County Healthcare Limited

St Mary's Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 20 and 21 April 2016. Three breaches of legal requirements were found and a warning notice was issued in relation to one of them which involved the governance of the service. We gave the provider until 20 June 2016 to meet the legal requirements of this regulation.

We undertook this focused inspection to check that the service had undertaken changes to meet the legal requirements of this regulation. This report only covers the findings in relation to the warning notice. You can read the report from our last comprehensive inspection in April 2016, by selecting the 'all reports' link for St Mary's Care Home on our website at www.cqc.org.uk.

At this inspection carried out on 1 September 2016 we found that there were still considerable concerns in relation to the governance of the home. We have not changed the overall rating for this service as a result of this inspection as it was only undertaken to follow up our enforcement action. The service, and the domain of well-led, remains as requires improvement.

St Mary's Care Home provides residential care for up to 44 people, some of whom may be living with dementia. At the time of our inspection 36 people were living there. Accommodation is on one floor with a number of communal areas.

At the time of this inspection, the home did not have a registered manager in post and a number of recent changes had occurred in the management of it. 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.

The registered manager had left at the end of July 2016 and an interim manager had been in post. This person had also recently left the service and an acting manager had been appointed the week prior to our inspection. The acting manager had been employed by the provider for approximately five weeks having been originally appointed as a deputy manager at St Mary's Care Home. During our visit, two registered managers from other homes owned by the provider were present to support the acting manager during the inspection.

At this visit carried out on 1 September 2016 the managers we spoke with could not provide us with all the information we requested. We therefore gave the provider the opportunity to submit any further information in relation to the warning notice up until 5pm the following day. No additional information was submitted.

At the inspection in April 2016, concerns were identified that demonstrated that the provider did not have effective systems in place to monitor the quality and safety of the service delivered. This had resulted in some people receiving a poor service.

At this inspection we saw that although some improvements had been made, the service was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to governance.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Although some processes were in place to monitor the quality and safety of the service provided, these were not wholly effective. The service had failed to appropriately manage the concerns highlighted in this report. These included a lack of staff to meet people's needs in a person-centred manner resulting in people having to wait for assistance. Issues in relation to medicines administration and management had not been identified by the service. There was also a lack of clear action plans when it had been identified that the service fell short of the required standard.

Some improvements had been made since our last inspection in April 2016. The service had identified some issues that were contributing to staff shortages and had introduced measures to address this. In addition, more consistent and comprehensive recording of people's medicines and their administration was noted. Senior staff told us that they had received training in medicines administration and that their competency to do so had been audited and assessed. Additional support had been received by senior staff in relation to their role and in medicines administration. Medicines, particularly topical medicines, were securely stored which had mitigated the risk of potential ingestion and misuse by the people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Requires Improvement

The service was not well-led.

The auditing system in place to monitor the quality and safety of the service was not wholly effective and some issues identified on our previous inspection in April 2016 were still evident.

St Mary's 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced focused inspection of St Mary's Care Home on 1 September 2016. This was carried out to check that requirements of a warning notice, issued after our comprehensive inspection in April 2016, had been met. The warning notice had been issued as the service was not meeting all legal requirements in relation to the governance of the service. The team inspected the service against the well-led question. The inspection was carried out by two inspectors.

During our visit we spoke with nine people who used the service and three of their relatives. We also spoke with the acting manager, two registered managers from other homes owned by the provider, two senior care assistants and four care staff. We looked at a number of records and audits in relation to the monitoring of the quality and safety of the service. In addition, we reviewed the care and support records for one person and the medicines administration and associated records for six people.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection carried out on 20 and 21 April 2016, we found that the systems to monitor the quality and safety of the service were either not effective or were not in place. This resulted in some people experiencing poor care and support. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We subsequently served the registered persons with a warning notice informing them that they had to comply with this regulation by 20 June 2016. At this inspection carried out on 1 September 2016, we found that the necessary improvements had not been made and that the provider was still in breach of this regulation.

The concerns found during the inspection in April 2016 included the management and administration of people's medicines and the staff response times for people requesting assistance. Although the provider had an auditing system in place to monitor the medicines management and administration, this had not been effective and had failed to identify and rectify concerns. The provider used a dependency tool to calculate staffing levels but no other system was in place to monitor whether these staffing levels were effectively meeting people's needs.

At this inspection carried out on 1 September 2016 we found continued concerns in relation to the governance of the home. Audits on the medicines management and administration had continued not to be effective at identifying issues. People, their relatives and staff told us there were still not enough staff to meet people's needs and that the home often ran without the staffing levels specified by the provider.

Out of the nine people we spoke with who used the service, six told us that their needs were not met in a timely manner. Two people told us that, on a number of occasions, the wait for assistance to use the toilet had been so long they had soiled themselves as a result. One person told us staffing was, "Still an issue." Whilst a second person said, "Staff come eventually." One relative told us that, when they visited their family member, they often had to provide personal care to them. They told us this was due to their family member not receiving the care they required due to a general lack of staff. Another relative told us that there had been no improvement in call bell response times since our last inspection in April 2016.

Each staff member we spoke with told us that people sometimes had to wait up to 15 minutes for assistance when they used their call bell. One staff member said, "That's a long time if you need to use the toilet." Another told us that when the shift was short on staff people had to wait for assistance. They said, "Which isn't fair on people." Staff told us that staffing levels were still an issue and that the home sometimes worked short of the staffing levels specified by the provider. Staff told us this was usually down to staff sickness and that this was an issue. The service had not identified that people were waiting for assistance. Although a dependency tool was used to calculate staffing levels, no system was in place to audit whether people's needs were being met safely and in a timely and person-centred manner.

