St. Matthews Limited

St Matthews Unit

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Matthews Unit is a care home providing personal and nursing care to 55 people with a diagnosis of dementia and/or mental health at the time of the inspection. The service can support up to 58 people.

People's experience of using this service and what we found
Systems to protect people from abuse required improvement. Injuries and when staff used physical intervention had not always been recorded, investigated or audited.

Risks to people had not always been identified, recorded or strategies put into place to reduce these risks. The environment required some improvement.

Cleaning records had significant gaps in the recording of tasks and not all areas of the home were clean.

Staff did not fully understand the legal framework around restraint. Staff had not received adequate training to understand how and when to physically intervene.

Systems and process in place to maintain oversight of the service required improvement.

People were supported by staff who knew them well and who had been safely recruited. People told us staff were 'kind and cheerful.'

People were able to access food and fluid as they wanted. There were 'hydration stations' throughout the building and people told us the food was good.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff read people's care plans which detailed their communication, religious and support needs. When people required support from healthcare professionals, staff referred or supported people to access this support.

People, relatives and staff were able to feedback on the service and knew how to complain if needed.

The provider and registered manager sent an action plan outlining the strategies they were implementing to mitigate the concerns found on inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (Published 31 October 2017)

Why we inspected
We received concerns in relation to safe care and treatment. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Mathews Unit on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to risk assessments, safeguarding and oversight of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

St Matthews Unit

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by two inspectors, an assistant inspector and an expert by experience. An Expert by Experience contacted relatives of people who use the service via telephone following the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection
We spoke with 10 people who used the service and four relatives about their experience of the care

provided. We spoke with nine members of staff including the registered manager, deputy manager, nurses and care workers.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, complaints and governance and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were not consistently protected from abuse. Injuries sustained to people had not been consistently logged on a body map or investigated to establish the cause of the injury. This put people at risk of abuse.
- When staff used physical interventions, this task was not recorded appropriately. This meant there were no records of when staff had used restraint techniques and no evidence if the techniques used were appropriate.
- Staff had not received adequate training to understand and know the correct techniques to be used when physically restraining people. This put people at risk of harm from inappropriate practices being used.

Systems and processes were insufficient to ensure people were safeguarded from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management

- People at risk of pressure skin damage did not always have this need met. We found gaps in the repositioning charts. This people at risk of developing pressure damage to their skin.
- Care plans and risk assessments did not always contain sufficient details to ensure staff understood their roles in care tasks. For example, when care plans stated multiple staff were required to support a person with personal care, there was no information regarding what each staff member was meant to do.
- When additional staff supported a person with personal care, there was no clear documentation of the reason. For example, we found that at times an extra staff member supported a person with personal care. There was no rationale why the staffing level had increased.
- Some care plans and risk assessments held conflicting information to that held elsewhere. For example, one person's records had a different consistency of food required than that held by the kitchen staff. This put people at risk of choking.
- The environment required improvement. We found exposed pipes and broken pipe work which had not been identified prior to the inspection. This put people at risk of scalding. The provider arranged for maintenance to rectify these issues immediately after feedback

We found no evidence that people were harmed, however, the provider had failed to ensure that all strategies to mitigate risks had been completed. This was a breach of Regulation 12) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises or that the provider was making sure infection outbreaks can be effectively prevented or managed. We found multiple gaps in cleaning records, limited records for shared toilets/bathrooms being cleaned between use and we found areas of the home that did not appear clean.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment

● Staff were recruited safely. The provider completed pre employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

● The provider did not use a dependency tool to establish minimum staffing levels required. However, we did not find any concerns relating to staff levels. People told us they could summon staff as required. One person said, "There are plenty of staff around."

Using medicines safely

● People received their medicines as prescribed.

● When people had 'as required' medicines, there was a protocol in place and staff recorded the reasons for giving the medicine.

Learning lessons when things go wrong

● The provider sent out case studies to ensure all services learnt from each other. Lessons learnt included safeguarding, accidents and incidents.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not received all the necessary training required to fulfil their roles. For example, we found not all staff had up to date training in breakaway and safeguarding. The provider was in the process of ensuring all staff received up to date training.
- When staff started their employment at St Matthew's Unit, they received an induction which included training and shadow shifts.

Supporting people to eat and drink enough to maintain a balanced diet

- Food choices for people who had preferences were not always in place. For example, during the inspection both staff and a person told us the only option offered that lunchtime to a vegetarian was potatoes and vegetables.
- Most people told us the food was nice. One person said, "I love the food, I often have seconds.".
- People had snacks and drinks offered throughout the day. There were drink stations available throughout the service.

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

- Dementia friendly signs were in place within the dementia floor. However, we found some did not have the appropriate directional information, which could be confusing for people living with dementia. The provider arranged for maintenance to rectify these issues immediately after feedback.

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

- People's needs were assessed prior to support being offered. Care plans included people's diverse needs. This included support required in relation to their culture, language, religion, lifestyle choices and diet.
- People told us staff knew them well. One person said, "Staff know me well and what I like."
- Staff told us if they identified a change in a person's needs, they informed the management team who would change the care plans.

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

- People received support from health care professionals as and when needed, such as GPs, speech and language therapists and psychiatrists. People told us that staff supported them with and to health appointments and sought support as required.
- Staff knew what action to take in an event of an incident or emergency.

● Care plans documented people's healthcare requirements and clearly identified and recorded any involvement with healthcare services.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Where people lacked capacity, decision specific mental capacity assessments had been completed and best interest decisions had been made with all the relevant people being involved.
● The registered manager had appropriately submitted DoLS applications to the local authority.
● People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Staff and the registered manager were unclear regarding what constituted a restraint. We were told that staff did not use restraint. However, we found that staff used low level restraint to support people with personal care and to remove people from a challenging situation.
- We found no evidence that the use of restraint had been audited or that the registered manager had oversight of when restraint was used.
- Systems and processes were not robust enough to identify the issues we found during the inspection. For example, concerns found with environment, one person's prescribed medicine had not been signed for and there were gaps in records or conflicting information held.
- Audits completed on infection control were clear and had actions recorded. However, we found no audits on the cleaning schedules which were found to have gaps and incorrect information recorded on them.

We found no evidence that people had been harmed however, systems and processes were not effective or robust enough to monitor the quality and safety of the service. This placed people at risk of harm. This was a breach of regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager submitted relevant statutory notifications to CQC promptly. This ensured we could effectively monitor the service between our inspections. When needed, the registered manager provided information to us to help with our enquiries into matters.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The manager understood, and acted on, their duty of candour responsibility.
- Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns were not acted upon.
- People and relatives told us they knew how to complain, and they felt listened to when raising concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were asked to feedback on the service they received via a survey. The last survey completed evidence people were happy with the support they received. The surveys were available in pictorial formats and large print if required.
● We received mixed views from relatives regarding giving their feedback. One relative told us, "I have completed questionnaires and given feedback." Another relative said, "I have never been asked what I think or my feedback on the service."
● Staff felt supported by the registered manager and told us they were able to make suggestions and give feedback.

Continuous learning and improving care; Working in partnership with others
● The provider sent an action plan outlining the strategies they were implementing to mitigate the concerns found on inspection.
● Relatives told us the service kept in contact with them and updated them as required with any changes to their loved one's care or health.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and process were not effective in ensuring strategies to mitigate risks had been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were insufficient to ensure people were safeguarded from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective or robust enough to monitor the quality and safety of the service.