St. Cloud Care Limited

The Boynes Care Centre

Inspection report

Upper Hook Road
Upton-upon-Severn
Worcester
Worcestershire
WR8 0SB

Tel: 01684594001
Website: www.stcloudcare.co.uk

Date of inspection visit:
04 August 2021
09 August 2021

Date of publication:
30 September 2021

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
The Boynes Care Centre is a nursing home providing nursing and personal care for up to 40 people living with dementia. At the time of the inspection 18 people were residing at the service.

The Boynes Care Centre consists of a two-storey building with two wings, Malvern and Cedars. The home consists of both a period and more modern purpose-built accommodation.

People's experience of using this service and what we found
Risks to people were not always identified effectively to ensure people were not at risk of harm.

Medicines were not always managed safely to ensure people always received their medicines as prescribed. Audits in place were not effective in ensuring management practices were identifying shortfalls.

Omissions regarding fire safety monitoring and checks to protect people against the risk of fire were insufficient and had not fully identified and rectified concerns identified as part of the inspection.

Environmental checks to ensure the safety of people were not always undertaken in line with guidance and the provider's own procedures or sufficient action was not always taken when risks were identified.

Care plans were in place and reviewed however these did not always fully identify people's care needs and how these were to be met.

Improvement was needed in the recording of valuables when handed in for safekeeping.

Procedures were in place to prevent the spread of COVID-19. Staff were however at times seen not to wear a facemask to assist in reducing the risk of potential infection. Testing of people and staff members took place regarding the pandemic. Systems were in place for relatives and friend to visit and infection control measure where in place regarding these people.

Systems to monitor the quality of the service provided were not always effective in identifying risks to people. As a result, action had not always been taken in a timely way to reduce risks.

The provider had systems in place for the safe recruitment of staff. Staff were seen to engage with people in meaningful pastimes.

Staff were aware of their responsibilities regarding the reporting of abuse. People felt safe living at the home and liked the staff who provided their care and support.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published August 2019).
At this inspection not enough improvement had been made in the safe domain previously rated as requires improvement.

Why we inspected
We received concerns in relation to staffing and communication. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Boynes Care Centre 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 monitor the service.

We have identified breaches in relation to medicine management, monitoring the safety of the environment, care documentation and governance at this inspection.

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

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

The Boynes 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 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
The Boynes Care Centre 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.

At the time of the inspection the service did not have a manager registered with the Care Quality Commission in post. This means the provider is solely legally responsible for how the service is run and for the quality and safety of the care provided.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report.
We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experiences of the care provided. We spoke with sixteen members of staff including the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. In addition, we spoke with the deputy manager of the service, the deputy manager from another service who was providing management support, the group quality and systems manager, three nurses, care staff, the administrator, domestic and maintenance staff.

We reviewed a range of records. These included three people's care records and multiple medicine records. We looked at staff files in relation to their recruitment. In addition, we looked at a variety of records relating to the management of the service.

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 family members to discuss their experience of the service provided to their loved one.

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 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 and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management

● People's medicines were not always managed safely. Concerns with medicine management were identified as part of this inspection and brought to the attention of the nominated individual and other managers present at the time.

● People could not be sure they would receive their medicines as prescribed. One person was prescribed two tablets once a day. The records showed staff had at times only administered one tablet. This placed people at risk of harm as they were not receiving medicines as prescribed.

● The balance of medicines remaining in stock did not always reconcile with the records held. One person had seven tablets left. However, the records indicated six tablets held. Therefore, there was one tablet too many remaining. The amount of another medicine remaining, for the same person, was however short and the tablets could not be accounted for. This meant the provider could not be assured people had always received their medicines as prescribed to meet their health needs.

● The provider had an electronic care planning system. Care records were not always completed fully to evidence people's care needs as met. For example it was not always clear where creams were to be applied and the application of these. These shortfalls meant people may not have received the care and support they needed in line with the prescriber's instructions.

● Some people were prescribed thickener in their drinks to assist with swallowing difficulties. The date the thickener was opened was not indicated on a container in use. Other people on thickening powder had a new container opened at the time of the inspection as staff informed us theirs was emptied earlier in the day. Thickening powder has a limited time when opened before the manufacturer recommends the disposal of any remaining powder. There was a risk the thickener could be used beyond this time frame therefore not in line with instructions and placed people at potential risk.

