

Private Medicare Limited

# St Marys Care Centre

## Inspection report

Beverley Road  
Anlaby  
Hull  
Humberside  
HU10 7BQ

Tel: 01482307592

Website: [www.burlingtoncare.com](http://www.burlingtoncare.com)

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Requires Improvement** 

Is the service caring?

**Requires Improvement** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

### About the service

St Marys Care Centre is a residential care home providing personal and nursing care up to 60 people. The service providers support to older people, some of whom may be living with dementia or a physical disability. The premises are on one ground floor level split into two areas; residential and nursing. At the time of the inspection, there were 47 people using the service.

### People's experience of using this service and what we found

The service had recently had a change in management, including a new manager and clinical lead. The manager had started to make changes to the service, but these were not yet embedded.

There was a lack of consistency in how well the service was managed and led. Systems in place were ineffective at identifying risk. The provider had failed to ensure effective infection and prevention control measures were in place.

We received mixed feedback about the quality and quantity of food provided. We fed back people's experiences regarding the quality and quantity of food to the provider. They told us they were confident people's dietary needs were being met. We have made a recommendation about this.

People were not always supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. We have made a recommendation about this.

Staff training, appraisals and supervision had not been kept updated. The service continually reviewed their staffing levels and had recently increased these. However, people told us that they felt the service was short staffed. People felt rushed and did not feel their care was person centred.

Complaints had not always been dealt with in line with the provider's policy. Relatives found raising concerns difficult. We made a recommendation for the provider in relation to complaints.

Medicines were managed safely.

Staff were kind and caring but did not always promote people's dignity and privacy.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

The last rating for this service was good (published 13 February 2021).

At our last inspection we recommended that the provider sought advice and reviewed their practice in relation to IPC practice. We made a second recommendation in relation to governance and oversight of the service.

At this inspection we found that these recommendations had not been actioned sufficiently.

#### Why we inspected

The inspection was prompted in part due to concerns received about medicines management. A decision was made for us to inspect and examine those risks.

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.

#### Enforcement and Recommendations

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 monitor the service and will take further action if needed.

We have identified breaches in relation to the management of risk, person centred care, governance and oversight at this inspection. Please see the action we have told the provider to take at the end of this report.

#### 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 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?**

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### **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 caring findings below.

**Requires Improvement** ●

### **Is the service responsive?**

The service was not always responsive.

Details are in our responsive findings below.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Details are in our well-Led findings below.

**Requires Improvement** ●

# St Marys Care Centre

## 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 Health and Social Care Act 2008.

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 completed by two inspectors and an Expert by Experience. 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 Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Mary's Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. A manager was in post and had started the process to be registered with the CQC.

#### Notice of inspection

This inspection was unannounced.

### 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 safeguarding team and quality assurance team.

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 nine people who use the service, and 12 relatives about the experience of care provided. We spoke to 11 staff including kitchen staff, domestic staff, care assistants and the management team.

We reviewed six care plans and various records relating to the health and safety of the building. We reviewed four staff files looking at their recruitment, supervision and training. We reviewed the provider's policies and procedures.

We sought advice and shared our findings from the inspection with the local Infection Control Team.

# 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 has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. This means there was an increased risk that people could be harmed.

### Preventing and controlling infection

At our last inspection, we recommended the provider reviews their Infection Prevention and Control (IPC) policies and audits to bring them in line with current guidance. We found the provider had not made the required improvements.

- People were at increased risk of infection as IPC processes were not consistently being followed by staff. At the time of our inspection, the service had an outbreak of COVID-19.
- Staff were not wearing or disposing of their Personal Protective Equipment (PPE) correctly. One staff member was observed not wearing a mask during the inspection and others were observed wearing masks under their noses.
- Practice regarding self-isolation was not always robust and consistent.
- Advice from the local authority infection control team had not been acted upon to reduce the risk of spreading infection. For example, advice regarding social distancing during staff breaks and the use of visors.

The provider had failed to ensure effective infection and prevention control measures were in place. 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 took immediate action to address the issues raised.

