Private Medicare Limited

St Marys Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Mary's Nursing Home is a residential care home providing nursing and personal care to up to 48 people aged 65 and over, younger adults and people with a physical disability. The service was supporting 32 people at the time of the inspection.

People's experience of using this service and what we found
The provider had failed to ensure the ongoing maintenance of the environment which put people at increased risk of infection.

The provider had systems in place for oversight and monitoring the safety and quality of the service which under the new management had mostly resulted in improvements. The new manager and new deputy manager were aware of further improvements that were required to be made. They were open and honest and committed to making positive changes.

People' care plans required review to ensure they were up to date and reflected people's risk accurately. Not all care plans were up to date, followed by staff or reviewed regularly. The manager had identified this as an area for improvement and along with the deputy manager, had started reviewing these.

Staffing levels had started to improve in the service. Recruitment of new staff had been a priority for the new manager which would provide better consistency in care for people. People and relatives felt more activities were needed, and a new activities worker had started employment on the day of the inspection.

People and their relatives told us they felt safe. People were supported to remain safe. Staff knew how to report allegations and concerns of abuse and understood their roles clearly and what was expected of them. People's medicines were managed safely. Safe recruitment and selection processes were in place.

People and relatives were getting to know the new manager. They felt they were approachable and would address any concerns they may have.

People were supported to have maximum choice and control of their lives and staff supported in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on Care Quality Commission's (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 25 November 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and standards of care. A decision was made for us to inspect and examine those risks. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

Enforcement
We have identified a breach in relation to the environment not keeping people safe from the risk of infection, at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

St Marys 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.

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
One inspector and a specialist advisor carried out this inspection, and an Expert by Experience made telephone calls to people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for three months and had applied to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the manager, deputy manager, a senior care worker, nurse, laundry assistant, head chef, 3 care assistants and an activities coordinator. We received email feedback from another care assistant. We spoke with 2 people who used the service about their experience of the care provided. We spoke with 10 relatives via telephone. We reviewed a range of records. This included 4 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service were reviewed. 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.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating for this key question has changed to requires improvement. 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.

Preventing and controlling infection

● The provider had not maintained the building to allow effective cleaning. The provider was in the process of building a new home for people, within the grounds. They had not planned to address worn fixtures and fittings and dirty carpets. This put people at risk of the spread of infection.

Failure to maintain minimum standards to allow effective cleaning placed people at risk of harm. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured by the practices of the staff to help prevent the spread of infection. Staff wore and had access to appropriate PPE. The manager was aware of up to date guidance and took advice from local teams in relation to infection outbreaks.

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

● Care planning was not always clear and consistent in identifying risk and guiding staff on how to reduce that risk. The management team had already identified that all care plans required review and regular monitoring moving forward. The manager assured us that care plans we identified concerns in, would be reviewed and updated as a priority.

● Personal emergency evacuation plans were available and detailed the level of support each person would require in the event of an emergency evacuation

● The equipment used in the service had regular checks, and these were recorded.

● Accidents and incidents were analysed by the provider to look for themes and trends. Learning had been captured and actions taken.

Staffing and recruitment

● There were enough staff available to support people's needs. Staffing had been an issue prior to the inspection and the service had recruited a number of new staff. Staff were undertaking inductions and shadowing to reduce the pressure on the current staff team.

● Staff did not always have detailed knowledge of people's needs. This was due to staff being new to the service. A relative told us, "A lot of experienced staff who had a good rapport with residents left. There was a loss of close caring relationships between relatives and staff which has not yet been replaced fully by new staff, the majority of whom have not yet established long-term relationships with the residents". New staff were caring and enthusiastic to learn and understand their new roles.

● Recent recruitment included care workers, domestics, kitchen assistants and an activities worker. Relatives told us, "There has been no activity co-ordinator for 18 months; life for [Name of person] is very

boring" and "I am not happy with the cleanliness and cleaning regime, which is inconsistent and selective in the areas of room cleaned." The manager was confident with the recruitment of new staff, these areas would be improved.
● Safe recruitment and selection processes were followed. Staff files contained all the necessary pre-employment checks which showed only fit and proper applicants were offered roles.

Systems and processes to safeguard people from the risk of abuse; Using medicines safely
● The provider had effective safeguarding systems in place.
● People and their relatives felt the service was safe.
● People received their medicines as prescribed. Medicines were safely received, stored, administered and returned to pharmacy when they were no longer required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating for this key question has changed to 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; Continuous learning and improving care

- Whilst managers had identified shortfalls in the maintenance of the environment, the provider had not taken proactive action to address this whilst people continued to reside in the home. Action plans reflected that the provider was relying on the new home being built, instead of carrying out required maintenance.
- The new manager and deputy manager had not been in post long, however, they had already identified areas for improvement and were positively taking action to try and embed new ways of working. The manager gave assurance that staffing levels would continue to be monitored closely, along with quality of care provided to people.
- There were systems in place to provide oversight of the running of the service and drive forward improvements. With the exception of the environment, action plans were in place and monitored.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The new manager engaged with people receiving care, their relatives and staff. One person said, "I see management about, I would go to them with a problem and they would do their best to sort it out."
- Relative's recognised that things were improving under the new management team. One relative told us, "There were instant improvements with the new manager and her assistant; in meetings she is approachable, listening and responsive".
- The service regularly worked in partnership with other health and social care professionals to ensure people received ongoing support to meet their needs.
- Checks to ensure people were now feeling safe and happy with the service had been introduced and more were scheduled. A relative said, "Meetings with family members are now taking place and there is consultation on care plans."

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 new management team recognised that a positive culture within the service was needed and were making changes to ensure this was achieved. They were focusing on providing more support to staff in their roles.
- Staff told us they felt the new management team were trying their best to make improvements and

support them. One staff member told us, "I believe management are trying their best in running the home and supporting me. It's been a big change with staff leaving, new staff in and under new management. The team morale is very low, but I do have hope. Our manager wants a fantastic care home to be proud of."

● The manager understood their responsibility in relation to duty of candour and when to inform CQC of incidents which occurred within the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the environment was maintained to ensure people were safe from risk of infection. Regulation 12(1)(2)(h)