St Marks Care Home Limited

St Marks Residential Care Home

Inspection report

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21 February 2018
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of St Marks Residential Care Home over three days: 21 and 22 February and 5 March 2018. We reviewed the progress of the provider's planned improvements following our comprehensive inspection on the 6 and 9 February 2017 and focused inspection on the 9 and 13 November 2017. These had found the provider was not meeting some legal requirements. This inspection was also prompted in part by information we had received from whistle blowers and safeguarding reports to the local authority.

People living at St Marks Residential Care Home receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides personal care for up to 17 older people, some people living with dementia. There were 14 people living at the service when we inspected.

At the inspection in November 2017 we identified continued breaches of legal requirements. There was poor leadership, management and provider oversight of the service. This led to people receiving poor care where risks to their health and welfare were not adequately protected. We took urgent enforcement action to mitigate the risks to people and restricted any new admissions to the service until we were satisfied improvements were made.

St Marks Residential Care Home is in Special Measures, which resulted from an Inadequate rating following a focused inspection undertaken in November 2017. The purpose of Special measures is to ensure providers found to be providing inadequate care significantly improve. We keep services placed into Special Measures 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 be providing inadequate care should have made significant improvements within this time frame.

You can read the reports from our previous inspections by selecting the 'all reports' link for St Marks Residential Care Home on our website at www.cqc.org.uk

Since the last inspection the provider has employed several different external consultants to help improve quality and safety. The local authority safeguarding and quality monitoring teams also continued to monitor the service through regular visits and support, mitigating the risks to people using the service and reviewing the provider's improvement plan.

Despite this support the Commission continued to receive concerns from members of the public and professionals about the provider's ineffective oversight of the service. This included concerns about the provider's ability to improve the overall quality of the service. As a result there continued to be concerns about the ability of the provider to drive improvement and ensure people received safe, effective care. We therefore carried out this focused inspection to check progress against their improvement plan and check how those living in the service were being protected from the risk of potential harm. The inspection team

inspected the service against two of the five questions we ask about services: is the service safe and well led.

There was a registered manager in post, who was also a Director of the company which owned the service (the registered provider). A registered manager is a person who has registered with the Care Quality Commission 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.

At this inspection we found although some improvements had been made, sufficient action had not been taken to mitigate the risk of harm and the provider remained in breach of the Regulations. The provider had delegated some of the improvement goals to consultants but had not retained effective oversight of their progress or responded promptly when they escalated concerns which needed the provider to take forward. This had led to disjointed work and poor communication about who was responsible for what, timescales and measures for improvement. Information received by the Commission included frustration from staff, professionals and others involved in the service about the Director/Registered Manager's understanding of how the service needed to be run safely and effectively.

Assessments and controls had been introduced but they were not robust enough or monitored to ensure they were making improvements. For example risks associated with legionella, unsafe recruitment, fire safety and continued concerns around cleanliness and infection control.

Robust recruitment and employment systems were not in place to ensure appropriate and ongoing checks of employees. This put people at potential risk of being supported by staff whose identity, work permits, ability to work with vulnerable people, or qualifications could not be demonstrated by the provider. Where there were gaps in information no assessment of the risk that may pose had been explored. The provider was unable to demonstrate they could consistently ensure enough skilled staff can be deployed across the service to provide safe, personalised, quality care.

The overall governance structure in place relied on the Director/Registered Manager to make all decisions and be in control of all changes. Although some tasks were delegated to consultants and other staff the Director/Registered Manager had no effective oversight to ensure changes were embedded and carried through. The service remains Inadequate and the improvement plan put in place has not been effective at identifying and addressing the root causes effectively. We remain seriously concerned that the provider lacks the ability to drive the improvement needed and the service is continuing to fail people who live there.

The Commission is continuing to monitor this service. You can see what action we told the provider to take at the back of the full version of the report.' Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work there.

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.

Systems were not in place which robustly identified and reduced risks to people living in the service.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have systems in place to ensure the drive for improvement was making progress and people were not benefiting from improved quality of care.

St Marks Residential 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection was unannounced and took place over three days: 21 and 22 February and 5 March 2018. The majority of the inspection was carried out by one inspector, with, on the second day, support from two other inspectors during the afternoon.

This inspection was prompted in part by information we had received from whistle blowers and safeguarding, as well as checking to ensure sufficient action had been taken to address the breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified at the time.

Prior to the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and feedback we had received through the Care Quality Commission 'share your experience' website.

We spoke with the registered manager who is also a director of St Mark's Care Home Limited, and five members of staff including catering, care, activity and management staff.

