Saroia Staffing Services Ltd

St Mary's Nursing Home

Inspection report

101 Thorne Road
Doncaster
South Yorkshire
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Date of inspection visit:
14 August 2019

Date of publication:
10 October 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Mary's Nursing Home provides accommodation for up to 56 people. The home consists of two separate units, one providing accommodation and personal care and the other providing nursing care. Some people receiving support at the home were living with dementia. The home is in Doncaster near to the town centre. At the time of our inspection there were 44 people using the service.

People's experience of using this service and what we found
Medication systems were in place however, these were not always followed. Risks associated with people's care and support had been identified, however, from records and observations staff were not supporting people following the assessments. Therefore, risks were not managed safely. Staff understood safeguarding and whistleblowing procedures and would use them when required. However, we identified safeguarding concerns had not be reported appropriately. We completed a tour of the home with the registered manager and found many areas in need of a deep clean and the home was not always well maintained.

People's needs were assessed, but care was not always delivered in line with their preferences and choices. Care records we looked at did not record all food and fluid intake. People who were losing weight or at risk of weight loss did not have snack, supper and some meals recorded. People had access to healthcare professionals. People who lacked capacity to make decisions were supported to make decisions in the persons best interest.

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.

When staff engaged with people they were mostly kind and caring. However, we observed some staff did not engage when providing support and were task focused. From care plans we looked at it was not possible to see if people were involved in their care planning. Staff we spoke with understood people's needs however, did not always follow care plans to ensure they respected their choices. Care and support provided and observed was not person-centred.

Care plans were not person centred and lacked information about people's preferences and choices. The care plans we saw did not contain advise from health care professionals to ensure people's needs were met. On the day of our inspection we saw no activities taking place and staff told us the activity co-ordinator was very often needed to cover care shifts. People told us they were bored. End of life care plans were very sparse and did not contain people's preferences. People had assisted technology that they couldn't use due to poor internet connection.

Care was not always planned in a way that promoted people's independence. People who used the service did not have much opportunity to express their views. The provider had a range of audits in place to monitor

the service delivery however these were not effective.

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 requires improvement (published 26 September 2018). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

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

Enforcement
We have identified breaches in relation to safe care and treatment, person centred care, staffing, safeguarding and leadership and oversight at this inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. Since our inspection we have been provided with a detailed action plan form the provider who is addressing the issues we identified at inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our effective findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our effective findings below.

Requires Improvement

Is the service well-led?

The service was not well led.

Details are in our effective findings below.

Inadequate

St Mary's Nursing 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.

Inspection team
The inspection was carried out by two inspectors and an expert by experience.

Service and service type
St Mary's Nursing Home is a 'care home.' People in care homes 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 had a manager who was 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.

What we did before the inspection
Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We asked the provider to complete a provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the PIR as part of our planning. We also spoke with other professionals supporting people at the service, to gain further information about the service.

During the inspection

We spoke with seven people who used the service and three of their relatives. We spent time observing staff interacting with people. We spoke with eight staff including, the nurse, care workers, senior care workers, the cook, the laundry staff, the registered manager. We looked at documentation relating to five people who used the service and information relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We asked the registered manager and provider to send us further information in relation to actions they were going to take to address our concerns. We also contacted the fire service and the Local Authority in relation to infection control issues and safeguarding concerns.

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 requires improvement. At this inspection this key question had deteriorated to inadequate.

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

● We spoke with people who used the service and their relatives, and they told us they didn't always feel safe living at the home. One person said, "I sit in the sitting room all day because the call buzzer doesn't work in my room." Another person said, "No I'm not safe the lino on the floor is torn and has a big hole in it and I could trip."

● Risks associated with people's care and support had been identified. However, we found these were not followed, putting people at risk of harm. For example, people who used the hoist to be moved had detailed assessments in place completed by the occupational therapist, these were in the nurse's office not detailed in the electronic care plan, and we observed staff did not followed the correct procedure to move people safely.

● Staff we spoke with could tell us about the risks associated with people's care. However, the documentation staff completed lacked detail and was not reviewed to assess if risks were managed. For example, people who were at risk of poor nutritional intake and weight loss had food charts in place for staff to document what people had eaten. These were not always completed and were not reviewed. One person also should have been weighed monthly but had not been weighed since June 2019 and in the previous five months had lost four kilograms. This was over 5% of their body weight.

● We saw a lack of monitoring of dietary intake. For example, one person required support to ensure they received the correct nutrition and food and fluid should have been recorded. However, we saw many occasions where meals and drinks were not recorded, and it was therefore difficult to establish if people had received an appropriate diet which met their needs.

● We completed a tour of the home with the registered manager and found fire doors had been wedged open with items of furniture, such as coffee tables and chairs. Due to the nature of these concerns we raised these issues with South Yorkshire Fire and Rescue who conducted an onsite visit to ensure the home was safe.

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

● At our last inspection we found concerns in relation to medicine management. These included lack of detail in relation to medicines prescribed on an 'as and when' required basis, known as PRN, no account of the medicines in stock and issues regarding the temperature of the medicine store rooms. This was a breach

of regulation 12 (Safe Care and Treatment) 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.

