".

Relatives said, "The carers are great. My loved one is always clean, well fed and they always have a drink" and "My relative has always got a drink and they [staff] help feed them. The staff are kind and caring". Relatives and staff told us that there had been occasions when there had not been food and drink available at the service. We were told the service had run out of basic foods such as yoghurts, teacakes and there was no squash available. A member of staff said, "Last week there was no squash to give people so they had to have water". The deputy manager said that on the day there had been no squash they went out and purchased a bottle.

Some people were given a fortified diet, where ingredients such as cream, butter and full fat milk is added to meals, or give prescribed nutritional supplement drinks. Staff completed food and fluid charts for people with poor appetites or when fluid intake needed to be monitored to make sure they ate and drank well. The fluid charts were totalled at the end of each day and checked by the trainee manager. The trainee manager did not know what people's individual target fluid intake was or what a normal amount for each person to drink was. When they checked the charts they had noted on them comments such as 'Fluids need to be encouraged'. There was no process in place to follow this up and take action if staff were concerned.

The provider has failed to meet people's nutritional and hydration needs. This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Staff and relatives told us that they felt the service was not well-led. They said that staff were kind and caring but that the provider lacked the skills to provide an effective service. One relative told us, "Knowing [the provider] as I do, I do not trust them". Other relatives said, "In terms of [my loved one's] care they are fine. I don't think we are communicated with enough. The phone line did not work and we were not told. We had to send someone who lived locally to check everything was ok. The doorbell does not work and they don't do anything about it, it is like the provider doesn't care" and "The deputy manager has worked really hard. She is understaffed and dumped on. I think the owner is not interested".

The service had been without a registered manager since April 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 a lack of leadership and a lack of support for the deputy managers and staff. The provider visited the service one day a week and in recent weeks this had reduced. The provider had failed to meet the requirements of their registration with the CQC by not having a registered manager. The provider was aware of their responsibility to have a registered manager because the condition was recorded on their registration certificate.

Since August 2017 the management structure of the service had changed and the provider had employed a consultant to assist with the day to day running of the service. There was now also a trainee manager in post and a deputy manager. There was still no registered manager in place, and although the provider had submitted an application to CQC it was withdrawn and no further application was received.

Following the last inspection CQC took urgent enforcement action to prevent the provider admitting any new people to the service. CQC imposed a condition on the provider's registration requiring the provider to send CQC regular action plans and reports about the required improvements. The provider failed to comply with this condition and did not send action plans as requested. CQC has taken further action that we will publish in due course. .

The provider had failed to comply with conditions applied to their registration requiring them to ensure that the service is managed by an individual who is registered as a manager and to send CQC detailed reports. This is a continued breach of Section 33 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action has been taken. At the previous inspection the provider had not submitted notifications to CQC, as required by law.

At this inspection we found that two safeguarding incidents had occurred when people had potentially harmed each other. These should have been reported to both the local safeguarding authority, who would have taken action to ensure that people were safe and to CQC. The consultant told us they were unaware

these incidents had happened. The trainee manager said they knew they had happened but had not taken any action to prevent them from happening again. The provider had not notified anyone regarding these incidents.

The provider had failed to notify CQC of notifiable events. This was a continued breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

At our previous inspection in July 2017 we found that the systems and processes to ensure the service was stocked with necessary food and equipment were not in place. Staff had not always been paid the correct amount or on time. Before this inspection we received whistleblowing information where staff raised similar concerns.

At this inspection the provider had failed to provide basic provisions to enable people to have choices about their meals. The provider had not ensured there were enough supplies on the premises so that people had enough to eat and drink. The trainee manager was buying food on a daily basis for the next day's meal.

Staff told us that their pay had been late, and when it had arrived there had been multiple errors. The trainee manager told us there were "A couple of discrepancies". Throughout the inspection staff spoke with the management team about the errors in their wages. Some staff had not arrived for their shift because they had not been paid money that was owed to them. The trainee manager confirmed this. The provider was aware of these issues as this had happened in the past but had not taken action to resolve the issues.

