St Martins Care Home LTD

St Martins Care Home Ltd

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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Martin's Care Home is a residential care home providing personal care and accommodation to 15 people aged 65 and over at the time of the inspection. The service can support up to 15 people in one house and is situated in a residential area. Some people living at St Martin's Care Home were living with dementia and others had high dependency needs due to reduced mobility.

People's experience of using this service and what we found
People did not always feel there were enough staff working at St Martins Care Home Ltd. Staffing levels in the evening meant people were left unsupervised or supervised by visitors to the home whilst staff attended to other people's needs. Daily checks of the premises and oversight of the building's maintenance to ensure its safety were not routinely carried out, which exposed people to unnecessary risk. There were missed opportunities to interact and staffing levels meant care workers did not always have time to spend with people engaged in meaningful activity or conversation. Although staff could tell us how to respect people's dignity and privacy, care practices did not always support this.

Referrals to healthcare agencies to improve people's outcomes was inconsistent. People were referred to some health professionals including district nurses, their G.P, and speech and language therapists. However, the provider had not always referred people for assessments following declines in their mobility which meant them needing to be cared for in bed. There were not enough activities for people to help stimulate, engage and minimise isolation. Activities were not planned in partnership with people to make them responsive to people's enjoyment.

Systems to monitor and improve the safety and quality of the service were not effective. Tools were used to calculate staffing numbers, but lack of oversight meant staffing levels did not always safely meet the needs of people. Maintenance of the building and its safety was not monitored effectively which meant people were exposed to unnecessary risks. There was no system to safely store people's confidential information. Audits were carried out but not always recorded and failed to identify the issues discovered during the inspection.

People felt safe living at St Martins Care Home Ltd, and risks to people's health were assessed with risk management plans for staff to follow. Accidents and incidents were recorded and monitored by management to learn from them. Staff were confident reporting safeguarding concerns and contact information for reporting concerns was located on people's bedroom doors. Medicines were administered and stored safely.

Staff had access to online training relevant to their roles and some had completed vocational qualifications in health and social care. People were supported by regular care workers who knew them, because staff had worked at St Martins Care Home Ltd for a long time. People enjoyed the food and were given options and choices. Staff understood people's needs relating to their eating and drinking and provided appropriate

support and encouragement for those who needed it. Overall, 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. However, staff did not always respond to the needs of one person living with dementia in a positive way. This person liked to explore their environment but was sometimes told to sit down rather than being encouraged to interact or engage. However, people said staff were kind and caring and the atmosphere at St Martins Care Home Ltd was homely and friendly. There were friendly and warm interactions between staff and people.

Staff were fully engaged in a game of 'bingo' and supported people to take part. Internet access was installed throughout the home so people could maintain contact with others through social media or video calls. The internal decoration had been improved in response to feedback, but further improvement was needed to address the quality and maintenance of people's environment and make it more conducive to the needs of people living with dementia. Care plans were personalised and included guidance for staff to support people who experienced distress. Complaints were responded to promptly and in writing.

Staff described the registered manager as approachable and supportive and were confident sharing their concerns if they needed to. Meetings for people who used the service and annual questionnaires were used to encourage views and opinions. However, improvements were needed to promote and value people's engagement in these. The provider had plans to improve the garden and internal decoration.

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 17 January 2019) and there were two breaches of regulation. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made and the provider was no longer in breach of Regulation 12. However, enough improvement had not been made in relation to Regulation 17 and the provider remained in breach of this regulation.

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. The provider has taken some immediate action to mitigate the risks relating to staffing and introduced daily checks of the premises to ensure its safety. Gas and electrical inspections were also completed immediately following our inspection.

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

Enforcement

We have identified breaches in relation to safe staffing levels and their knowledge of fire safety and evacuation, and management systems which oversee the quality and safety of the service at this inspection.

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?

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 caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive 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 Care Home Ltd

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.

Inspection team
The inspection team consisted of one inspector.

Service and service type
St Martins Care Home Ltd 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced but we told the provider we would return the following day. Our return on the third day was also unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with six 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, care workers, activities coordinator and domestic cleaner.

We reviewed a range of records. This included three people's care plans, two people's medication records, daily notes, staff handovers, fluid, food and turn charts. A variety of records relating to the management of the service including falls risk analysis, audits and records relating to premises and environment were also viewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staff rotas and records relating to fire safety and maintenance.