### Assessing risk, safety monitoring and management

- People's risk assessments and care plans did not guide staff to mitigate risks effectively.
- Care plans gave contradicting information as to how a person is best cared for and this increased the risk to people. For example, one person's care plan gave different examples of how frequently they needed support changing position to reduce risk of skin breakdown.
- Information regarding people's dietary needs had not been effectively communicated to the kitchen staff. This meant people were at increased risk of malnutrition and dehydration.
- We found health risks such as choking, or diabetes were not effectively monitored or mitigated.
- One relative told us, "[Name] is left alone eating and the table can be left too far away, meaning no thought is given or safety thought of when looking after [Name]."
- Environmental risks to people had not always been considered. We found two external doors were left open to allow staff from a neighbouring home to have access to their laundry facilities. There had not been

any consideration to the risk this may pose to people entering or leaving the building. We fed this back to the provider on the first day of inspection, who took immediate action. However, changes were not fully implemented and embedded before the inspection was concluded.

Individual risks to people had not been effectively identified or mitigated. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People we spoke with told us they were not satisfied with the quality of care, but they felt safe.
- The provider was keen to respond and act on our findings during the inspection.

#### Using medicines safely

- People received their medicines as prescribed. However, medication administration records for topical medicines and body maps were not always in place we brought this to the attention of the supporting manager who began actioning this during the inspection.
- Medicines were stored securely, and appropriate checks were in place. The medicines room was clean, tidy and well organised.
- Medicines training and competency records were in place and up to date.
- Although the provider had a near miss and medication incidents process, we found this was not in place at the home; the supporting manager stated this would be taken forward and actioned so learning from incidents could take place.

#### Staffing and recruitment

- Recruitment checks were carried out when people were first employed. However, Disclosure and Barring Service (DBS) checks to ensure people remained of good character were not always carried out or renewed after a significant amount of time. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- The provider had a staff dependency tool in place to calculate the staff numbers required to run the service safely. The service had recently made changes to their staffing levels and increased the number of staff working during the day.
- We observed there was enough staff to meet people's needs. However, people we spoke with felt staff were rushed.
- Relatives we spoke with consistently told us they felt staff appeared stressed. One relative told us, "Sometimes [relative] has to wait too long for help and that is when I am there, so I hate to think what it is like when I am not there." We fed this back to the provider so they could consider people's experiences.

#### Systems and processes to safeguard people from the risk of abuse

- The service had systems and processes in place to safeguard people from abuse. Staff had knowledge of how to identify abuse and how to report it.
- Incidents and accidents had been notified to the local authority safeguarding team in accordance with the provider's policy. The provider had completed adequate investigations to allegations of abuse.

#### Learning lessons when things go wrong

- The service had responded to incidents appropriately. Clinical staff were provided with refresher knowledge sessions after an incident had occurred.



# 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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff inductions had been completed. Two staff we spoke with said they did not feel their induction was thorough.
- Staff training files did not reflect mandatory training was kept up to date. Records showed less than a quarter of the staff had completed mandatory emergency first aid training.
- Staff supervisions were not completed as set out in the provider's policy. Staff supervision had started to be implemented before the inspection; most staff had received supervision in March 2022 after not receiving it for over 12 months.
- We received mixed feedback about the support staff received. We fed this back to the provider who confirmed they were working proactively with the staff team to increase staff morale.

Supporting people to eat and drink enough to maintain a balanced diet

- We were not assured people's nutrition and hydration needs were being met effectively.
- Information regarding people's dietary requirements and preferences had not always been communicated with the staff responsible for preparing people's food.
- People with specific dietary requirements such as diabetes, were not always provided with alternatives. Staff told us people with specialised needs often had two of the same meals a day due to a lack of variation and choice.
- We received mixed feedback about the quality and quantity of food provided. Relatives we spoke with had consistent feedback regarding meals; one relative said, "The food quality has gone downhill and there is a lack of fresh veg just white cabbage which does not look appetising".
- We fed back people's experiences regarding the quality and quantity of food to the provider. They told us they were confident people's dietary needs were being met.

