

Mr Richard Marchant

St Anne's Residential Care Home

Inspection report

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Tel: 01752263263

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14 January 2021

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Ratings

Overall rating for this service	Inspected but not rated
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Is the service safe?	Inspected but not rated
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Summary of findings

Overall summary

St Anne's Residential Care Home hereafter referred to as 'St Anne's', is registered to provide accommodation and personal care for up to 23 older people. At the time of our inspection, 18 people were living at the service.

We were not fully assured that Infection Prevention and Control (IPC) practice was safe and the service was compliant with IPC measures.

The arrangements in place for the donning and doffing of personal protective equipment (PPE) for staff entering and leaving the service, were not sufficiently robust to reduce the risk of transmission and or control/prevent the spread of infection.

Personal protective equipment (PPE) was readily available, however, staff were not always wearing PPE safely and in line with current guidance. We observed, staff were not changing their gloves between tasks or interactions with people living at the service.

Whilst individual risk assessments had been completed for most staff working at the service, risk assessments had not been completed for all newly recruited staff.

It was not evident from our observations that staff were supporting or encouraging people to socially distance or that seating arrangements in the lounge or dining room enabled people to socially distance, in line with Public Health England's current Covid 19 guidelines. We have made a recommendation in relation to this.

We found the following examples of good practice.

Systems were in place to help manage the risks and prevent the spread of COVID-19.

Visitors to the service had been restricted. There was a clear system in place for visitors to ensure they followed the current guidance on the use of personal protective equipment (PPE) and social distancing.

Staff provided instructions on arrival at the service to ensure visitors understood the infection prevention and control protocols they needed to follow to keep people safe.

There were sufficient stocks of PPE available.

People and staff took part in regular COVID-19 "whole home" testing.

Cleaning schedules and procedures had been enhanced to include more frequent cleaning of touch points such as handrails and light switches.

We were not fully assured this service met good infection prevention and control guidelines.

Further information is in the detailed findings below.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach in relation to Infection Prevention Control. 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 continue to monitor information we receive about the service until we 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?

Inspected but not rated

Further information is in the detailed findings below.

St Anne's 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.

As part of CQC's response to the coronavirus pandemic we are looking at the preparedness of care homes in relation to infection prevention and control. This was a targeted inspection looking at the infection control and prevention measures the provider has in place.

This inspection took place on 14 January 2021 and was unannounced.

Is the service safe?

Our findings

S5□ How well are people protected by the prevention and control of infection?

- We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. The registered manager described the services infection control procedure and donning and doffing arrangements for staff entering and leaving the building and people's bedrooms. We found staff were not always following these procedures as described.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. For example, the arrangements in place for the donning and doffing of personal protective equipment (PPE) for staff entering and leaving the service, were not sufficiently robust to reduce the risk of transmission and or control/prevent the spread of infection. The service's designated area for donning/doffing PPE for staff entering or leaving the service was located in the basement of the property and accessed via the laundry. The donning and doffing area did not contain any personal protective equipment, was poorly lit, cluttered, and was also being used by staff as an area in which to take their breaks.
- We were not assured that the current arrangements for the disposal of used PPE was sufficient to prevent the spread of infection and/or cross-contamination. A clinical waste bin was not specifically provided within the basement donning/doffing area to dispose of used PPE safely.
- We were not assured that staff were using PPE effectively and safely as the arrangements in place to mitigate and reduce the risk of transmission within the service were not sufficiently robust to control and prevent the spread of infection. For example, throughout the inspection we observed all staff members wearing gloves. When asked the registered managers told us this was to mitigate the risks associated with transmission and/or cross contamination. However, we found the wearing of gloves may have provided a false sense of security as we did not observe staff changing their gloves between tasks or interactions with people living at the service. Although we found hand gel/sanitiser was available throughout the service we did not observe staff actively washing or sanitising their hands between care tasks and/or close contact with people living at the service or each other.
- We could not be fully assured that the provider had fully assessed risks in relation to staff who might be at higher risk or identify which staff might be in a clinically vulnerable group because of their individual health needs and/or their ethnicity. Whilst individual risk assessments had been completed for most staff working at the service, risk assessments had not been completed for all.

Whilst we found no evidence that people had been harmed, the provider had failed to ensure that risks relating to the management of infection prevention and control were being effectively managed and this placed people at increased risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were not fully assured that the provider was meeting shielding and social distancing rules. It was not evident from our observations that staff were supporting or encouraging people to socially distance. Seating arrangements in communal areas, including the lounge and dining room did not enable people to socially distance and maintain the minimum distance from each other when sitting down, in line with Public Health

England's current Covid 19 guidelines (Covid 19: How to work safely in care homes.gov.uk).

We recommend the provider undertakes a review to ensure they are meeting best practice guidance in relation to social distancing.

- We were assured that the provider was preventing visitors from catching and spreading infections. There was a clear system in place for visitors to ensure they followed the current guidance on the use of personal protective equipment (PPE) and social distancing. Visitors to the service were asked to wear PPE, have their temperature checked and wash their hands before they were allowed to enter the main part of the building.
- We were assured that the provider was admitting people safely to the service. People were tested before admission and only admitted if negative to COVID-19. People were then isolated for 14 days in line with government guidelines.
- We were assured that the provider was accessing testing for people using the service and staff. The registered manager had arranged for the regular testing of staff and people living at the service
- We were assured that the provider's infection prevention and control policy was up to date. The provider had in place an infection prevention and control policy which contained Covid 19 specific policies and risk assessments relating to all aspects of service delivery. The provider had also developed a 'Winter plan' for the service looking at the impact of staffing, recruitment and supplies as well as consideration to the services flu vaccination programme and how this would be rolled out.

We have also signposted the provider to resources to develop their approach.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that risks relating to the management of infection prevention and control were being effectively managed and this placed people at increased risk of harm. Regulation 12, (1)(2)(a)(b)(h)

The enforcement action we took:

On the 18th January 2021, the Care Quality Commission served a warning notice under Section 29 of the Health and Social Care Act 2008 for failing to comply with Regulation 12, (1)(2)(a)(b)(h), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to become compliant with Regulation 12, section (1)(2)(a)(b)(h), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 25 January 2021.