

Jasmine Healthcare Limited

# St Andrew's Nursing and Care 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 Andrew's Nursing and Care Home is situated in Ewerby near Sleaford, providing accommodation for people who require residential and nursing care. The service can support up to 45 older and younger adults, some of whom may experience memory loss. There were 33 people living in the service at the time of inspection.

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

There were quality assurance processes in place. However, audits continued to be ineffective and had not identified shortfalls in the service.

People's care records were not always accurate or effective in order to give staff guidance on how to meet the nutritional needs of people.

People were not always 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; the policies and systems in the service did not support this practice.

Systems and processes around safe recruitment needed improvement. Checks had not consistently been carried out in respect of some staff's right to work in the UK. The provider had not always assured themselves of gaps in employment and had not always ensured references were sought from staff's last employer when staff were recruited by a recruitment agency.

Medicines management at the service had improved. There was guidance for staff to follow on how to safely administer "As and when medicines." However, the service would benefit from improvements in the recording of medicated creams.

There had been an inconsistency in management at the service since the last inspection. Managers at the service have been interim, with no registered manager since August 2021.

Staff had received training in order to recognise how to protect people from abuse. People and their families told us they felt safe at the service.

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 and update

The last rating for this service was requires improvement (published 09 August 2021) and there were breaches of regulation 12 and 17. CQC issued the provider with a warning notice in relation to Regulation 17 (Good governance).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulation 17 (Good governance.)

#### Why we inspected

We carried out an unannounced focused inspection of this service on 27 May 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

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.

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 remains requires improvement. 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 Andrew's Nursing and Care Home on our website at [www.cqc.org.uk](http://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 monitor the service and will take further action if needed.

We have identified breaches in relation to the safety of people's care and good governance at the service.

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 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 well-led?**

The service was not always well-led.

Details are in our well-Led findings below.

**Requires Improvement** ●

# St Andrew's Nursing and 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 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 carried out by two inspectors.

#### Service and service type

St Andrew's Nursing and Care Home 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 Andrew's Nursing and Care Home 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.

#### 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 and professionals who work with the service. We used information the provider sent us. We used all of this information to plan out inspection.

#### During the inspection

We spoke with one person who used the service and four relatives about their experience of the care provided. We spoke with seven staff members including the interim manager, deputy manager, nurses, carers, cook and housekeeper.

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

# 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 requires improvement. At this inspection the rating for this key question has remained 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.

At the last inspection the provider had failed to robustly assess the risk relating to people's nutritional needs, risk associated with COVID-19 and medicines management. This was a breach of regulation 12(1) 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 12

Assessing risk, safety monitoring and management

- People's nutritional care needs, and risks associated with their nutrition were not effectively assessed or mitigated. This placed people at risk of malnutrition, high blood sugar and choking.
- One person's care records stated the person had been assessed to need "soft meat options".as they had difficulties with chewing "soft meat" is not a term used in IDDSI (International Dysphagia Diet Standardisation Initiative). IDDSI is a global standard with definitions to describe textured modified foods and liquids. When we spoke with staff, they informed us they were not aware of the person experiencing any difficulties with meat and that the person was given a normal diet. This placed the person at risk of avoidable harm.
- Diabetes information in one person's care records was conflicting and did not give staff the guidance needed. Additionally, staff were supporting the person to eat and drink sugary foods, without assessing the risks this may pose. Staff were not effectively recording when the person received these foods, there was a risk of the person having high blood sugars and becoming unwell.
- Another person had been assessed as requiring to be weighed weekly in order to monitor their weight loss. Weekly weights had not consistently been recorded nor had action been taken in a timely manner when the person continued to lose a significant amount of weight. This posed a risk that deterioration in people's health would not be recognised and support would not be sought from health professional in a timely manner.
- Environmental risks were not always mitigated. During the inspection we found the laundry doors had been left unlocked and therefore accessible to vulnerable people. We found the doors unlocked and the laundry room unattended where irons and trouser presses were hot to the touch. This placed people at risk of burns?

Risks were not effectively assessed or mitigated which placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure risks associated with safeguarding practices had not been identified and mitigated. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

- People at the service were protected from the risk of abuse. Staff were trained to recognise signs of abuse and reported any concerns to the interim manager who in turn reported concerns to the local authority.
- Where concerns had been raised the interim manager acted quickly, to ensure the safety of people at the service.
- People and their families told us they felt safe at the service.

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 were not provided with sufficient information relating to the services management of DoLS and MCA. There were people at the service with a DoLS in place. We considered this to be a recording issue and have covered this in more detail in the well led section of this report.

#### Staffing and recruitment

- The provider had systems and processes in place regarding safe recruitment. However, these were not robust and did not identify shortfalls in ensuring staff had the right to work in the UK and when recruitment agencies were used to employ senior staff.
- Following the inspection, we were assured by the provider that lessons had been learnt in regard to recruitment processes and they were reviewing all processes to ensure all relevant checks and references were sourced.
- Staffing levels at the service were effective. However, the service had been relying heavily on agency staff in order to ensure staffing levels were maintained. The provider was working on a recruitment program and was hoping to reduce the amount of agency staff used.