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 requires improvement. At this inspection this key question has remained the same. 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.

Staffing and recruitment; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- At our last inspection, staffing levels were identified as an area of concern due to the high dependency needs of some people living at St Martins Care Home. At this inspection we found continued concerns about staffing levels.
- People, their relatives and staff told us there were not always enough staff. Sometimes only two members of staff were on shift which meant there were daily occasions where people were left unsupervised or supervised by visitors. Some of these people were living with dementia and experienced distressed behaviours.
- During the night two members of staff were on shift. One member of staff was 'waking' and the other member of staff was 'sleep in'. Staff spoken with told us the only way they could summon help in an emergency from the 'sleep in' staff member was to go to their bedroom and wake them.
- We spoke with two care workers in the evening who said they had not taken part in a fire drill or received fire training. The same two staff members did not know what equipment was available or where it was located to safely transfer one person downstairs in the event of an emergency.

We found systems to calculate staffing dependency levels were in place and being used. However, the provider could not demonstrate how this information was used to determine safe staffing levels. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. Evening staffing levels were increased to three until 10:00pm and the provider planned to carry out a review of the care needs of people over forthcoming weeks. Fire training and drills were planned to take place as a priority for all staff.

- Risks to people's physical health and safety were assessed with guidance for staff on how to manage them. This information was used to develop care plans for people.
- Accidents and incidents were recorded and analysed for trends, patterns and themes. The registered manager used this information to refer people to the falls prevention team and introduced additional safety measures.
- The provider used the 'Herbert Protocol'. This is a national scheme introduced by the police to provide key information about vulnerable people should they go missing.

Preventing and controlling infection

● Overall, the environment at St Martins was kept clean. However, there were some odours in a couple of bedrooms and in one shower room. One electrical item in a person's bedroom was dirty and dusty and there were old spillages on some skirting boards.
● The registered manager told us checks of skirting boards were included in domestic schedules and some skirting boards needed repainting due to staining.
● Staff could tell us what they did to prevent and control infection such as the use of personal protective equipment. Staff used this equipment when supporting people.

Using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people to provide care and treatment in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.
● A new medication management system had been introduced by the registered manager since our last inspection to improve care in this area.
● Medicines were ordered, stored and administered safely in line with legislation.
● Protocols gave guidance for staff responsible for administering 'as required' medicine. We looked at one protocol for a person who had minimal verbal communication and needed pain relief 'as required'. Guidance included how this person communicated pain and the severity of their expression could determine the dose required. Staff were guided to note whether the person's response had changed, to check their temperature and record any adverse reactions.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding information was located on people's bedroom doors. It promoted a 'zero tolerance' to any form of abuse and encouraged people to speak to the registered manager, CQC or the police.
● Staff spoken with could recognise different forms of abuse and were confident reporting concerns both internally to their manager, or externally if they needed to.
● The registered manager understood their responsibility to safeguard people from the risk of abuse and avoidable harm. Safeguarding referrals were made to the local authority and CQC were notified.

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 requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Access to healthcare services and support was inconsistent. Records lacked clarity regarding external referrals and assessments for people after their health declined, and the registered manager could not always identify whether referrals had been made in response to significant health changes.
- One relative spoken with said, "We were told [person] couldn't come out of their room because of agitation and there being no special pressure chair to use. We had to buy our own chair for [person] to come out of their room." Another relative said, "It worries me the time [person] spends alone in their bedroom. Last time [person] came out was last summer for their birthday."
- Staff monitored people's health for signs of change and used staff handovers to share key information. Records viewed showed people were referred to district nurses when changes to their skin were identified. However, the level of detail recorded was variable, and follow up information and outcomes were not always recorded.
- People's oral healthcare needs were assessed and included within care planning.
- The provider used the 'Red Bag' scheme which is a recognised NHS initiative of sharing information between care homes and hospitals.

Staff support: induction, training, skills and experience

- Staff had online training and some had completed vocational qualifications in health and social care. However, training data showed significant gaps in staff who had not completed mandatory training expected by the provider. Data for four staff members showed they had not completed any of the expected mandatory training.
- Staff received face to face training in manual handling and equipment including hoists .