● At the time of the inspection several fire doors had been identified as in need of replacement or adjustment to ensure they were fully compliant with current requirements. We brought to the attention of the nominated individual one fire door where due to the removal of a door handle there was a hole in the door. In the event of a fire this would have allowed smoke to pass. A chair was in front of another fire door which would have prevented the door closing in the event of the alarm activating. We were assured shortfalls noted with fire doors throughout the building were to receive the attention needed.

● Fire safety checks were not always carried out or fully recorded to ensure safe systems were in place. The fire alarm system was not always checked on a weekly basis and did not always show where it was activated from within the home environment. This meant the provider could not be assured the alarm was in good working order throughout the home.

● The daily checks on fire escapes were not always happening to ensure people had a safe means of escape if required. In addition, weekly checking of the fire doors was not recorded as having taken place and the

monthly check of the emergency grab bag was not always done. The grab bag would contain important information which needs to be readily available in case of emergency such as contact numbers of healthcare professionals and family members.
● Hot water temperatures were being taken as a means of identifying any potential risks to people obtaining an injury due to scalding. The health and safety executive (HSE) guidance states water temperatures in care homes should not exceed 44 degree celsius. Temperatures were recorded above this level up to 46.5 degree celsius. No action was recorded to evidence how these temperatures were adjusted to reduce the risk. High temperatures were recorded as found within the same room on consecutive months placing people at potential risk.
● The descaling of shower heads was not recorded as having taken place as scheduled in April and July 2021. These shortfalls placed people at a potential risk of harm from waterborne infections such as legionella.
● Weekly bedrail checks to ensure these were safe to use were not recorded as having taken place on a regular basis. The provider therefore could not be assured these items of equipment were correctly fitted and potential risks to people such as entrapment were considered.
● A sluice door was found to be unlocked on the first day of our inspection and brought to the attention of management. The same door was seen to be open twice on the second day of the inspection. This meant the area was not secured and unauthorised entry was possible into this area. This could have placed people at potential risk of harm.
● A bedroom carpet was seen to be damaged. This could potentially have resulted in a trip hazard to the person in the room as well as staff members.
● Information within one person's care plan regarding their oral hygiene was found to be incorrect and was in relation to another person. This meant staff did not have the correct information to enable them to deliver the care the person required to have their needs met.

Systems were either not in place or robust enough to ensure people were safe in relation to environmental factors and received their medicines as prescribed. This placed people at the risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although no harm was identified as a result of the medicine errors the provider did report our findings to the local authority by making made five safeguarding referrals. Notifications were sent to the Care Quality Commission (CQC) as required regarding these safeguarding's.
● Concerns regarding overall fire safety were brought to the attention of Hereford and Worcester fire and rescue service for them to assess the level of risk. A visit was undertaken by the fire and rescue service and assurances obtained from the provider regarding the work to be carried out.
● Medicines were stored safely. Medicines requiring additional recording and storage had regular stock checks undertaken.
● Where people had prescribed medicines on an "as required" basis there were protocols for nurses and other staff to follow. This meant information was available to guide staff as to when these were to be administered.
● During the inspection the hole within an identified fire door was repaired with the gap plugged. The nominated individual informed us funding was approved for the required improvements to fire doors.
● Following the inspection, we were assured a new door closure would be fitted to the sluice room and the carpet in a person's bedroom would be replaced.

Preventing and controlling infection
● We were somewhat assured that the provider was using personal protective equipment (PPE) effectively

and safely. However, two members of staff were seen at times to have their face mask below their nose. One of these staff members was seen not to have a face mask when they answered the door. Another member of staff was prompted to wear their facemask correctly. Relatives confirmed most staff were seen wearing face masks, however not in all cases. This posed a risk of avoidable infection transfer between staff and people living at the home. Our observations regarding staff practice and the wear of face masks was brought to the attention of the nominated individual and other manager's at the home.

● We were assured that the provider was preventing visitors from catching and spreading infections. Relatives confirmed they were required to take a COVID-19 test before entering the home and had their temperature taken. Visitors confirmed they were required to wear PPE throughout their visit.

● 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 accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. The nominated individual confirmed the corridor area near to the nurse's office and kitchen were to be redecorated.

● 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.

● We were assured the provider was facilitating visits for people living at the home in accordance with the current guidance. Relatives wishing to not enter the home could either use an area shielded off in a communal lounge to see and speak with their family member or make use of the gardens surrounding the home.

