Yara Enterprises Limited

St. Margarets Residential Home

Inspection report

5 Priestlands Park Road
Sidcup
Kent
DA15 7HR

Tel: 02083002745

Date of inspection visit:
21 August 2020

Date of publication:
23 September 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

St. Margarets Residential Home is a residential care home providing accommodation and personal care to 18 people aged 65 and over at the time of the inspection. The service can support up to 22 people.

People's experience of using this service and what we found
The service was not always safe and there was a lack of understanding regarding safe infection control procedures. Staff and the manager were not following government guidance issued as part of the COVID-19 pandemic, regarding social distancing, or wearing appropriate protective equipment such as masks.

Risks relating to people's care and support were not fully assessed and there was a lack of guidance for staff regarding key areas of people's healthcare needs such as epilepsy, diabetes and stoma care. Medicines were not always managed safely and were not always administered in line with the prescriber's instructions.
The environment was not always safe, as key risks in relation to fire were not fully mitigated. A fire door was unable to close as a stair gate was in the doorway and hallways were not kept free of combustible materials.

Staff were not always recruited safely. Full work histories had not always been gathered and references were not always verified. Some staff had criminal records checks, and these had not been risk assessed for possible risks to people safety.

There appeared to be enough staff to keep people safe, however, we have made recommendation regarding how to formally assess the number of staff needed at the service.

The long standing registered manager at the service had recently left and the new deputy manager was acting as manager at our inspection. Whilst they were receptive to our feedback and acted quickly to make changes neither they nor the provider had identified the serious concerns we found during this inspection.

Safeguarding procedures were adhered to and we saw positive feedback from a relative following a recent request for feedback. Notifications had been submitted to CQC when required.

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 19 July 2018.)

Why we inspected
This was planned as a targeted inspection looking at the infection control and prevention measures the provider has in place. As part of CQC's response to the coronavirus pandemic we are conducting a thematic review of infection control and prevention measures in care homes. This inspection took place on 21 August 2020 and was announced. The service was invited to take part in this thematic review which is seeking to identify examples of good practice in infection prevention and control.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We inspected and found there was a concern with infection control so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

The ratings from the previous comprehensive inspection for the key questions effective, caring and responsive were not looked at on this occasion so were used in calculating the overall rating at this inspection. The overall rating for the service has now changed from good to requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St. Margarets Residential Home 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 and we will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, infection control, medicines, recruitment and good governance.

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

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

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?

Inadequate

The service was not safe.

Details are in our safe 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. Margarets Residential Home

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 as part of our Thematic Review of infection control and prevention in care homes. Due to the concerns found at the inspection this became a focused inspection to consider the risks found.

Inspection team
This inspection was carried out by one inspector.

Service and service type
St. Margarets Residential Home 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
We gave the service 24 hours' notice of the inspection. This was because the service was initially chosen as part of our Thematic Review of infection control and prevention in care homes.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

During the inspection
We spoke with three people who used the service. We spoke with five members of staff including the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with the local authority and clinical commissioning group (CCG) about the service.

Inadequate

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 Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

● People were not protected from the spread of infection. When we arrived at the service staff were not wearing appropriate PPE, such as masks. The manager told us this was due to, "personal choice." No consideration had been given to the government guidance advising care homes how to operate safely during the COVID-19 pandemic.

● Staff were not adhering to the provider's policy on visiting, which was in place to reduce the spread of infection, which required relatives to stay in the garden of the service.

● During the inspection a relative told the manager they had previously visited their relative in their room and had used a small lift with a member of staff. No consideration had been given to how moving through the service and standing in close proximity in the lift could risk the spread of infection and the lift had not been cleaned following this incident.

● The environment was not suitable to prevent the spread of infection. There was a large lounge, with multiple chairs placed side by side. We observed people sitting next to one another, touching, whilst there were multiple unused chairs in the room.

●The manager told us no changes had been made to the lounge due to people's dementia. As such, there was no risk assessment in place regarding the lounge and no alternative layout had been considered which would support people to better adhere to guidance on safe social distancing.

The provider had failed to ensure appropriate infection prevention and control procedures were in place. This put people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did appear clean and free from malodour, and the laundry room appeared organised with systems to separate clean and dirty clothes.

Assessing risk, safety monitoring and management;

● Risks relating to people's care and support were not appropriately assessed and risks relating to fire were not adequately mitigated.

● We reviewed four people's care plans and whilst there were some risk assessments in place for areas such as moving and handling and bed rails, key areas of people's support needs had not been assessed.

● People were living with health care needs such as epilepsy, diabetes and stoma care and there were no risk assessments in place or guidance for staff regarding how to support people with these needs.

● We spoke to staff and they told us they would, "inform a senior" if they had any concerns about people's care in these areas. Whilst the senior was able to tell us how to support people, there was a risk without

accurate guidance that staff may not respond appropriately, particularly if the senior was not available.
● A stair safety gate had been placed in the middle of a fire door, which prevented it from closing reducing its fire resistance. Whilst this was rectified during the inspection, the manager told us it had been in place for several weeks, which had posed a fire risk.
● The provider's fire risk assessment stated, "The combustible materials stored in the corridor are to be removed and the area free of combustible materials." During the inspection a large stuffed armchair was located in the hallway, because it was dirty and required cleaning. Whilst this was removed on the day of the inspection, it had still posed a fire risk.