We spoke with five people living in the service, a relative of a person who used the service, two appointed consultants, and the safeguarding and quality team at Essex County Council about their visits to the service. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care needs were being met we reviewed four people's care records and other information, for example their risk assessments, pre-assessment, diet and fluid intake charts and medicines records.

We looked at four staff member's recruitment paperwork and records relating to the management of the service. This included training, staff duty rosters, fire evacuation plans and systems for assessing and monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Our focused inspection in November 2017 found continued concerns around infection control and there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although some actions had been taken, it was not effective and placed people at continued potential or actual risk of harm. We took enforcement action to force improvements. We also met with the registered manager / director on the 28 November 2017, which enabled them to discuss the action they would take to address the issues we had identified and make sure improvements were made and sustained.

Although some changes to the environment had been made and there was an ongoing program of refurbishment and decoration, risks to people had still not been recognised and acted on.

The provider did not have systems in place to independently identify, respond and manage risk effectively. Lessons were not being learnt from previous inspections, incidents and safeguarding referalls to minimise reoccurrence and demonstrate that any new systems were working as they should.

Management and staff did not demonstrate understanding of what keeping safe means or how to take effective action to minimise risks. In many cases external professionals had brought risk areas to their attention. This included out of date servicing and checking of manual handling equipment, such as transfer slings for any signs of wear and tear, which could impact on their ability to be used safely and mitigate the risk of harm.

Concerns had been raised about people living in the service having access to the kitchen. Risks had not been assessed, for example, around infection control, accessing knifes, hot fluids, and cleaning products. To address the concerns, digital locks had been fitted to both access points to the kitchen. However, these precautions were not effective as we saw doors being left open and we had to alert the registered manager that a person was in the kitchen area. Staff were seen wearing gloves when preparing food but their use in preventing cross infection was not effective because the continued to use them when assisting people with care and touching non-food items. The use of gloves were therefore not an effective barrier to prevent cross infection/contamination.

Care records maintained did not demonstrate that known risks to people were being reduced. For example, one person who had a 'pressure ulcer prevention care plan ' in place had been assessed as 'High risk' of their skin becoming sore and breaking down when laying in the same positon in bed too long. Gaps in the records did not demonstrate staff were following the guidance given 'requires re-position every 4 hours'. When we checked at 3.00pm their chart stated they were last supported with their continence, and reposition at 6.00am. Other days there were gaps or no records of turns. Staff said it could be because the person had got up that day but records were contradictory and this could not be verified.

Even when risks were pointed out actions were not all followed through or checked on to ensure they were complete. Our November 2017 inspection identified that the management of the risk of legionella had not been monitored effectively to safeguard people living and working in the service. We took urgent action to

ensure the provider addressed this. Following a legionella risk assessment carried out by a competent person on 14 December 2017, the report showed several areas of high risk. However, no immediate action was taken by the provider to get the water tested for any signs of legionella until 26 February 2018. Although the tests came back clear, the provider wouldn't have known this and we were concerned over the provider's lack of urgency in taking action on this matter.

A small wooden shed as a smoking area for people living in the service. The shed was also used for storage of broken items no longer in use, used matches were strewn across the floor and on top of discarded net curtains. The scorch marks on the rug identified a potential fire risk. There was no risk assessment in place. When we raised our concern with the registered manager, they locked the shed, and said that the area should not be used. However no alternative for people using the service was identified and we later found it was still accessible with staff unware it should not be in use.

The fire evacuation plan and staff signing in book did not consistently provide accurate information for emergency services on the number of people living in, attending day care, respite care and working in the service. This put them at risk of not being accounted for in an emergency. When we asked the two staff on duty neither had been shown how to use the emergency evacuation equipment.

A 'schedule of maintenance contract servicing agreement' and minutes of the 18 January 2018 staff meeting, identified areas of the service where call bells were 'inaudible to staff'. Staff confirmed it had been like that for some time. The registered manager/director told us they were taking action to upgrade the system so it could be heard. There was no risk assessment in place during the interim with control measures to ensure staff could respond to people's needs for support.

The registered manager used a dependency tool to support them in setting the staffing levels according to people's assessed needs. However, this did not take into account where staff were expected to undertake duties which impacted on their availability to provide direct personal care. For example, food preparation, cleaning and interacting with visitors and health professionals. In addition there was no consideration associated with the layout of the building. This was important as some people remained in their bedroom for long periods or cared for in bed. Risks around social isolation had not been considered. A visitor told us that staff, "Were always in the kitchen," preparing drinks and meals, which left no visible presence in the lounges. We were therefore not assured that there were sufficient numbers of staff available at all times to meet people's care and support needs.