When we viewed the staff rotas for 8 August 2016 to 31 August 2016 we saw that on nine days the service did not have the amount of staff the acting manager told us they should have.

We discussed people having to wait for assistance and how this was being monitored and audited with the acting manager and one of the registered managers of another service owned by the provider. They told us there was currently no system in place for this. We asked if call bell records were being printed and audited. They told us that they were aware there had been a continued fault with the call bell system and that this would not be a reliable way to audit how long people were waiting for assistance. They told us that the provider was currently looking into a replacement system. As a result, the managers told us that regular checks on all the people who used the service had been initiated. They told us checks should be completed on either a one or two hourly basis dependent on any risk factors associated with each individual. The managers told us that it was the senior care assistant's responsibility to check these were happening and sign the records to show they had been audited.

When we discussed this with one member of staff they were unaware of the two hourly checks and told us that they were only aware of those people that were on one hourly checks. They were able to tell us which people required regular checks and why. However, when we checked the records in relation to these checks, we saw that they had not been consistently completed and large gaps were evident. No audits had been completed by the senior staff. When we brought this to the attention of the managers, they told us that they were unaware that the audits had not been completed till they had checked them during our visit. They confirmed that procedures had not been followed as the service had specified.

We checked the medicines administration record (MAR) charts for six people who used the service. The MAR charts for three of these people did not show that medicines had been given as intended by prescribers, as there were gaps in the records. Some of the MAR charts did not give staff clear instructions in relation to the safe administration of medicines. For example, for one person who had not had some of their medicines administered at the specified time, the MAR recorded a code for this. However, no explanation had been given as to what this code meant and no further information was available. We saw that these medicines had been administered later in the day however the records in relation to this were not clear and did not mitigate the risk of a potential medicine error.

Two handwritten MAR charts we viewed, for two separate people who used the service, did not follow good practice. They had not been completed in a way that mitigated the risk of a potential medicine error. For each person, different medicines had been prescribed on different dates meaning the start date for the administration was different for each medicine. However, the administration dates for each individual medicine was not aligned on the MAR chart. This increased the risk of a medicine administration error. In addition, the handwritten entries had not been signed by two members of staff to ensure accuracy in the transcription of the information and administration instructions.

The service had a number of audits in place to review the medicines administration and management within the home but these had failed to identify concerns that were found during our inspection on 1 September 2016. The service's procedure dictated that both daily and weekly audits should be completed in relation to medicines management. These were then analysed on a monthly basis. We looked at the analysis for the daily audits and found that, for June, July and August 2016, each showed that not all medicines were in stock within the home and that this had not been rectified. The audits did not contain any associated action plans nor state whose responsibility it was to rectify the issue. No date was specified for the action to be completed by. The analysis of the daily audits completed in August 2016 showed that the MAR charts contained gaps where signatures should have been to record that medicines had been administered. We could therefore not be sure that people had received their medicines as the prescriber had intended.

Weekly medication management audits had not been completed as specified by the provider. For June and August 2016 three audits had been completed for each month. Only one weekly audit had been completed

throughout July 2016. The audits did not specify whose medicines had been audited or, where concerns had been identified, who was responsible for actioning them and by when. We noted that the audit carried out by the regional manager on 20 July 2016 had not identified that the weekly audits had not been completed as required. We concluded that the auditing system in relation to medicines management was not effective.

In addition, senior staff told us that all boxed medicines had to be counted and recorded at the start of each shift change. This had not been completed as specified and staff told us that they did not have time to do this. From the records we viewed we saw that this check had only been completed either once or twice a day instead of the three times the shifts changed.

These concerns meant that the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had previously warned the provider that there was a lack of systems in place to effectively monitor the quality of the service provided. The provider had taken some steps to action this which included the use of agency staff when staff shortages were apparent. They had recognised that staff sickness and poor management of annual leave had also been a contributing factor and introduced measures to address this. A new call bell system was also in the process of being ordered as faults had been recognised with the current system.

At our inspection in April 2016, a number of concerns had been identified in relation to medicines administration and management. Although the medicines audit system the provider had in place had not been wholly effective, some improvements were identified at this inspection. At our inspection in April 2016, we saw that the MAR charts for people did not record why medicines that were only needed on an 'as required' basis had been administered. At this inspection we saw that this had been recorded. In addition, the service had information in place to guide staff in the administration of these medicines.

We noted that steps had been taken to securely store topical creams. During our visit we saw that all medicines, including topical creams, were stored in a secure manner. They were no longer accessible to people helping to protect them from potential harm from their misuse or accidental ingestion.

The staff we spoke with who were responsible for administering medicines told us improvements had been made in relation to this. They told us they had recently received refresher training in medicines administration and had their competency to perform this task assessed. However, when we asked to see the training records to demonstrate this, the provider could not produce them. We saw, however, that competency assessments had been completed which were robust and comprehensive.

Staff also told us that the pharmacist had completed an audit on medicines management which had helped them to make improvements. However, when we asked to see this, the provider couldn't produce the audit so we could not see what actions were required and what had been completed.

At our April 2016 inspection, we found that people had refused their medicines for a number of days and that the service had taken no action in response to this. At this inspection, senior staff were able to tell us what actions they would take and when if this occurred again. This demonstrated that staff had the appropriate knowledge to manage this and maintain people's health and wellbeing whilst understanding their role in people's capacity to make their own decisions.

Despite the provider having taken some action to address the issues around the governance of the service, sufficient improvements had not been made and it remains in breach of Regulation 17 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.