The provider told us that staff wages would be rectified and that money owed to staff would be paid that day. They emailed us confirmation that this had been done after the inspection. We requested further evidence from the provider, asking them to demonstrate that staff had received all of the money they were owed. This information was not provided.

At our previous inspection staff told us that equipment needed to move people safely had broken and the provider had not taken any action to ensure that it was fixed. There was a lack of charged and working batteries for equipment so staff told us, "We are having to share the battery between two different hoists". At this inspection staff told us they still did not have a replacement battery. The trainee manager told us there was a new battery but that it was not in the service. This had still not arrived at the service by the end of the inspection. The one battery was being shared between two hoists so people who needed to use the hoist had to wait if they needed to move or use the toilet.

Staff told us they had to buy their own latex gloves because there were occasions when there were none in the service. Domestic staff told us they were not always given the cleaning products they needed and had, at times brought their own. Staff told us that there were occasions when there had been no washing powder and soiled laundry had built up. The provider was aware of these issues as CQC had contacted provider to make them aware and asked the provider to take action and they were noted in the previous inspection report but effective action had not been taken to resolve the issues.

At our previous inspection in July 2017 checks and audits had not identified the serious shortfalls we found. At this inspection we asked the consultant, employed by the provider, for evidence of checks completed on the service. They told us they had introduced new room checks and checks of food and fluid charts. These checks were not effective. For example, some people were at risk of harming themselves by eating items, such as toiletries, left around the service. During the inspection a person who was at risk of doing this had access to five aerosols, a prescribed cream and a body lotion which had been left out in a person's room. We alerted the trainee manager and told them to take immediate action to make sure people were kept

safe. The trainee manager told us that staff had been reminded not to leave toiletries out. The room checks had not identified this.

Although we previously identified serious shortfalls in the guidance for staff regarding people's care and support, care plans had not been systematically reviewed or updated. The provider had not completed any audits of the service to assess what areas needed to be addressed. The provider visited the service once a week, less frequently recently but did not complete any checks or audits either.

Records were not consistently completed and in some cases were contradictory. For example, when a person had been in hospital during the day we asked the trainee manager to show what time the person left the service and what time they returned. They reviewed the records and were unable to tell us. We found a record of the person being discharged from hospital; however the person's daily records had been completed throughout the day and did not mention any admission to hospital and were therefore incorrect.

People and staff were not actively involved in developing the service. The consultant had arranged one staff meeting in September 2017. Staff told us they were made to feel that the shortfalls in the service were entirely their fault. They said they felt the provider was not investing in the service. Relatives told us that they had not been informed of the outcome of our previous inspection by the provider. One relative said, "We found out about the last inspection report from the local authority. I think the provider should have told us it was inadequate, but they did not". The provider had written to relatives to inform them they had employed a consultant, but there had been no action to gain feedback or relatives views on the service. People had also not been consulted with and their views had not been sought.

During this focused inspection we found continued breaches of Regulations 11, 12, 17 and Section 33 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a continued breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009. In addition we found new breaches of Regulations 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to take appropriate action to mitigate risks and improve the quality and safety of the service and records were not completed fully or accurately. This was a continued breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection we contacted the service, seeking further assurances and were informed the provider organisation had gone into administration. The provider was therefore no longer the nominated individual of the service and an administration agency had taken over the management of the service. They were taking immediate action to ensure staff had been paid and that there was enough staff to keep people safe. The local authority was informed and plans were in place to ensure people were kept safe long term.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of notifiable events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition The provider had failed to comply with conditions applied to their registration requiring them to ensure that the service is managed by an individual who is registered as a manager and to send CQC detailed reports.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider has failed to ensure that staff were working within the principles of the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that people received safe support with their healthcare needs.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider has failed to meet people's nutritional and hydration needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to take appropriate action to mitigate risks and improve the quality and safety of the service and records were not completed fully or accurately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has failed to ensure staff receive the appropriate support, training and supervision as is necessary to carry out the duties they are required to perform.