Staffing and recruitment

● Concerns raised with the Care Quality Commission shortly before the inspection were brought to the attention of the nominated individual for them to investigate and report back on their findings in relation to staffing and communication.

● During the inspection we saw an appropriate number of staff on duty. However, concerns were raised prior and during the inspection regarding the use of agency nurses.

● The provider's recruitment procedures included checks prior to new members of staff commencing their employment. These included reference checks to ensure they were of good character and checks through the Disclosure and Barring Service (DBS).

● People told us they enjoyed taking part in discussion groups with other people and staff. These included areas such as people's interests and pets.

● Family members spoke positively about the staff team and their ability to care for their loved ones. Staff were described as, "Amazing". For example, how they responded to people's needs during lockdown to support them.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living at the home. Relatives confirmed they believed their family member to have received the individual care required to meet their loved ones needs and to be safe.

● Staff were aware of their responsibility to report unsafe care or where people were at risk of harm. Staff assured us people received safe and effective care and support.

● Information was seen within a communal area regarding how visitors could report concerns to safeguarding authorities.

Learning lessons when things go wrong

● Management systems enabled reports to be generated to provide data regarding accidents and incidents

to assist in the recognition of trends. This information was available to managers as a means of preventing reoccurrences.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

- At the time of the inspection no registered manager was working at the home. The person named as registered manager had left the provider's employment some weeks beforehand. Over the previous three years the provider has had three different registered managers at the home. The deputy manager was receiving support from a deputy manager employed at another of the provider's locations as well as the nominated individual and other manager's from the provider's head office.
- Staff members and relatives spoke of their concern regarding the number of manager's the provider had had working for them at The Boynes over recent years and the need to have a permanent and stable team. One relative spoke of their disappointment as they were not aware the registered manager had recently left.
- During the inspection shortfalls were identified which had not either come to the attention of the management or were not sufficiently resolved to drive the improvement needed.
- Although medicine audits were undertaken these did not identify concerns similar to those identified as part of this inspection. Therefore, these audits were not always effective.
- Monitoring of health and safety records had not been carried out in line with the providers own procedures. Although shortfalls had been apparent to the provider and changes made regarding staffing arrangements improvements had not taken place. For example, the testing of the fire alarm, checking fire escape routes, checking fire doors and the emergency grab bag used in case of emergency.
- Records regarding the testing of the fire alarm showed a test had taken place on the day of the inspection,04 August 2021. However, the fire alarm test was not heard by the inspector or managers present at the home. It was not possible at the time of the inspection to determine who had recorded this test as having occurred.
- The provider acted following the inspector bringing to their attention concerns such as a sluice door not closing, a damaged carpet and a hole in a fire door. These did however need the instigation of the inspector for these to be actioned.
- Regular reviewing of a care plan had failed to identify incorrect information was included within it. Therefore, the care plan, failed to provide the correct details for staff members to follow in order to meet a person's care need.
- Systems were in place to safeguard people's money held in safekeeping. Records were maintained and accurate. Any valuables handed to family members were signed out of the home although they were not actually recorded, or a receipt given when handed in to the office. This presented a potential risk as these systems were not fully in place.

The provider's governance systems were not fully effective in areas including quality assurance and auditing systems. These shortfalls placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

● The nominated individual and management working at the home during the inspection were open and transparent and engaged positively during the inspection.
● The nominated individual undertook to hold an internal investigation in relation to the apparent false recording of a fire alarm test taking place.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The deputy manager was receiving support from another of the provider's local deputy manager as well as the nominated individual and other management within the organisation.
● Staff members told us they felt supported by the deputy manager during a period where they were without a manager.
● The majority of family members believed the communication between them and staff at the home to be effective in ensuring information was passed to them as appropriate. Relatives were aware of visiting arrangements in relation to government guidance as a result of the pandemic.

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; Working in partnership with others
● The nominated individual and other managers present at the inspection acknowledged the findings of this inspection and gave assurance to make improvements. Referrals were made to the local authority safeguarding team in relation to medicine errors identified.
● The managers seen at the home were aware of the requirement to inform the Care Quality Commission of certain events through statutory notifications.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have fully effective systems in place to ensure risks to people were identified and acted upon to ensure people received safe care. Regulation 17 (1) (2) (a), (b), (c)

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 failed to ensure the safe management of medicines, the environment and environmental checks to ensure people were not at risk of unsafe care and treatment. Regulation 12 (1), (2) (a), (b), (d), (g)

The enforcement action we took:

Warning Notice issued to the provider.