#### Preventing and controlling infection

- Staff did not always follow good hygiene practices in relation to the management of soiled laundry. We observed laundry hoppers were soiled. We found soiled laundry had been mixed with unsoiled laundry. There was also a back log of laundry due to one of the washing machines being out of order. We have been assured by the provider that action has been taken and all laundry machines are now in good working order.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.



- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

#### Visiting in care homes

- People were able to receive visitors without any restrictions at the service as the service was following government guidance. We observed people to be enjoying visits from family members in both communal areas and in the privacy of their own room.

#### Using medicines safely

- Improvements had been made. We found medicines at this inspection to be managed safely. However, improvements were still needed to ensure people received medicated creams as they were prescribed. There was a risk that people were not receiving their medicated creams due the system used to record the administration not being robust.
- All medicines were stored securely. Medicines that were required to be kept refrigerated were now stored appropriately.
- People who required "As and when" medicines had protocols in place to ensure staff had guidance in how and when to administer the medicines

#### Learning lessons when things go wrong

- There have been several managerial changes at the service over the past year. There was evidence that lessons had been learnt. Such as improvements to the management of medicines However, some of the improvement needed at the service such as improvements to nutritional care plans were yet to happen.
- Where medicine errors had occurred, they were thoroughly investigated and actions such as staff training or disciplinary took place.

# 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. At this inspection the rating for this key question has remained 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.

At our last inspection the provider had failed to robustly ensure the quality and governance at the service. This was a breach of regulation 17. 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 17

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

- At the last inspection, systems and processes to assess, monitor and reduce risks to people's health, safety and welfare were ineffective. At this inspection systems and processes continued to place people at risk. Environmental risks found during the inspection had not been identified by the provider.
- In addition to there not being a consistent manager in place at the service, other senior staff such as the clinical lead and deputy manager had either left the service or stepped down into other roles. The clinical lead's responsibilities were being shared between the interim manager and nurses at the service. There was a lack of oversight of clinical issues at the service. During the inspection we were informed a new clinical lead would be starting in a month's time.
- Quality audits at the service did not always identify areas of concern. For example, two care plan audits we reviewed showed that people had Malnutrition Universal Screening Tools (MUST) in place. However, they did not identify that the MUST had not been calculated incorrectly leading to a delay in obtaining professional support for people who were losing weight. The delay in identifying issues and contacting health professionals poses a risk of people being unsupported with their health conditions.
- The system used to monitor if people required a DoLs application or a review of their existing DoLs was ineffective, as it did not identify when peoples DoLs had expired. There is a risk of the service not asking the supervisory body at the local authority to review peoples DoLs when they have expired. This is the responsibility of the care provider.
- We reviewed people's care records in relation to MCA. We found that not all people had assessments in their records to evidence, that the decisions were made in their best interest. When the person lacked the capacity to make these decisions themselves. The interim manager told us MCA and best interest decisions had been made. However, they did not provide us with the information needed to review their processes.
- Systems and processes to ensure safe recruitment were not robust. The provider had failed to ensure an agency who had supplied a staff had requested a reference from the staff members last employer. There was a risk that this person was unsuitable to work at the service.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

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

- We received mixed feedback from relatives of people living at the service regarding the candour of the managers at the service. One relative said, "I am not sure who is in charge there have been so many changes. I don't feel I am kept up to date on my loved one's care." Whereas another relative said. "I visit the home regularly the new manager always says hello and asks if there is anything, they can do to help with my relatives care. They have contacted me when my relative was not well."

Continuous learning and improving care

- The provider recognised that errors had accrued in relation to the management of the service. They were actively looking at how they can improve the service and were regretful that more improvements had not been made in the time since the last inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Since the last inspection there have been three managers at the service. None of these managers had completed the registration process with CQC before leaving the service. The third manager left the service during the inspection period. This inconsistency has not benefited the culture at the service and meant the service has been without a registered manager since August 2021.
- Despite the managerial changes we recognised some improvements had been made. We reviewed staff supervisions where staff performance was discussed, and how disciplinary process had been effective when staff had been found to not be treating people with dignity and respect.

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

- The provider ensured people and staff had the opportunity to give feedback.
- People at the service attended regular resident meetings where they were informed about improvements to the building and asked for feedback about the service.
- Staff were encouraged to give feedback about the management of the service via a staff survey. Staff supervisions were up to date. However, some staff informed us that prior to April 2022 they had not received regular supervision.
- The service worked well with other professionals. However, improvements were needed to ensure all referrals and advice was sought in a timely manner.

This section is primarily information for the provider

## Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The provider had failed to robustly assess the risk relating to people's nutritional needs.

**The enforcement action we took:**

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The provider had failed to robustly ensure the quality and governance at the service.

**The enforcement action we took:**

Impose a condition