Although training was available, the provider did not make sure there were sufficient numbers of suitably competent and skilled staff by ensuring they had completed mandatory training as was necessary to enable them to carry out their duties. This was a breach of regulation 18 (Staffing) 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

- People's needs were assessed prior to moving to St Martins Care Home Ltd. This was used to identify health conditions and the type and level of support people needed to keep them safe.
- Nationally recognised tools were used to assess needs and manage care. For example, the provider used

the Malnutrition Universal Screening Tool (MUST) for adults at risk of malnutrition to monitor people's BMI.

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

● People told us they enjoyed the food and were given a choice of what to eat and drink. Staff responded to people living with dementia who needed positive encouragement to eat and drink. For example, one person became slightly agitated during tea and was encouraged by two staff members to have some sandwiches and crisps to which they responded positively.

● People's nutritional needs were identified, and care plans contained guidance for staff on supporting people to eat and drink safely. Additional information was located on people's bedroom doors to alert staff to people at risk of choking and who required thickened fluids.

● Staff could tell us who needed help to eat and drink and staff supported people accordingly. Fluid and food charts were used for people identified as needing them. However, there were gaps in some of these records and information about what people had eaten lacked detail.

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

● The provider put in new carpets and flooring and the registered manager had plans to further improve the internal decoration.

● The provider had some signage to help orientate people particularly those living with dementia to their environment.

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.

● The registered manager made Deprivation of Liberty Safeguard applications for those who needed them. When people's care and support needs changed, the registered manager consulted with the authorising body to check whether new applications should be submitted.

● Mental capacity assessments were carried out for people identified as needing them. However, information about how decisions were reached was unclear and contradictory. We raised this with the registered manager who took immediate action to rectify it.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● Some staff did not recognise when people needed privacy. For example, two staff members interrupted a conversation we had with one person without checking if it was ok to disturb the conversation. This showed a lack of understanding of people's right to privacy.
● Confidential information was not stored securely in line with legislation.
● Some staff could tell us how they respected people's dignity. However, there were indiscreet interactions between staff in communal areas that did not protect people's dignity. For example, staff spoke openly in the lounge about going to support people with continence care and asked one person if they needed the toilet.

Ensuring people are well treated and supported; respecting equality and diversity
● People told us staff were kind and caring and there were some nice interactions between staff and people. However, there were also missed opportunities. For example, one person liked to explore their environment a lot but was frequently told to sit down. On the second day of inspection two staff members were in the lounge and used personal mobile phones and the provider's tablet on their own, rather than using this time to speak with people.
● Staff did not always have time to spend with people engaged in meaningful activity or conversation. One relative said, "If they had extra staff [person] could be taken out around the block. In the summer they didn't sit in the garden, but that's all staffing isn't it. [Person's] quite lucky they get us to take outside, but some people here don't." One care worker said, "[Person] often asks for someone to sit with them and I say I can't because we don't have time. I'll stay for five minutes for a chat."
● There was a homely and friendly atmosphere during mealtimes. Staff engaged positively with people and provided them with choices.
● Some staff recognised people as individuals and wanted to support people to the best of their ability. One care worker said, "Everyone is absolutely different, if they want to talk I just sit and listen." Another care worker said, "We are a caring home because everyone puts the service users first and cares for one another."
● The registered manager had an inclusive approach and accepted "people as people." An equality and diversity statement was located on the staff notice board, alongside information by the Alzheimer's Society on supporting people who identify as LGBTQ +.

Supporting people to express their views and be involved in making decisions about their care
● The provider worked with people and their families so care was assessed and planned in partnership with them. Requests for advocacy services were made for people who did not have family or friends to support

