Assistwide Limited

St Martins Residential Home

Inspection report

63 St Martin's Lane
Wallasey
Merseyside
CH44 1BG

Tel: 01516399877
Website: www.richmondresidentialhome.co.uk

Date of inspection visit:
09 March 2023

Date of publication:
03 May 2023

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 Martins Residential Home is a care home providing accommodation and personal and care to 16 people with mental health needs. At the time of the inspection there were 13 people living in the home.

People's experience of using this service and what we found
Risks in relation to people's care had not been effectively assessed and medicines were not always managed safely. There was a lack of understanding around the Mental Capacity Act 2005 and, it's application. The provider did not show the appropriate knowledge around their responsibilities in relation to finance and consent. The systems in place to monitor the quality and safety of the service were not always used effectively to identify and mitigate risks. We have made a recommendation regarding recruitment.

People were not supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests; however, the policies and systems in the service did not support this practice.

The registered manager had improved the environment and the safety checks where up to date however we identified additional fire safety improvements were required.

Staff received regular training, supervisions and attended staff meetings and there were enough staff on duty on the day of inspection to meet people's needs. Referrals were made to other professionals in a timely when people living in the home were in need.

Feedback we received from staff, people and relatives was positive in regard to the registered manager. We observed support being provided in the home and saw this was done in a caring, responsive, and patient manner. We saw people were comfortable in the presence of staff and positive relationships had developed between people receiving support and staff.

People were consulted with in the form of residents meeting s and quality assurance questionnaires. There was evidence of how the registered manager acted on people's opinions.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 20 May 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about fire safety. A decision was made for us

to inspect and examine those risks. 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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to risk management, consent and governance at this inspection.

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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 Martins 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 Health and Social Care Act 2008.

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 carried out by 2 inspectors and an Expert by Experience. 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 Martins Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Martins Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 members of staff and the registered manager. We reviewed a range of records. This included 2 people's care records and multiple medication records. We looked at 4 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 and the provider was able to provide evidence of actions taken following the inspection.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- Risks had not been sufficiently assessed or mitigated and care plans were not always in place to guide safe practice.
- Support plans lacked adequate information on people needs, risks and the support they required. There was limited information on people's medical and mental health needs and there was lack of person-centred information on how these conditions affected people, for example what steps were required if someone's mental health declined and identifying the symptoms they experienced.
- People's support needs were not always monitored accurately. For example, support plans and daily records were not always up to date or completed accurately.
- Some of the fire doors would not be effective in the event of a fire as they did not close properly into their rebates of their own accord, for example the laundry and kitchen.
- The smoking shelter was not big enough to accommodate more than two smokers at any one time, there was no adequate lighting in the smoking shelter.
- We found fire doors upstairs not alarmed so staff would not know if anyone left the building via these doors. This is a risk to people's personal safety.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some of the decisions people made in relation to their own health were respected, for example smoking with specific health concerns.
- People we spoke with all felt safe in the home, comments we received included, "Very good yes I feel very safe, feel safe in the building" and "I feel safe and cared for, yes, they have enough staff and yes I take my meds."
- Staff we spoke with knew what action to take if a safeguarding incident occurred.

Using medicines safely; Learning lessons when things go wrong

- Medicines were not always managed safely.
- There was lack of documentation for medicines given 'as and when needed' for example Diazepam, prescribed creams and inhalers. This meant there was a risk these would not be administered when needed or appropriately.

● The count sheets in relation to the amounts of medicines in the home completed daily were not always accurate
● Some medication administration records (MARs) were handwritten and had not been signed by any member of staff or double checked by another member of staff as correct; stock levels were not always correct.

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

● Medicines were stored securely and controlled drug counts were correct.

Staffing and recruitment
● A process was in place to ensure staff were recruited safely. However, we identified aspects of this was not robust.
● Appropriate risk assessments where not in place for when DBS checks indicated convictions or cautions. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

We recommend the provider consider current guidance on keeping appropriate documentation and records in relation to recruitment and take action to update their practice accordingly.

● There appeared to be sufficient numbers of staff on each shift to meet people's needs.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes
● The provider was facilitating visits for people living in the home in accordance with the current guidance.

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 a previous inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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.

