St Marks Care Home Limited

St Marks Residential Care Home

Inspection report

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21 June 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Marks is a residential care home providing accommodation and personal care for up to 17 people aged 65 and over, in one adapted building. There were 15 people living in the service at the time of the inspection, who were vulnerable due to their age and frailty, including varying levels of dementia related needs.

People's experience of using this service and what we found
We found the provider had not made sufficient and sustained improvement which means the service has deteriorated to a rating of inadequate. We continue to have concerns about the providers inconsistent governance and leadership resulting in the inability to achieve a rating of good. The providers approach continues to be reactive and not pro-active to driving improvement.

There continued to be a lack of recognition and understanding of risk, and lack of robust assessments and controls in place to protect people and keep them safe. We had concerns regarding infection control and fire safety and we are addressing this separately.

We continued to have concerns about the skills, experience and knowledge of staff. While they had received some element of training in dementia care, not all staff demonstrated an understanding of dementia and how this affected people in their day to day lives. Learning and development was not effectively managed to ensure staff had the right knowledge and skills to carry out their roles and provide the right care and support.

There were no clear plans of care and best practice approaches to supporting people with anxieties or rehabilitation needs. People were not provided with regular access to meaningful activities and stimulation, appropriate to their needs, to protect them from social isolation, and promote their wellbeing.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests.

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 6 December 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained and there was a continued breach of regulations. The service is again inadequate.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-

led which contain those requirements.

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 COVID-19 and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Marks Residential 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 Regulation 9,12, 13, 17 and 18 at this inspection. 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 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.

Special Measures
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 of 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? The service was not safe	**Inadequate**
Is the service well-led? The service was not well led	**Inadequate**

St Marks Residential Care 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.

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 was carried out by one inspector.

Service and service type
St Marks residential 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.

There was a registered manager in post who was also the sole director of the company which owned the service. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Notice of Inspection
This inspection was unannounced. The inspection activity started on 24 May 2021 and finished on 21 June

2021. We visited the service on 24 and 27 May 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used this information to plan our inspection.

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.

During the inspection-
We spoke with three people who used the service. We spoke with six members of staff including the provider/registered manager, senior care worker, care workers and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and medicine records. We looked at one staff file in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with six relatives and one professional who regularly visited the service.

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 has remained the same. This meant some aspects of the service were not always safe. There was limited assurance about safety and therefore an increased risk that people could be harmed.

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

At our last inspection we found the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The front door fire exit is kept locked and requires a key to open it. On the first day of our inspection we waited seven minutes for the door to be unlocked because staff were unable to locate the key to unlock it. This would impact on staff to open the door quickly in the event of a fire and was highlighted in our inspection of February 2018.
- The last fire risk assessment carried out by an independent and appropriately qualified person was in 2016. There was no evidence to demonstrate anyone with the appropriate competency had re-assessed the risk of fire at this service since 2016.
- Personal emergency evacuation plans (PEEPS) were in place for each individual but were not regularly reviewed and revised to reflect a current and accurate account of the persons needs. For example, a PEEP for one person said they could evacuate independently. This was no longer the case since their mobility needs had deteriorated.
- At our last inspection we found the provider had not identified associated risks and put control measures in place in relation to external contractors working in the home. This still remained the case, and lessons had not been learned. Prior to this inspection a person, at risk if out in the community unsupported, went out unnoticed through the front door which had been left open by a contractor.
- A person with limited and unsteady mobility had difficulty managing a rollator walking frame, a self closing fire door and a ramp between their bedroom corridor and communal areas. We observed them to topple off the side of the ramp each time whilst trying to slow the door closure with their elbows and holding on to the rollator. The provider was aware of the situation. A risk assessment in relation to this situation did not provide any active measures to reduce the risk of injury or harm.
- Two people who were cared for in bed, should have been regularly repositioned to prevent pressure ulcers, they were unable to move themselves and were at high risk of skin damage. Their repositioning records did not demonstrate that either person had been repositioned regularly and there was no system in place to oversee and ensure appropriate care was being delivered.

●The provider was unable to demonstrate how they identified any trends and themes in incidents and accidents across the service and where improvements were needed in order to minimise risks of similar incidents happening again.

Preventing and controlling infection

● The provider did not have a contingency plan in place to ensure effective management of COVID-19 infection in the event of an outbreak. There was no planned and written guidance for staff to know how to immediately instigate full infection control measures to care for people with symptoms and minimise the spread of infection.

● A corrugated galvanised shed was used as the laundry facility. The wall surfaces and wooden shelving were not designed to minimise risk of decontamination, they were not permeable and did not allow for effective cleaning. The flooring and sink was also dirty and unhygienic. Fluff from the tumble dryers had accumulated on electrical wiring, plugs and sockets, not only a risk to cross infection but a fire hazard.

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

● The provider had some preventative measures in place to help prevent the catching and spreading of COVID-19 infection. There were plenty of personal protective equipment (PPE) and this was being used effectively and safely.

● Arrangements were in place for relatives to visit safely which included testing facilities and screening, a booking system to stagger visiting and minimise visitor numbers.

Staffing and recruitment

● Although staff felt there were sufficient numbers of staff to meet people's needs, staff continued to work long hours. Most working at least one 13 hour shift a week, which could impact on their ability to provide safe care. There were three staff on duty throughout the day and two at night.

● Staff were not deployed sufficiently to ensure people were supported to promote their wellbeing. There was an absence of inclusive activity throughout the day after 11:30 when the activity person finished. People begun to walk around searching, trying to get out, becoming agitated and emotionally distressed.

● There were not enough staff to enable and support people to go out for a walk.