them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People and relatives told us there were few activities to keep people stimulated with things they enjoyed. One person said, "There aren't really any activities, not enough to keep me occupied." One relative said, "There isn't enough going on at times. This is the third or fourth time I've come, and they've done bingo."
- Planning for activities was not done in partnership with people. We asked the staff member responsible for activities in the home how they encouraged people to plan activities. They said, "I usually do it on my own – I know what I'm doing. Most people pick bingo."
- People who could not leave their rooms were allocated one hour a week for activities to avoid social isolation. Activities provided to them included hand or foot massages, crafts, or looking at videos using the tablet. However, one person unable to leave their room told us they wished they could, and staff told us they did not have time to sit and speak with this person despite them often asking.
- A game of bingo was played during the inspection. Staff were fully engaged with this and supported people to take part.
- There was not enough to keep people stimulated and the opportunities to those remaining in their rooms was minimal.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were personalised with guidance for staff on meeting people's needs. For example, care plans described people's preferences for how they liked their hair styled, clothing, food, drinks and going to bed.
- Staff spoken with said information in care plans was helpful and easy to follow. There was detailed guidance for one person living with dementia who experienced distress during caring interventions, so their needs could be met, in their best interests, whilst managing their anxiety. Staff spoke with sensitivity about this person, understood their needs and how to meet them.
- One person was supported to engage in activities associated with their past occupation as a nurse. This included filling out paperwork and taking their own blood pressure with automatic equipment.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were assessed and included within care planning.
- The registered manager told us they could arrange for information to be available in different formats for

people who needed it. One staff member translated for a person whose first language was not English.

Improving care quality in response to complaints or concerns

● Some improvements to the internal decoration were made by the provider and further work was planned in this area in response to feedback.

● The provider had a system for responding to complaints. Records showed complaints were responded to promptly and in writing.

End of life care and support

● Conversations about end of life care and wishes took place with people and their relatives as part of general care planning. The registered manager was sensitive to people's situations and recognised the importance of timing these conversations carefully.

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 requires improvement. At this inspection this key question has remained the same. 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

At our last inspection the provider's systems and processes had failed to robustly assess, monitor and improve the quality and safety of the services and assess, monitor and mitigate the risks relating to the health, safety and welfare of service user and others. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- Processes to monitor safe staffing levels and their deployment had failed. This was due to poor governance and oversight.
- Systems to monitor maintenance and safety of the building had failed. The provider had not acted on some of the recommendations made by the fire authority when they inspected in 2019. Inspection of mains electrical installation had lapsed for two years past their recommended due date. Gas safety inspection had also been allowed to expire. The rear of the property was left unlocked which exposed people to unnecessary risk.
- Quality assurance systems of the premises was not effective. Placemats used were stained and there was rubbish in the garden. Mobility equipment and spare headboards were stored in bathrooms and toilets which were not in use. Staff did not know where certain mobility equipment, needed for use in an emergency, was located.
- Confidential information was not stored securely. Care plans and daily records were stored on open shelving and cupboards in an unlocked office. Staff were not aware of any keys to lock the office as part of daily checks.
- Audits were carried out randomly to quality assure medicine management and monthly for care plans. However, records of medication audits were not kept, and care plan audits had not identified the issues found at inspection. For example, mental capacity act assessments lacked clarity, fluid, food and turning charts were not recorded consistently, and details of referrals and assessments for people following a decline in their health could not be found.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all the actions from the fire risk assessment were now completed, fire re- training and drills would take place as a priority, and electrical and gas inspections were completed. Staffing levels were increased immediately to three at all times during the day and use of equipment to evacuate people in an emergency would be included within fire and drill training.

● The provider had a business continuity plan used in the event of an emergency which could disrupt the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems to engage and involve people who used the service required improvement. People were not encouraged to plan activities to make them responsive to people's enjoyment.
● Relatives' meetings were not promoted enough which meant a significant lack of engagement in these forums.
● Annual questionnaires were used to gather people's views on the quality of service provided.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and staff said St Martins Care Home Ltd provided a homely atmosphere.
● Staff spoken with said the registered manager was supportive and approachable.

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 registered manager understood their responsibility to tell CQC of important events and incidents.
● The registered manager had an open an honest approach and informed us of current complaints being responded to at the time of inspection.

Working in partnership with others
● The provider planned to develop a joint policy for sharing information with the local G.P service to improve partnership working.
● The provider used specialists in speech and language therapy and tissue viability to improve outcomes for people.

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 18 HSCA RA Regulations 2014 Staffing People who use services and others were not protected against the risks associated with staffing levels and knowledge. Regulation 18 (1) (2) (a) Staffing of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 People who use services and others were not protected against the risks associated with staffing levels and inadequate governance systems to monitor and improve the safety and quality of services Regulation 17 (1) (2) (a - b) Good Governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Section 29 Warning Notice