● Medication systems and procedures were in place. However, we identified some issues and staff were not always following the procedures to ensure people's safety. For example, stock sheets had been introduced following our last inspection, these were not in place for all medicines and there were no carried over amounts on the medication administration record (MAR), so it was not possible to determine how many were in stock to evidence medicines were given as prescribed.

● People did not always receive their medicines as prescribed. For example, one person was prescribed aspirin to be given daily this was in a box and not in the blister pack. We found 28 had been dispensed at the start of the cycle, the cycle was at day 24 and yet 18 were left so only 10 had been given. Therefore on 14 days no aspirin had been given as prescribed.

● Protocols were in place when people were prescribed medicines to be given as and when required. However, the protocols lacked detail to guide staff. For example, they did not detail how people presented when they were in pain and many people were living with dementia and were not able to vocalise when they were in pain. Staff were also not recording if the medicine when given had been effective so were unable to review effectively.

● There was risk of cross infection from the medicine pots, staff were washing single use pots in the wash hand basin in the medicine room. The pots were not designed for multiple use and the wash process was not effective. The wash basin was stained and dirty and the seal around the basin was engrained with black dirt.

● The stock checks introduced had not been completed since June and the errors we identified had not been picked up as part of the audit process.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe systems were not in place to manage medicines.

Staffing and recruitment

● It was not evident from observations and talking with staff if adequate staff were on duty to meet people's needs. Staff we spoke with told us they were short staffed and were covering shifts. They told us they struggled to meet people's needs in a timely way with the amount of staff on duty. One staff member said, "We have been telling the manager for ages we need more staff." Staff also told us the activity coordinator was always supporting people with care rather than activities. One staff member said, "There are never any activities as the activity person is always pulled onto care, if they didn't we wouldn't cope at all." All staff we spoke with said they felt there was not enough staff.

● We spoke with people who used the service and their relatives, and they told us there were not enough staff. One person said, "They don't have enough staff, so we have to wait a long time for the buzzer to be answered."

● Following our inspection, we asked the provider to clarify how staffing numbers were calculated based on people's dependency and if the layout of the building was taken in to consideration. We did not receive this information in the timeframe requested.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were not always protected by the risk and spread of infection. We completed a tour of the home in part with the manager and found some areas were not able to be kept clean. For example, the sluice rooms

were in need of a deep clean and items such as bed pans and urinals were worn and stained and required replacing.
● The provider had identified the need to replace floor coverings in bedrooms as they were damaged and split and not able to be kept clean.
● Linen store rooms had items of bedding and other objects stored on the floor.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always ensure that people were protected from the risk and spread of infection.

Learning lessons when things go wrong
● Accident forms were in place to record accidents and incidents. The registered manager had completed a section on the form in response to actions taken following the incident.
●There was no record of trends and patterns and how incidents could be used as lessons learned to minimise future events occurring of a similar nature. However, we saw that following a medication error, staff competencies were undertaken to minimise the risk.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems in place to safeguard people from the risk of abuse. Staff told us they completed training in this subject and knew what actions to take if they needed to.
● The registered manager kept a record of incidents reported to the safeguarding authority. We saw four incidents had been reported to the safeguarding authority, but only two of them had been reported to the Care Quality Commission.
● Following our inspection, we raised four safeguarding concerns with the safeguarding authority. The provider had failed to recognise these safeguarding concerns.

This was a breach of regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question had deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were assessed but care and support was not always person-centred or delivered in line with people's choices and preferences. Staff told us they were always rushed as not enough staff and was difficult to deliver person-centred care.

Staff support: induction, training, skills and experience.
- Staff we spoke with told us they received training and support to carry out their role.
- Following our inspection, we asked for a copy of the training record to be sent to us, but we did not receive this.

Supporting people to eat and drink enough to maintain a balanced diet
- We looked at care records in relation to dietary requirements. We found people were not always supported to maintain a healthy balanced diet which met their needs.
- We spoke with people about the quality of meals they received. One person said, "The food is ok, nothing special." Another person said, "We have nothing to eat after 5pm, just a cup of tea at 7pm or 8pm if we are up." Another person said, "They run out of food often and then you have to have what's left. They ran out of porridge, so I had nothing, I can only eat porridge."

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 health care professionals when required.
- We looked at care plans and saw that when healthcare advice had been given, however, this was not always followed.

Adapting service, design, decoration to meet people's needs
- The service was not appropriately decorated or designed to meet people's needs.
- There was a lack of signage to help people navigate around the home and bedroom doors were blank which did not assist people in locating their bedroom.
- The décor was bland and there was a lack of pictures which would have assisted in brightening the walls.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 provider was working within the principles of the MCA and DoLS applications had been made, some of which were awaiting authorisation.
- Where decisions had been made on behalf of people, they had been completed in the person's best interests and documented within their care plan.