We recommend the provider reviews mealtime experiences to ensure people are consistently happy that their dietary needs are met.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The service had clear systems and processes for referring people to external services. However, three relatives we spoke with did not always feel referrals had always been made in a timely manner. We fed back relative's concerns to the provider so they could review this.
- The service monitored people's health, care and support needs but did not consistently act on issues

identified. For example, one person had received advice from a dietitian, but we could not be fully assured that this guidance was implemented in a timely manner.

- People were supported to access health care. The service had a weekly visit by the local practice nurse.
- Nurses' shifts allowed for a one-hour crossover time to ensure for a clear handover. Staff said this was a helpful way of learning information about people's needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments of people's needs were not always clear enough for staff to provide care effectively.
- People did not always receive care in line with standards.

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

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 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff we spoke with were able to demonstrate a good knowledge of the mental capacity act and how it is used in their practice.
- Staff gained consent from people and care plans instructed staff to seek consent.
- Mental capacity assessments and best interest decisions were in place for some decisions but not all. For example, one person had a capacity assessment which was not time and decision specific and did not follow best practice.
- Some people had been identified as requiring a DoLS but the home had not yet completed the referral to the local authority meaning people who could not consent to their care did not have safeguards in place.

We recommend the provider reviews their DoLS application process to ensure referrals are identified and completed in a timely manner.

Adapting service, design, decoration to meet people's needs

- The service was clean and well maintained.
- People had access to outside spaces, quiet areas and an area suitable for activities or to see visitors.
- People had been able to personalise their rooms, for example putting photos up.

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

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

- People and their relatives were not always involved in decisions about care.
- People were not fully supported to express their views. One person we spoke with told us that the "Resident's meetings" were great for people who could access them but did not include people who were cared for in bed or struggled to hear well.
- Relatives consistently provided feedback that they did not feel involved in their relative's care. One relative told us, "I would like to be more involved with [their] care and we have never been shown a care plan and are never asked for any information or input."
- The provider had stopped regular relative meetings due to the pandemic. Some relatives felt communication could be improved further.
- We fed this back to the provider who told us they were in the process of changing their care planning system and would be involving residents and relatives once their systems were fully implemented.

Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity and respect. We observed staff entering people's rooms without knocking or asking for permission. When people were having private conversations in their rooms, staff would interrupt these.
- Relatives consistently felt that their relative was not always treated in a dignified way. One relative told us, "If I arrive unannounced, [relative] looks dishevelled and is in a mess".
- People were not always supported to maintain family relationships. People told us they did not always feel matters relating to COVID were communicated to them. Relatives told us that communication regarding visiting was poor. This impacted people's choice around visiting.

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

- People told us they had their basic needs met and were safe, but staff lacked in time to be attentive and meaningful.
- One person said, "Staff are really lovely, there is just not always enough of them sometimes - sometimes they are a bit stressed because they are short staffed and sometimes, they have to use agency staff."
- Relatives consistently told us they felt the staff were kind and caring. However, relatives commented staff were "tired", "frazzled" and "rushed".
- People told us the regular staff knew their preferences and how they would like to be cared for.
- The service had received compliments regarding the care workers manner and caring nature.

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question outstanding. At this inspection the rating has 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 have choice and control in all aspects of their care. For example, people with a specialised diet did not consistently have a choice of meal.
- Care plans were generic and not personalised to reflect people's individual needs. Care plans did not contain people's likes and dislikes. One care plan instructed staff to follow the person's preferences but did not outline what these were. This did not support agency staff or new staff.
- Where care plans had been developed for specific medical conditions these contained generic information taken from a database and were not tailored to the person.
- People we spoke with felt they did not receive personalised care due to staff being too busy and rushed.
- Relatives we spoke to consistently commented on their concerns regarding staffing. One relative told us, "It is not person centred at all".

This was a breach of regulation 9 Person Centred Care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Complaints were not effectively managed.
- The complaints log had not been kept up to date and did not reflect all complaints received. We were informed of complaints relatives had made without a response.
- People we spoke to did not feel comfortable to raise a concern or had not had positive experiences when raising concerns.
- Relatives consistently had poor feedback in relation to raising complaints or concerns. Relatives told us they felt "fobbed off" and ignored.
- One relative told us, "on the whole, making a complaint or communicating has all been very difficult." Another said "They were made to feel like a problem" for raising their concerns.