The registered manager/director advised staffing levels had been reduced in the afternoon because people chose to go to bed at this time, and that there was a manger on site to provide support if required. When we arrived in the afternoon there were two staff on duty and people sitting in two of the lounges. A staff member told us if someone requested to go out it could not be a "spontaneous" action because it would only leave one carer. We also found reduction in staffing levels impacted on their ability to ensure people were supported by their preferred gender of staff.

A system to prevent the staff member who was administering medicines from becoming distracted had been introduced. They wore a 'do not disturb' tabard whilst completing this role. However, we saw this was not effective, as they were constantly interrupted to answer the mobile telephone they carried with them.

In February 2018 a local authority quality monitoring team identified improvements were still needed to ensure the service was following safe administration of medicines. This included completing records accurately, giving medicines as prescribed with robust auditing systems in place to ensure effective stock control and monitoring of staff practice.

The provider had submitted an action plan to advise us of how they would address the shortfalls by 15 April 2018. Some actions had been completed whilst others were still in progress. Therefore it was not possible to see that the action they had taken had been effective in improving this area.

Despite previous inspections and requirements to improve the registered manager/director has been unable to ensure improvements are being made, sustained and built on. This is because the leadership is not effective at monitoring, training and risk management to embed a culture of safety to mitigate people from the risk of harm.

This demonstrated an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 20014.

People continued to be put at potential risk of unsuitable staff being employed because the registered manager/director continued to not operate safe recruitment procedures. An audit carried out in January 2018 of the service's recruitment showed shortfalls in evidencing required paperwork to confirm staff's identify, qualifications, fitness to work with vulnerable people, and where applicable, valid work permits. Concerns had been raised previously with the registered manager/director over commencing staff without an enhanced Disclosure and Barring Service (DBS) check in place and/or an appropriate risk assessment including arrangements for supervision. Records showed a staff member starting work without a DBS in place and no risk assessment to demonstrate they were of good character. The registered manager/director had not learned from the previous concerns raised, or acted on advice given at that time.

This demonstrated a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Inadequate

Is the service well-led?

Our findings

Following our previous inspection, we informed the provider in writing and in face to face meetings of the seriousness of our concerns. We placed additional conditions on their registration requiring them to take urgent action to address the concerns and restricted further admissions.

During 2017 we met with the provider twice to discuss their plans to improve the service. First in May 2017 when it was rated Requires Improvement and then following further deterioration when it was rated as Inadequate following the November 2017 inspection. Despite plans to increase the management team and introduce a new quality monitoring tool we continued to receive information and contact from multiple sources which raised concerns that improvements were not being made or sustained. This included contact via our website, relatives, professionals and commissioners of care.

At this inspection we found the provider was still unable to demonstrate that they had effective oversight and governance. Improvements required from the previous inspections and attempts to force improvement through taking enforcement action had not been effective and the registered manager/director had not taken the opportunity to ensure a robust, workable and sustainable improvement plan was developed. The registered manager/director did not always demonstrate their knowledge and understanding of their responsibilities to ensure the service improved and blamed others for the failures and continued shortfalls. They could not demonstrate they were developing any track record of improvements, however small, to help build confidence in the service. Instead they continued to demonstrate an inability to effectively work with others, instigate systems, monitor, imitate risk and drive improvements despite the advice, guidance and support provided from multiple agencies. This included social care professionals, external professionals and appointed consultants. Therefore the overall quality and safety was not addressed and breaches continued. This included staffing, recruitment, training, governance and risk management which all link directly to a lack of effective leadership.

We found no clear agreements for delegation of duties and responsibilities. When delegating to others, the registered manager/director had not retained effective oversight to ensure staff and consultants knew what was expected of them. Staff told us about systems put in place by appointed consultants to improve practice, which were then removed or stopped by the registered manager/director because they, "Did not like it," or wanted to do something else.

The culture was not open and transparent. There was no clear set of values, aims and aspirations for the service which staff could follow or be a part of. Staff spoken with were not aware of the improvement plan and what their role was in it. They were not engaged in the process. They told us they had been told it was "their fault" the service was in special measures, and this had impacted on morale. Staff had not been empowered to be part of the solutions. There was no copy of the last report made available, conditions imposed, or action plan to demonstrate the work being undertaken and keep people updated on improvements and what was happening in the service. People using the service, staff, relatives and others had not been communicated with to ensure they were aware of the position. As a result the registered manager/director has failed to take basic action forward which demonstrates their ability and intention to

ensure those people living in the service have future stability are safe and receive the expected standard of care.

This demonstrated an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.