County Healthcare Limited

St Mary's Care Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
St Mary's Care Home is a residential care home providing personal care for up to 44 older people living with dementia. At the time of our inspection, 27 people were using the service. The home is purpose built and all accommodation is on one floor.

People's experience of using this service and what we found
We found the provider had made improvements in most areas of the service we looked at during this inspection however the provider is still in breach of regulations and continued improvement is required.

Whilst the service had reported safeguarding incidents to the local authority and understood the associated policies and procedures, they had not reported these, and other notifiable safety incidents, to the Care Quality Commission (CQC) as required by law. This is a continued breach.

Following our last inspection in August 2020, we requested an urgent action plan from the provider detailing what action the provider would be taking and by when to improve the service people received. These actions were followed up at this inspection and whilst the provider's action plan had driven improvements in most areas we looked at, some actions had not been completed as stated and/or within the timeframes given.

Assessments of risk to people who had drug allergies and sensitivities had not been completed as stated in the provider's action plan. This was of concern given that an incident had previously occurred within the service where a person who used the service had been given a medicine they were allergic to. Some improvements had been made to the management of medicines however concerns remained

We saw improvements in infection prevention and control (IPC) systems although further embedding and development was required. We saw that government guidance was being followed. However, staff did not always adhere to social distancing which increased the risk to people. Additionally, the service had failed to consider that actions may be needed to reduce the risks associated with COVID-19 in those people who used the service, and staff, who were disproportionally at risk of the virus.

Governance systems were in place to drive improvement although some of these had been sporadic in completion and had not fully identified issues. The completion of care documentation had improved but further improvements was required.

The people who used the service, their relatives and staff all told us kind care was being delivered and that improvements had been made since our last inspection, particularly around communication.

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 inadequate (report published 14 September 2020) and there were multiple breaches of regulation. The provider was also issued with a letter of intent to take urgent action due to concerns found. The provider completed a service improvement plan to show what they would do and by when to improve; we have followed this up at this inspection.

At this inspection although improvements were found, enough had not been made and the provider was still in breach of regulations. The provider needs to continue to make improvements regarding medicines and risk management, infection prevention and control, governance and ensuring procedures are in place to report notifiable safety incidents to CQC.

Why we inspected
We undertook this targeted inspection to check on specific concerns we had about managing risk, reporting safety incidents to CQC and to assess the actions the provider told us they would take following our last inspection in August 2020. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

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

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 breaches in relation to risk management, governance and reporting safety incidents to CQC.

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 meet with the provider, and request an action plan, following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 overall rating for this service is 'Inadequate' and the service therefore remains 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.

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

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

St Mary's Care Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection on specific concerns we had about managing risk, reporting safety incidents to the Care Quality Commission and to assess the actions the provider told us they would take following our last inspection in August 2020.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of four inspectors. One worked remotely from their desk, coordinating and leading the inspection whilst two inspectors visited the home on 12 November 2020. A further site visit was completed by a medicine's inspector on 16 November 2020.

Service and service type
St Mary's Care Home 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 did not have a manager registered with the Care Quality Commission. This means that the provider alone is legally responsible for how the service is run and for the quality and safety of the care provided. There was, however, a covering manager in place and they will be referred to as 'the manager' throughout this report.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was to ascertain any health and safety information regarding COVID-19.

What we did before inspection
We reviewed information we had received about the service including the service improvement plan the

provider submitted following our last inspection in August 2020; this told us what actions the provider planned to make, and in what timeframe, to make improvements to the service. We also sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service and seven relatives about their experience of the care provided. We spoke with twelve members of staff including the regional manager, regional support manager who is currently overseeing the day to day management of the service, deputy manager, administrator, two agency nurses, one senior care assistant, four care assistants and the head housekeeper.

