Gem Care 6 Limited

St Peter's Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Peter's Care Home is a residential care home providing personal care to 22 older people and people living with dementia. The service accommodates people over four floors in one adapted building with a lift. The service can support up to 43 people.

People's experience of using this service and what we found
People were not protected from the risk of avoidable harm. When concerns were identified about people's safety, information was not shared with appropriate stakeholders so investigations could be conducted. Risks were not well managed. The provider had not ensured all risks associated with people and the service had been assessed. People were not supported with their health needs. The providers oversight of incidents and accidents was poor, lessons had not been learnt when things went wrong.

Medicines were not always managed or stored safely. We were not assured that the provider was protecting people from the risk of infection. High touch points had not been included on cleaning schedules and not all staff wore the appropriate Personal Protective Equipment (PPE) to reduce the risk of infection transmission. Although there were enough staff to meet people's needs staff had not been given the training to support people well. Staff were not always recruited safely.

There was a lack of leadership, oversight and direction resulting in poor outcomes for people. The culture was poor. Staff did not understand their responsibilities and were not consulted or engaged so improvements could be made. There was no evidence of continuous learning and the provider had little knowledge of their service. The provider had not identified any of the concerns identified during our inspection. People were not engaged or consulted about their care or service in a formal way so improvement could continually be made.

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

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 08 January 2020).

Why we inspected
We received concerns in relation to leadership of the services, failure to notify outside agencies of incidents and management of health risks. 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 have found evidence that the provider needs to make improvements. Please see the Safe and Well led sections of this full report.

We reviewed the information we held about the service. 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 Inadequate. This is based on the findings at this inspection.
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 St Peter's Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, risk, staffing, recruitment and management and oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

St Peter's Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
St Peters Care 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.

The service had a manager registered with the Care Quality Commission. 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. The registered manager was absent from the service. The deputy manager was in day to day charge and was supported by a care consulted two days per week.

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 asked for feedback from Healthwatch about the service. Healthwatch is an independent consumer champion that gathers and

represents the views of the public about health and social care services in England. 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 five people who used the service and two relatives about their experience of the care provided. We spoke with seven members of staff including the deputy manager, two senior care workers, the receptionist, the finance manager and the maintenance person. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service and is also the provider. We also spoke with one health and social care professional visiting the service on the day of the inspection.

We reviewed a range of records. This included five people's care records and a sample of medicine records. We looked at three staff files in relation to recruitment and 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 requested information relating to training, safeguarding, environmental safety checks and auditing. We did not receive all of the requested information regarding training information, safeguarding, environmental safety checks or auditing. We spoke with two care consultants and a manager from the providers other service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risk of avoidable harm. An incident had occurred where a person had sustained a serious injury. Safeguarding protocols and procedures had not been followed. The incident had not been reported to any outside agencies such as the Care Quality Commission (CQC) or the local authority. This is important so agencies can assess if the service has taken adequate measures to keep people safe and act if the service have not.
- Staff had a poor understanding of safeguarding protocols and what action should be taken if there were concerns around people's safety. The deputy manager said, "This safeguarding situation is very new to me. All staff get trained in safeguarding, but it needs updating".
- After the inspection we raised several safeguarding alerts to the local authority regarding the treatment and support people received around the management of their health and mobility needs.

The failure to protect people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management

- Risks to people were not well managed. There had been a high number of people falling at the service. Some people, who were at risk of falling, did not have falls risk assessments in place. Other people had been identified as being at high risk of falls, but no action had been taken to mitigate the risks.
- Staff did not always have clear guidance on the actions they should take to protect people from avoidable harm. Risk assessments did not always have the correct information recorded and, in some instances, risk assessments had not been completed at all.
- Risks around people's health needs were poorly managed. Some people were at risk of not drinking enough. Fluid charts where either missing or poorly completed. Staff were not aware of how much people should aim to drink in a day and daily total amounts were not added up. Staff did not know if people had drank enough. There was no evidence of any action taken when people's fluid intake was low. One person was at risk of developing urine infections and to reduce the risk of these occurring they needed to drink plenty of fluids. Their fluid intake was not monitored. After the inspection we were informed the person had been admitted to hospital with a urine infection.
- One person had a catheter in place to drain urine from their bladder. There was no care plan or associated risk assessment in place to tell staff how to support the person with their catheter care. Staff did not know how to recognise if there were concerns with the persons catheter. There was no information to inform staff about what action to take if the catheter was not working properly or the signs to look for if there was the risk of infection developing.