We found no evidence that people had been harmed however, the provider had failed to ensure there were systems and processes in place to keep people safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always managed safely.
● During the inspection we observed staff completing the lunchtime medication round. One person was prescribed a medicine to treat an underactive thyroid which should have been administered in the morning before any food or drink. Staff were going to administer this medicine to the person after they had eaten their lunch, they only stopped when we highlighted this was not in line with the prescribing instructions.
● Staff and the manager told us this person regularly got up late and they usually administered the medicine after they had eaten. However, no one at the service had consulted with the person's GP or pharmacist to discuss potential risks in relation to this or the fact they weren't adhering to the prescribing instructions.
● The manager told us they had started to implement guidance for medicines prescribed on an 'as and when basis' (PRN). However, we identified one person was prescribed an as and when sedative and there was no guidance in place for this. Staff had administered this every night since 3 August 2020 up until the day of the inspection. There was no indication the person had been distressed or unable to sleep. There was a risk the person had been sedated when they did not need to be. We raised a safeguarding alert about this.

The provider had failed to ensure medicines were managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager acted quickly during and after the inspection and contacted people's GPs for advice. They told us they had already implemented improvements with regards to medicines since being in post, and the number of missed signatures on medicine administration records (MARs) had reduced.

Staffing and recruitment
● Staff were not recruited safely. We reviewed three staff files and in two of them staff had declared criminal convictions, including for serious crimes such as assault. There was no risk assessment in place to show the manager had considered these convictions and how staff could work safely with vulnerable people.
● Another staff member did not have a full work history in place, and the manager had not verified their sole reference, which had come from an individual and not the provider the staff member had previously worked for.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure safe recruitment processes. This placed people at risk of harm. This was a breach of regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● From our observations and people's feedback there appeared to be enough staff to keep people safe. One person told us, "They are always doing their jobs perfectly. They are perfect." We saw that staff were responsive to people's needs and available when they asked for assistance.
● During the inspection the manager spoke with a potential new admission. We asked the manager how they decided how many staff were needed, and they told us this decision had been made by the previous manager. There was no formal tool in place to assess the number of staff needed to support people safely and no system of assessing if more staff would be needed if the new person moved in.

We recommend the provider and manager take advice from a reputable source regarding implementing a formal assessment tool to determine staffing numbers at the service.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● There were systems and processes in place to safeguard people from the risk of abuse.
● Staff knew how to recognise and respond to abuse and spoke confidently about the action they would take to keep people safe. One staff member told us they would, "Go to [the manager] I trust them. If needed I would go to CQC or the local authority."
● The manager had only been in post for a month, and there had not been any safeguarding issues during that time. They told us they would report any safeguarding concerns to the local authority if they occurred.
● There had only been two incidents which had occurred since the new manager had been in post. They told us they planned to implement a monitoring tool to look at trends and patterns for accidents and incidents and safeguarding concerns, to prevent them from occurring again.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- We found serious concerns in relation to infection control, risk management, medicines and recruitment. Both a medicines audit and infection control audit had been completed by the new manager since they had been in post and neither of these identified any of the concerns we found.
- The long-standing registered manager at the service had left in July. The deputy of the service was acting as manager during our inspection and told us it was difficult stepping up to a new role during the COVID-19 pandemic.
- Whilst some of the concerns we identified would have been in place before the new manager had started, the provider's quality assurance processes had failed to identify any shortfalls.
- The infection control audit and policy, and the provider's disaster management plan had not been updated to reflect essential changes regarding Government guidance about personal protective equipment (PPE) and how to support people, visitors and staff safely during the COVID-19 pandemic.

The provider had failed to ensure there were effective systems and processes in place to ensure adequate oversight at 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- The new manager was open and receptive to our feedback. Where they were able to rectify concerns immediately they did so, and they contacted people's GPs for advice regarding their medicines.
- The new manager recognised to make the essential improvements needed at the service they would need to work closely with the local authority and other partners to ensure they had up to date knowledge. We shared our concerns with the local authority and CCG and they immediately offered additional support with infection prevention and control.
- Staff told us the new manager was making positive changes. One staff member told us, "It has got a lot better you know, I can see the work they are putting in. I have learnt a lot about filling out medicines records, and there are less errors now."

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

●The provider had sent out questionnaires recently to relatives of people living at the service, asking for their feedback. Whilst only two had been returned, we saw that relatives had said positive things about the service. Comments included, "St. Margarets continues to be quite exceptional with its real family atmosphere. I just hope this never changes."

● During the COVID-19 pandemic staff had helped people speak with their relatives via videophone and were able to seek individual feedback when this occurred. Because of the restriction on visiting no relatives' meetings had been held.

● There was a resident of the day system in place, where staff focused on one person daily, this system was also used to gather feedback.

● Staff told us they had access to regular training and came together to discuss aspects of the service during this time.

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 provider and manager recognised they needed to be open and honest when things went wrong.

● The manager had submitted appropriate notifications and told CQC when important things had happened at the service.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure adequate systems of oversight and governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure safe systems of recruitment.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure there were systems and processes in place to keep people safe. Infection prevention and control procedures were not adequate and medicines were not always managed safely.

The enforcement action we took:

CQC issued a Warning Notice requiring the Provider to become compliant with Regulation 12.