We reviewed a range of records. This included four people's care records relating to risk management. The medicines administration records for 19 service users were also viewed. We looked at records relating to infections prevention and control and governance systems.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inspected but not rated

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 inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check how risks to service users were managed including risks associated with medicines administration and infection prevention and control. We also assessed how lessons had been learned. We will assess all the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

- The individual COVID-19 infection risks to people who used the service, and staff, had not been assessed and managed; consideration had not been given to those who may be disproportionately at risk of COVID-19 and actions that may be required to reduce that risk and keep people safe.
- Following our last inspection in August 2020 where we identified an incident where a person was administered a medicine they were allergic to, the provider told us they would assess the risks to people with drug allergies; this had not been completed. We also found that some care records contained conflicting information regarding people's allergies which could lead to error.
- We continued to find some environmental issues that could pose a risk to people living in the home. We found one uncovered radiator which put people at risk of burns and scalds. Additionally, bottles of handwash were accessible risking possible ingestion by those people living with dementia.

This is a continued breach to Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Whilst we observed no harm to people as a result, records did not fully demonstrate that people had received the care they needed as planned.
- At our last inspection, we had concerns about the service meeting people's nutritional needs. At this inspection we saw that people were putting on weight and receiving the care they required to maintain their health and wellbeing. However, improvements were required in the completion of associated records such as monitoring charts for food and fluid intake.
- We saw that people had received input from healthcare professionals as required to promote health, safety and wellbeing.
- Since our last inspection the provider had assessed the risks associated with fire. However, this assessment had demonstrated that further action was required to fully mitigate the risks which the provider was actioning.

Using medicines safely

- The service had failed to administer medicines as prescribed to a person who used the service on their discharge from hospital. This could have led to serious harm to the person and placed their health and

welfare at risk.
● We found that for medicines prescribed for topical application such as for creams and emollients there were frequent gaps in their records that were unexplained.
● Written information was still not always available to staff to enable them to give medicines prescribed to people on an 'as required' basis consistently and appropriately. In addition, some of the written information available lacked enough person-centred detail and records for the reasons for their use had not always been documented.
● Details about people's known medicine sensitivities/allergies were sometimes written inconsistently in their records which could have led to confusion and errors.
● Records showed that when medicated patches were applied to a person's body, they were not always applied to different areas in rotation to avoid the possibility of adverse skin-contact effects.
● For people who lacked mental capacity and who would otherwise refuse their medicines, best interest decisions had been made to give them their medicines concealed in food or drink (covertly), however, for one person their records showed they had sometimes since refused their medicines and staff had not given them in line with the best interest decision. For another person recently prescribed a new medicine, records did not confirm that professional advice had been taken about how that medicine should be administered covertly.

This is a continued breach to Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found that regular checks of medicines were carried out by staff and that some improvements had been made, for example, people now received their medicines because they were obtained in time. Records showed that oral medicines were given as prescribed.

Preventing and controlling infection
● The service had made improvements in infection prevention and control however further improvements were needed. Since our last inspection, the provider's infection prevention and control policy had been updated.
● The home was visibly clean with no malodours and the service told us they were completing regular deep cleans of the environment. Whilst our observations confirmed this, the service's cleaning records could not demonstrate that all areas of the home had been thoroughly cleaned.
● We saw that staff had access to personal protective equipment (PPE) and were using it in line with government guidance. However, staff were seen not to be consistently adhering to social distancing guidance which put people at increased risk of COVID-19.
● Not all staff had received training in infection prevention and control and only a small number of staff had received training in COVID-19. However, staff told us COVID-19 and infection prevention and control practices and policies were regularly discussed in flash meetings and handovers. Discussions with staff also demonstrated they were aware of associated government guidance.
● Relatives told us communication regarding COVID-19 had improved since our last inspection and that government guidance was being followed when they visited the home. They told us they had been made aware of the provider's visiting policy and that they had received more regular updates from the service and provider.
● Screening procedures were in place for all visitors to help mitigate the risks of COVID-19 and our inspection team saw these were adhered to.
● Regular testing was in place for all staff and service users in line with government guidance which helped mitigate the risk of COVID-19.
● Safe admission processes were in place and we saw that the service used cohorting to further reduce risk.

This meant people who used the service were placed in smaller groups to reduce the amount of contact they had with others.

Learning lessons when things go wrong

● We identified improvements in all areas of the service we looked at during this inspection although further improvements, development and embedding was required. However, some actions the provider told us they would take to make improvements had not been completed.