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 good. At this inspection this key question had deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- We spent time observing staff interacting with people who used the service. We found staff were mainly task orientated.
- Staff were task focused and provided an institutional environment for people. For example, people were taken to the lounge and left sat in a queue waiting for staff to get the hoist and then move people into chairs, This was not individualised care and support. Staff interacted with people when they needed to complete a task, there was no friendly banter exchanged between them.
- Staff also struggled to meet the needs of people who presented with behaviours that could challenge. This affected other people and one person became very upset. The registered manager intervened, however, people told us this happened every day and nothing had been put in place to support the person.

Supporting people to express their views and be involved in making decisions about their care

- Care plan documentation did not reflect that people had been involved in creating and updating them.
- We spoke with people who used the service and their relatives. One relative said, "It's very basic and needs lots of improving and more staff. Caring? not really." One person said, "I have a kidney infection and they don't come quickly so I have to wear a pad."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity were maintained. We saw staff knocked on bedroom doors before entering and kept bathroom and toilet doors closed when carrying our personal care.
- The service ensured they maintained their responsibilities in line with the General Data Protection Regulation (GDPR). GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals. Records were electronic and stored safely which maintained people's confidentiality.

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 good. At this inspection this key question had deteriorated to requires improvement.

This meant people's needs were not always met.

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

- People did not always receive person-centred care which met their needs and preferences.
- The care records were kept on an electronic system, but we found they did not contain enough detail to ensure care was delivered in a consistent way and in line with people's choices and preferences.
- One person we spoke with told us, "I can't sleep at night because a woman screams all the time that's why I sleep in the chair in the lounge in the day." This was not the person choice and showed that support had not been offered to either party to resolve the situation.
- Another person told us, "I don't like a lot of noise, so they sit me on my own in this sitting room and I can look out of the window. There isn't much else to do."
- The provider employed an activity co-ordinator, but they were currently covering a support worker role due to staff shortages. No meaningful activities took place during our inspection.
- Staff we spoke with told us that people sometimes visit the local garden centre and entertainers have visited the home.
- People we spoke with told us there was not much to do. One person said, "Nothing to do, we have bingo on Friday, that's all." Another person said, "There is nothing to do so my family bring me books to read."
- People's diverse needs were not always met in all areas of their support. Therefore, protected characteristics under the Equalities Act 2010 such as age, culture, religion and disability, were not always recorded or taken into consideration.

End of life care and support

- At the time of our inspection people were at the end of their lives, the care plans were in place however, lacked detail did not evidence people's preferences, choices or decisions.
- We spoke with the registered manager and they told us there were currently 13 people at the home receiving end of life care. The registered manager told us they would look at the care plans for these people in more depth to ensure their needs and preferences were included.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

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.

● We saw information was available in the entrance area of the home. This was information about how to complain, the last CQC inspection report and dates of future meetings.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure in place. This was displayed in the entrance of the home.

● We saw the registered manager kept a record of concerns and what action had been taken.

● People we spoke with and their relatives told us they didn't feel listened to. One relative said, "We made a complaint but got no response."

Inadequate

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. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems in place to monitor the service were not always effective. At this inspection we found the audits were still not effective and this key question 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
• There was a lack of monitoring of daily care records to ensure people received support from appropriate staff in line with their assessed needs and risks.
• The dependency tool, used to assess the number of staff required, had been ineffective in ensuring there were enough staff available to provide support.
• Records were not always accurate and had not been updated to reflect a change in people's needs. For example; one person's care plan stated that they were not to eat bread, yet the food and fluid charts seen reflected that sandwiches and toast had been given.

Working in partnership with others; Continuous learning and improving care
• The service worked with other professionals such as health care workers. The provider ensured that appropriate support was obtained as required. However, guidance obtained was not always followed.
• There continued to be a lack of effective governance systems in place to monitor the service and mitigate risks to people. For example; medicine audits had not identified the concerns raised at the inspection.
• The audit in place for infection control had scored 97% and had not identified the concerns we had in relation to the risk and spread of infection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 did not promote a person-centred culture that ensured people achieved good outcomes. People were at risk of receiving poor care because the risks to their safety and wellbeing were not mitigated to protect them from harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Feedback gained from people had not been acted on to inform service delivery and to rectify the service. Quality surveys completed were kept in a file but not analysed.

We asked people if they attended meetings to discuss the service they received and to be involved in service improvements. One person said, "We don't have meetings." Another person said, "No residents meetings, I've never been to one. I have never had a questionnaire. I'm never asked my opinion."

The above evidence shows a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person-centred care which met their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not always refer safeguarding concerns to the appropriate bodies.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing It was not evident from observations and talking with staff if adequate staff were on duty to meet people's needs.

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
Treatment of disease, disorder or injury	Risks associated with people's care and support had been identified. However, we found these were not followed putting people at risk of harm. People's medicines were not always managed safely. It was not evident from observations and talking with staff if adequate staff were on duty to meet people's needs. People were not always protected from the risk and spread of infection.

The enforcement action we took:

Issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems in place to monitor the service were not effective. There was a lack of governance and oversight.

The enforcement action we took:

Issued a warning notice