We recommend the provider reviews their complaints policy and process.

- Following the inspection, the provider told us there was an open-door policy and welcomed any feedback from people relatives.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have

to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were reflected in their care plans, so staff understood what support people needed. However, we found this was not always translated into practice. Relatives told us that their family members were not always able to communicate with them because their hearing aids were either missing or broken.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The service had two activity co-ordinators employed who were responsible for activities throughout the week which included weekly activities such as armchair exercises, bowling and bingo.
- During periods of lockdown, where people had to isolate in their rooms, the service had facilitated events which could be completed in isolation such as "cheese and wine nights" and "pamper sessions".
- Not all people who lived at the home were happy with the content of activities provided. We fed this back to the provider who told us that no one had raised any concerns with them about the range of activities at the home but would explore this further. They told us that activities within the home had been affected due to the recent outbreak in the home.

End of life care and support

- People's care plans recorded their preferences in relation to the last stages of their life and how they would like to be cared for.
- The service made referrals to the local specialist nurses to support with palliative care.
- Staff had received training in relation to end of life care.

# 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 requires improvement. The rating for this key question has remained the same. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection, we recommended the provider reviewed their auditing and oversight processes to ensure they remain compliant with all regulations. At this inspection, we found this had not been actioned appropriately.

- The governance systems were in effective at identifying and addressing the areas we identified at this inspection. This left people at risk of harm. Various risks to individuals and the environment had not been identified or mitigated appropriately.
- There was a lack of oversight within the service. For example, staff training, supervisions and appraisals had not been kept up to date. People had not had DoLS applied for when identified and care plans were not always an accurate and consistent reflection of people's needs.
- Records were not thorough enough to give assurances that people's needs were being met appropriately. Care records showed people were left for up to 9 hours without their positional changes; this had not been identified.
- People's risk assessments were not updated following incidents. We found one risk assessment in relation to falls had not been updated or reviewed following multiple falls. This meant staff did not have the most current and accurate information to suitably care for the person.
- The medicines audit process within the home was not robust, individual unit audits and monthly manager's audits were not completed on a regular basis. For the audits that were completed there was a lack of clarity on the outcome of the audit and no clear action plan was recorded as part of the audit paperwork.

This was a breach of regulation 17 Good Governance, 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

- The service did not ask for feedback or engage with relatives or professionals. One relative said, "we have not been asked for our views and not had a questionnaire or survey."
- Staff did not always feel valued and listened to. Staff had mixed feedback regarding the new manager.

- Relatives consistently told us communication was poor. One relative had tried to initiate regular meetings with the service, but this had not been accommodated.
- The manager told us there was an open-door policy, however this did not reflect the feedback we received from staff and relatives. One person said, "the manager is nowhere to be seen and it is impossible to communicate with her."

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

- It is a condition of registration the service must have a registered manager. At the time of the inspection, the manager had been in post less than 3 months and had recently started the process to be registered.
- Relatives did not feel the provider was open or honest with them. One relative said they had "An overwhelming feeling, when asking for help they are being obstructive."
- The service had notified the CQC of any incidents and events as required.

Continuous learning and improving care

- The provider had recently invested in an electronic recording system. Staff were optimistic this would support them in their role. One staff member told us, "The new computer system is really good, and we have access to everything at the touch of a button."
- Quality assurance systems were not robust and did not always identify current and potential concerns. There was not an action plan in place at the time of the inspection.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider was in breach of Regulation 9 (1) (a) (b) (c) (3) (a) (b) (c) (i) person centred care. People did not have access to choice regarding aspects of their care and treatment.
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	The provider was in breach of Regulation 12 (2) (a) (b) (c) (d) (h) safe care and treatment.  The provider had failed to ensure effective infection and prevention control measures were in place.  Individual risks to people had not been effectively identified or mitigated. This placed people at risk of harm.
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	The provider was in breach of Regulation 17 (1) (2) (a) (b) (c) (d) (e) good governance.  Systems had not been established to monitor and improve the safety and quality of people's care. There was a lack of oversight and governance.