- No one living in the home had a DoLS in place at the time of inspection.
- However, we found the provider was not working within the principles of the MCA and did not have, appropriate legal authorisations in place in regard to finance management.
- Evidence of consent from the people living in the home was not in place in regard to the provider management of their finances.
- Other aspects of care also had no evidence of consent for example, sharing a bedroom; COVID-19 vaccinations and advanced care plan consent.
- This was reported to the local authority and the registered manager immediately started to remedy this. However, the provider should have recognised this issue and not the inspector.

The provider failed to act in accordance with legislation regarding the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Assessments contained information and guidance specific to each person's wishes. However, assessments did not always give information on people's needs.

Supporting people to eat and drink enough to maintain a balanced diet
- People were supported to maintain a balanced diet.

● Catering staff knew about people's special dietary requirements or information about new people moving into the home. For instance, people who required low sugar foods.
●People we spoke with was happy with the food provided. Comments we received included "Yes, we get a good food choice," "I can have food and drink when I like am can do what I like" and "Food, no problem with food."
● The provider carried out the shopping for the food for the home. People were asked for their opinions on the menu at service user meetings however, the provider did not always consider their wishes when completing the shopping.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to healthcare services when they needed it. People were referred for healthcare assessments promptly if required
● When other health and social care professionals were involved in people's care staff were knowledgeable about people needs however, any advice given was not always documented within their plans of care.

Staff support: induction, training, skills and experience
● Staff spoken with confirmed had induction, training and felt supported.
● Staff had the appropriate skills and training. They demonstrated good knowledge and skills necessary for their role. We were able to view training matrices and documentation confirming the required competencies had been achieved.

Adapting service, design, decoration to meet people's needs
● The décor of home was dated and some of the furnishings need replacing.
● People's bedrooms were personalised and looked clean.
● The building had sufficient facilities to ensure people were able to access to kitchen and bathroom areas independently.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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; 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

At our last inspection the provider's systems to assess and monitor the quality and safety of the service, were not always effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found sufficient improvements had not been made and the provider was still in breach of regulation 17.

● The provider's quality assurance systems were not always effective in identifying and bringing about improvements to the service.
● The provider lacked understanding of their responsibilities to ensure decisions surrounding consent were appropriate.
● Support plan audits were not audits but rather reviews of activities that had taken place over the month. An audit is a quality improvement process looking at the effectiveness of the support being provided and the content of the support plan. This was ineffectual in driving improvement within the service.
● The provider did not have oversight of the service and had failed to ensure effective support and leadership.
● The provider's quality assurance systems did not identify some concerns we found during this inspection. For instance, we identified two accidents and incidents which had not been recorded or reported appropriately.

The provider's systems to assess and monitor the quality and safety of the service, continued to be ineffective. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager was receptive to feedback provided during the inspection and took action to rectify concerns.
● External audits of aspects of the home had been carried out, for example Food Hygiene Standards had

been very positive with the highest score being awarded.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The registered manager had implemented quality questionnaire which were very accessible and user friendly to ensure people were able to give their opinions easily.

● Everyone we spoke with were positive about the care provided and people said they were happy living at the home and felt they could approach the registered manager and staff with any concerns.

● Family members we spoke with were very positive about the registered manager and staff. One relative told us, "[Person] thinks the manager is wonderful."

● People were supported to maintain their independence, for example they were able to go out independently, and made their own snacks, drinks and breakfast.

● People appeared happy, content and relaxed in the home and the environment was calm, relaxing and therapeutic.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Regular meetings were being held and people were updated on processes and encouraged to air their views. We were able to see evidence people were listened to in the form of a 'you said, we did' picture file.

● Referrals with outside health agencies including the local authority and social care professionals were made to ensure people had access to the support they needed. This included the mental health team.

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 11 HSCA RA Regulations 2014 Need for consent Systems had not been established by the provider to make sure that they obtain the consent lawfully and that the provider had the necessary knowledge and understanding of the care that they are asking consent for.

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 not established systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

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 17 HSCA RA Regulations 2014 Good governance The provider's systems to assess and monitor the quality and safety of the service, continued to be ineffective.

The enforcement action we took:

Warning notice