● A relative told us staff, although kind, did not have the skills to meet their family members care and support needs. Their rehabilitation needs were not being supported and subsequently their health and wellbeing had deteriorated and not improved since admission.

● Staff did not demonstrate understanding or competence in how to effectively communicate, interact, engage with or support people living with dementia in a meaningful way.

● One staff member said, "Dementia care here needs to improve. Our training on line is very good and easy for everyone to understand but we need more."

● The provider had followed safe recruitment practices for the most recent staff member recruited. All required documentation was in place.

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

At our last inspection we found the provider had failed to have effective systems in place to safeguard people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper 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 of regulation 13

Systems and processes to safeguard people from the risk of abuse
● We received mixed feedback from people's relatives about whether they felt their loved ones received safe, quality care at St Marks.
● Staff had a limited understanding of dementia and did not recognise poor practice. Not all staff were able to tell us how they could support people to reduce their anxieties. They did not have the personalised information needed to intervene effectively through de-escalation techniques or other agreed good practice approaches.
● Where there were de-escalation strategies recorded they were clearly inappropriate.
● The provider failed to successfully investigate safeguarding concerns and effectively document their investigation actions and improvements as a result of a safeguarding concern. When we requested the investigation report for the most recently notified safeguarding incident the provider told us they were awaiting the outcome of the local authority investigation. There was no system in place to learn from incidents and protect people from reoccurrence.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safeguarding people was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made some improvement to systems and practices related to the safe management of people's monies, but further improvement was needed. A policy and procedure was now in place but it failed to include arrangements for any additional charges and the process for which they would be managed in an open and transparent way. There was a clear audit trail of expenditure with running total of accounts and correct corresponding receipts.

Using medicines safely
● People received their medicines as prescribed.
● There were systems in place to help ensure medicines were managed safely, to detect errors and take prompt action if any errors were found.
● Staff were trained and competent to administer medicines safely and medicine administration records were completed correctly.

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. At this inspection this key question has now deteriorated to inadequate. The leadership, governance and culture in place does not support or assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred , open, inclusive and empowering, which achieves good outcomes for people

- Governance and performance management were not reliable or effective. Actions taken by the provider were reactive with only short-term solutions to our previous inspection findings. The provider did not have a long term development plan as a means to plan for and drive improvement.
- Quality assurance arrangements failed to identify where improvements were needed. A quality monitoring audit was introduced and undertaken in May 2021. The audit failed to identify concerns we found at this inspection. This included checks on the laundry which did not identify infection control risk and actions needed to mitigate the risk.
- Bedroom checks had been introduced in response to our previous inspection. They were carried out by a staff member who demonstrated very little understanding of what they were actually checking for and why. Issues in relation to health, safety and dignity were not identified.
- The fire risk assessment of 2016 found the fire alarm system did not conform to the most recent edition of British Standard 5839 Pt 1 which states that premises such as care homes should have an intelligent addressable fire alarm system that gives a clear indication of where a fire has occurred. A recommendation was given to plan to upgrade the fire alarm system in long term planning. This had not been done.
- The provider was failing to demonstrate that the staff employed, who were responsible for the care and welfare of people had access to accurate and relevant information they required, were competent in terms of their skills, or that they fully understood their roles and responsibilities.
- The culture of the service was not focused on improving for the benefit of those living there and the management and staff did not have a clear vision of the service they were providing. None of the staff spoken with were able to tell us what the aims and values of the service were.
- The service provides care and support for people at various stages of dementia. There was no plan about how the service kept up to date with best practice and developments in dementia care. Our previous inspections as far back as 2017 have highlighted the service was not responsive to the needs of people related to dementia. This inspection found no improvement had been made.
- A more effective learning and development plan was needed to enable staff to develop the skills and expertise needed to carry out their roles effectively. In particular dementia, communication skills, person centred care, diversity and engaging with people in purposeful activity.

There continues to be a failure to recognise and identify significant failings impacting on the quality and

safety of service provision and a continued lack of consistency in how well the service is managed and led. This is a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was still no system in place to ensure care plans, risk assessments and summary profiles were fully reviewed and revised to reflect current and accurate information. A summary profile for one person did not reflect that their health had deteriorated to the end stage of their life nor did it provide a plan of care tailored to their needs on how to keep them comfortable at that time.
● Information continued to not always be accessible to staff. This did not demonstrate a personalised approach to care. The person or the those primarily caring for them were not involved in the planning of their care
● The provider had failed to identify care was not delivered in a person centred way and had not explored reasons for this. The provider therefore, could not demonstrate people were receiving the right care for their assessed needs. Nor were they able to demonstrate the quality of care or how they responded to changes of need.
● We were told one person did not have a plan of care because the service did not know how long they were staying for. They had already been there for two months. Their summary profile showed little understanding of their complex and diverse needs. A staff member told us how they relieved this person's anxiety but this was not documented to enable a consistent approach.

The provider had failed to ensure people received a service that was person centred. This is a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Insufficient attention was given to appropriately engaging with and involving people who had dementia. Questionnaires were completed on their behalf by the staff which did not give an accurate reflection of their experiences and views to inform an improvement plan.
● Staff were not actively involved in the improvement and development of the service. Staff said they were aware of the CQCs inspection report but knew nothing about an improvement plan in place.
● The provider has worked previously with the local authority to improve care provision, but improvement has not been sustained.
● The provider has worked with external consultants for service development and improvement but their relationships broke down and improvement has not been sustained.

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 understood their responsibilities under duty of candour and relatives told us they were very open and told them when things had gone wrong.
● Notifications had been sent to us to inform us about incidents and accidents that had occurred.