● The staff and relatives we spoke with confirmed the service had made improvements since our inspection in August 2020. One staff member said, "We have more personal protective equipment now, we have more housekeepers to make the home clean, the way we are doing things has changed and I feel we work better as a team now and we support each other more."

Systems and processes to safeguard people from the risk of abuse

● The people who used the service told us they felt safe living in the home. One person said, "There isn't any staff that I wouldn't feel safe with. They do their best and they are kind." Another person told us, "Staff are lovely."

● Since our last inspection in August 2020, the service had correctly identified potential incidents of abuse and referred these to the local authority safeguarding team for investigation and to provide support to help keep people safe.

● Most staff had received training in safeguarding and, through discussion, demonstrated they were aware of the types and symptoms of potential abuse and how to report concerns both within their organisation and externally.

● Staff told us they had more confidence that, should they raise concerns of a safeguarding nature, these would be managed appropriately by the management team.

● Relatives also confirmed that communication had improved since our last inspection and that they had been informed of safety incidents relating to their family members.

Inspected but not rated

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 inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check the effectiveness of the quality monitoring systems the provider had in place to drive improvements and their ability to report safety incidents to CQC. We also assessed whether the actions the provider told us they would take following our last inspection in August 2020 had been completed and had assisted in driving improvements. We will assess all the key question at the next comprehensive inspection of the service.

Continuous learning and improving care

● Following our last inspection in August 2020, the provider sent us a service improvement plan (SIP) that told us what actions they would be taking, and in what timeframe, to help drive improvement within the service. We assessed these actions at this inspection.

● Whilst we found the provider had made improvements to the service, further development was still required, and we found that not all the actions they told us they would make had been completed.

● Staff had not received supervisions as detailed in the provider's SIP nor observational competency checks to ensure they were performing as trained and required.

● Not all staff had been trained in infection prevention and control or COVID-19. The SIP indicated that human resources processes would be followed to ensure staff training compliance however these had not been implemented.

● Regular infection prevention and control audits were being completed and whilst these had driven improvements, they had failed to be fully effective at identifying and rectifying issues, particularly regarding COVID-19.

This is a continued breach to Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● We continued to find safety incidents that the provider had failed to report to CQC as required by law. These related to the health, safety and wellbeing of those people that used the service.

This is a continued breach to Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● There was no manager in place that was registered with CQC as required by the provider's registration. However, the provider was actively recruiting for a manager and one of the regional support managers was

overseeing the day to day management of the service (referred to as the manager in this report).

● Since our last inspection in August 2020, a new regional manager had been appointed who had good oversight of the service and the improvements required. They demonstrated a willingness to engage with the inspection team and were cooperative and communicative throughout the inspection which provided us with some assurance.

● Staffing had been increased since our last inspection and this had had a positive impact on the service delivered. The relatives we spoke with told us kind care was being given by staff who knew people well and understood their roles. One relative said, "We have confidence in the staff, they are doing an amazing job with [person who uses the service]."

● The people who used the service agreed with one telling us, "I feel safe with all the staff." Another said, "They are good to me and staff are lovely."

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 manager understood their responsibilities under the duty of candour requirement and told us it required them to be open and transparent in how they worked.

● All the relatives we spoke with told us they had been made aware of health, wellbeing and safety incidents involving their loved ones. They told us communication had improved. One relative said, "I feel [person who uses the service] is safe. They have had a few falls in the past, but they inform me and let me know if she is okay."

● Relatives told us the service had been open about our last inspection in August 2020 and that they had been made aware of the report and the concerns identified.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18(1) of the CQC 9Registration) Regulations 2009 The provider had failed to notify CQC of safety incidents. This prevented CQC from performing their regulatory role.

The enforcement action we took:

Notice of Proposal to impose a condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(a)(b)(d)(g) and (h) of the HSCA The provider had failed to fully assess the risks to people's health and safety and administer medicines appropriately.

The enforcement action we took:

Notice of Proposal to impose a condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1)(2)(a)(b)(c) and (f) of the HSCA The provider had failed to have systems and process in place to ensure they were able to comply with their regulatory requirements.

The enforcement action we took:

Notice of Proposal to impose a condition on the provider's registration