● Three people had diabetes. There were no care plans or risk assessments for staff to follow to support people manage their diabetes. Staff had a limited understanding of how to support people safety with their diabetes.
● Other risks were not well managed. No action was taken when water temperatures were high meaning people were at risk of scalding themselves. Fire risk were poorly manged. Staff did not have up to date training or undertake regular fire evacuations. They were unable to describe the action they should take in an emergency situation to evacuate people safely. We requested information relating to safety certificates and checks in respect of fire and electrical installation. We did not receive this information.

Learning lessons when things go wrong
● Lessons had not been learnt when things went wrong. There were no systems in place to monitor or analyse accidents and incidents to prevent them happening again.
● There was no oversight or analysis of falls. There had been approximately 70 incidents of people either slipping or falling which had not been analysed. When people had fallen no lessons were learnt or action taken to prevent further falls. Some people fell at the same time each day but the provider had not identified this pattern so they could understand why and prevent reoccurrence.
● When people were at risk of developing pressure sores action had not been taken to prevent this from happening and people were still at risk.
● The provider had not learnt lessons from serious incidents or implemented robust measures to improve the care and support people received.

Using medicines safely
● Medicines were not always managed or stored safely. Staff used an electronic system to record when medicines were administered. There were medicines that were active on the system which had been discontinued or changed. There was risk that people may receive medicines that were no longer prescribed.
● For most medicines to be effective they have to store at a temperature of under 25 degrees Celsius and temperatures checked daily. The temperature in the clinic room was checked inconsistently. When temperatures recorded, they were always above 25 degrees. No action had been taken to rectify this. Medicines people took daily were kept in locked cabinets in their bedrooms. No temperature checks were taken to make sure medicines remained effective. There was a risk that people were receiving medicines that may not be effective
● Stocks of people's medicines were stored in a clinical room. There were two large open boxes of unwanted medicines on the floor. The dates of some of the medicines went back to the beginning of March 2021. Unused medicines should be returned to the pharmacy as soon as possible and should be stored safely and securely.
● Some people were prescribed special creams to be applied to their skin to help keep it healthy. Staff had not consistently recorded that creams and had been applied to people's skin. There was a risk that cream would not be applied, and people's skin might become sore and 'break-down' as a result.
● No guidance was in place for staff to refer to where people required 'as and when' medicines. Staff were unable to tell us when the medicine should be given to ensure this was done consistently and in line with prescribing instructions.

Preventing and controlling infection
● We were not assured that the provider was protecting people from the risk of infection. There had been a Covid-19 outbreak at the service previously. A contingency plan to respond to another outbreak had not been implemented. The provider did not have a robust plan to cohort or isolate people to prevent the spread of infection to other people in the service. The deputy manager said, "No contingency for further outbreaks. It's in my head but no we don't have it written down. I would like to feel like the staff would know

what to do but there's no plan."
● A relative told us they were not allowed to come into the service to visit their loved one and had to sit behind a screen. We intervened so the relative was permitted to enter the service in line with the current government guidance around visiting.
● Some staff did not use PPE appropriately. We observed both cooks not wearing masks. When asked why the staff said they had never been told they had to. They then put face masks on.
● Neither inspector nor a visiting professional had their temperatures checked or were asked to give evidence of a negative Covid-19 test before being permitted to enter the service. Additional cleaning of high touch points had not been implemented to reduce the risk of transmission of infection.
● Risk assessments had not been carried out on people using the service and staff belonging to higher risk groups. Actions had not been taken to reduce the risks.

Care and treatment was not provided in a safe way. The provider had failed to assess risks and did not do all that was reasonably practicable to mitigate any such risks. Medicines and Infection control was not effectively managed leaving people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment
● The provider could not assure themselves staff could safely support people with their specific health needs such as managing catheters or diabetes. The provider did not provide any evidence that staff could safely move and transfer people using equipment such as hoists. Although there were enough staff to meet people's needs staff had not been given the training to support people well. We asked for information around the training of staff. The deputy manager and provider were unable to tell us how many staff had been trained in mandatory areas such as fire, health and safety, moving and handing or safeguarding. We did not receive the information about training we had requested after the inspection. After the inspection the provider told us staff had either received fire training or were booked to complete it.
● Staff were not competency checked or offered regular supervision. The provider could not assure themselves staff were competent or able to complete their roles effectivity. Staff including the deputy and senior carers were not able to provide information about how they supported people with their individual needs.

The failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not always recruited safely. The provider had not ensured that all the information and safety checks required before new members of staff started work were in place.
● From the three staff files we looked at we found missing information in two. One file only contained one character reference. There was no reference from the staff members previous employer who had been a care home provider and this had been not been followed up by the provider. A full exploration of another staff members employment history was missing. There was a risk there were gaps in their employment with no explanation as to why. There was a risk that staff might not be suitable to work in a care home setting. The provider did not have any systems in place to ensure oversight of recruitment was robust.

The provider had failed to ensure that staff had been safely recruited and had not ensured recruitment

procedures were operated effectively. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There was a lack of leadership and oversight at the service resulting in poor outcomes for people. Staff did not understand their responsibilities, as a result, people were harmed. A staff member said, "We get no management support. There is no direction. We just go day to day."
- The registered manager had been absent from the service for a number of weeks. The provider had not implemented effective management oversight in their absence. The deputy manager was in day to day charge with the support of a consultant two days per week. The deputy manager told us they felt out of their depth and had little support.
- Communication between staff was poor. Staff had not been given training to complete their roles well. For example, staff had not been trained to use the new electronic care planning system. Incorrect and insufficient information was being generated into people's care and support plans. Care plans had important information missing which left people at risk or receiving inappropriate care and support.

Continuous learning and improving care; 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

- There was no evidence of continuous learning. For example, the provider did not know how many falls incidents had occurred over the last three months. We asked the provider for the analysis of incidents at the service. The provider said, "Sorry I'm not a clinician you would need to ask the manager." No analysis of incidents had been completed by the provider or management of the service. Other risks associated with people were not known, therefore action taken to reduce the likelihood of harm had not been considered.
- The provider did not have a good understanding of the risks at their service or understand why it was important to analyse incidents to prevent repeated occurrences. Audits were supposed to be undertaken monthly on medicines. This had not happened consistently. The audits that had been completed had not identified any of the shortfalls we found at the inspection.
- The provider did not carry out robust auditing or checks of the service and had not identified any of the concerns we found during our inspection. The provider had not effectively identified and managed risk, therefore people were placed at significant risk of avoidable harm. We identified widespread and significant shortfalls in the management of risk and delivery of care, for example supporting people's health needs, falls management, medicines, and fire risks. These had not been identified by the provider.
- The duty of candour is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and

treatment. The provider had not been open and honest in line with their legal responsibilities. When people had been harmed or allegations of abuse were made the provider had not shared this information openly with stakeholders. When people had died the provider had not sent the CQC notifications which they are required to do.

● Outside healthcare professionals visited the service to support people with some of their health needs. However, the provider had not ensured all referrals were made when there were concerns with people's safety. For example, there had been a number of people falling at the service but referrals to falls specialists were inconsistent.

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

● There was a poor culture at the service which lacked direction and leadership. Comments from staff included, "I can't remember the last time I had supervision" and "We sometimes have staff meetings. Not very often. We suggest things but nothing ever gets done. There are no improvements".

● Assessment of people's continuous needs was inadequate. The provider had failed to ensure that people's needs were known and met. This had an impact on people's safety, and the quality of care they received. A person had recently been admitted from hospital. Before they were admitted into the service an assessment of their needs was not carried out. Their care plan missed important information about their health needs. The staff we spoke with were not able to describe well the person's needs. This meant the outcomes for this person were poor and they were at risk of inappropriate care and treatment.

● People were not asked for feedback in a formal way so the service could continually improve. There were no resident meetings or quality assurance system to gather feedback from people. There was no evidence that the opinions of relatives had been sought and acted on. When people raised concerns, they were not always responded to. For example, a person reported they had some jewellery taken from their room. They had reported the incident to staff, but no action had been taken and there was no information about the incident. We reported this to the provider who said they were unaware but would investigate the alleged incident.

● Staff did not feel listened to or empowered. Staff told us they had not received fire training, they had reported this to the management, but no action had been taken. A staff member said, "(During the Covid-19 outbreak) We were just left to it. We were fighting fire. No-one came to support us. It has had a big impact on the staff as we lost so many people. It was awful."

The failure to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service is a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.