St Peter's Care Home Limited

St Peter's House

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 Peter's House is a residential care home providing the regulated activity of accommodation for person's who require nursing or personal care for up to 66 people. The service does not provide nursing care. The service provides support to older people some of whom lived with dementia. At the time of our inspection there were 45 people using the service.

People's experience of using this service and what we found
We were not assured the systems, processes, and leadership currently in place to oversee the quality assurance of the service were robust and effective and regulatory requirements were not always being met. We received mixed feedback from people and their relatives about the standards of care and support provided.

People were not consistently protected against harm because all risks to their safety had not been identified and managed.

Medicines were not always safely managed and audits in place to monitor the safety of medicines were not effective in keeping people safe.

There was a lack of consistent and effective leadership at the service and quality assurance systems were not effective in identifying and addressing issues.

The provider took responsibility for the issues we found and responded immediately after the inspection to make improvements that were required.
Staff had been trained to safeguard people from abuse and understood when and how to report safeguarding concerns to the appropriate authority. Recruitment and criminal records checks were undertaken on staff to make sure they were suitable to support people.

Staff had access to personal protective equipment (PPE) and there were effective infection prevention control measures in place.

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

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

Rating at last inspection
The last rating for this service was good (published 24 May 2022)

Why we inspected
We received concerns in relation to the quality of people's personal care and the high number of falls people were having. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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 House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to the safe management of risk and medicines as well as the staffing levels and the providers governance at this inspection. Please see the action we have told the provider to take at the end of this report.

We will request an action plan from the provider and will also 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

St Peter's House

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
This inspection was undertaken by 2 inspectors, a pharmacist inspector, 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 Peter's 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 Peter's Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post, however, they left employment shortly after our inspection visit. The provider put in place a temporary manager whilst permanent recruitment took place.

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. 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 13 people who used the service and 7 relatives about their experience of the care provided. We spoke with the registered manager, deputy manager, business support manager, regional manager, kitchen staff, housekeeping staff and 7 care staff during our inspection visit.

Following the visit, we had email or telephone correspondence with a further 16 relatives and 12 staff members.

We reviewed a range of records. This included 6 people's care records, multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. We reviewed records relating to the management of the service including quality assurance monitoring and the services policies and procedures.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- 'Risks had not been sufficiently assessed. Risk assessments were missing detailed guidance for staff on how to reduce risks. Records failed to take into account the additional risks in relation to falls, for people prescribed anticoagulant medicines.'
- People's basic care needs were not consistently met. There was a lack of oral hygiene and care. We found the majority of people's toothbrushes were still dry at lunchtime and a lack of toothpaste in use. We were not assured people had been provided with daily oral care as required to maintain their health and wellbeing. This was also confirmed by some people's relatives. One told us, "There is a total lack of oral hygiene. Our relative asked us to clean their dentures for them as the staff didn't [assist]. We had to search for their toiletry bag which still had unopened toothpaste & [denture cleaning tablets] in it. We now clean their dentures every visit." This placed people at risk of harm, as the provider was not supporting people to maintain their basic standards of hygiene and prevent the risk of the spread of infection.
- People's food and fluid levels were not consistently monitored. Records contained multiple gaps which did not show people had received regular food or drink, particularly where they were at risk of weight loss or malnutrition?
- Free-standing bedroom wardrobes were not secured to the wall. This meant the person in that bedroom was at serious risk of injury if the wardrobe were to fall.

In relation to the above shortfalls, we found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate the management of risk was effectively managed. This placed people at 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.

The provider responded immediately during and after the inspection. They confirmed action would be taken to keep people safe and investigate the concerns identified.

Using medicines safely

- The provider was using an electronic system to record the administration of medicine. However, there were occasions where the information on the system was not clear enough, such as not specifying which eye when administering eye drops and a medicine that is recommended to be spaced apart from others being given at the same time.
- Medicine management policies and procedures were in place. Medicines were ordered and safely stored

except for some skin creams or gels which were found unsecured in people's rooms. We observed dispersible medicines being added to a glass of water but not always ensuring that the resident drank all the water.
● Where people refused to take their medicines, there was no evidence that any action was taken including informing their GP to seek resolution or alternative options to keep them well.
● Prescribed moisturising and protective skin creams were not always administered as prescribed, and there was no consistent way for staff to record administration. This meant people were at risk of not receiving these medicines in line with the prescribers instructions.
● Protocols to help staff know when to give 'as required' medicines were not always in place including those for pain relief.
● Medicine incidents were reported and investigated. However, on one occasion we found that records did not reflect when a resident had not received their medicines. The medicines had been found on the floor, but the records still showed that medicines had been taken.

Although we found no evidence that people had been harmed, the safe management of medicines was not always effective. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed staff ensuring that peoples preferences were taken into account when administering medicines.
● Homely remedy procedures supported people to have 'over the counter' medicines administered safely where appropriate and required.
● Staff had received medication training.

Staffing and recruitment
● People, their relatives and staff gave us mixed feedback in relation to the staffing levels and the effective deployment of staff to ensure people's needs were met in a timely manner.
● Some relatives told us of their concerns that there were staff shortages and the impact on their family member. One person's relative commented, "I do have concerns that sometimes when I visit, I sit in the dining room with my [family member] and other [people], and I do not see any staff in the room for at least 15 minutes sometimes."
● People, relatives, and staff told us of delays in people's call bells being answered, resulting in a delay in them receiving care. One person told us, "I have pressed my call bell and have had to wait 35 minutes to go to the toilet." Another person's relative said, "There have been a number of occasions when [family member's] buzzer has not been answered and this has led to [incontinence] and their clothes and bedsheets needing changing and washing."
● We also received mixed feedback from staff about the staffing levels with some concerned that there were insufficient numbers of them to respond to people when required and that as a result, people received a delay in their care. One staff member said, "Staffing levels aren't always short but in order for us to deliver person centred care I think we could benefit from having more carers on the floor as sometimes you can feel like you're spreading yourself a bit thin trying to complete things. I think more staff would help us to be able to spend more time in social areas with [people] which could cut down on falls."
● During the inspection we saw that staff were visible in the home, however they were moving between the two floors frequently. Interactions were task based at times and whilst interactions were positive staff appeared busy and as a result task focussed. We were not assured that the staff were effectively deployed to meet people's needs in a timely manner.

The provider had failed to ensure there were sufficient numbers of staff deployed. This placed people at risk

of harm. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff who had been recruited safely. Pre-employment checks included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations had been requested to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse
● The provider worked to reduce the risk of abuse to people. They engaged with the local authority with any enquiries.
● Staff had the knowledge and confidence to identify safeguarding concerns and act on them. Staff were required to complete safeguarding training as part of their induction.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● 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 and relatives were happy with visiting arrangements.
● People spent time with relatives and friends inside and outside of the service, as well as accessing the local community.

Learning lessons when things go wrong
● The registered manager had systems in place to monitor incidents and accidents, however, these were not always used proactively and effectively. Despite people experiencing a high number of falls, referrals to specialist services were not always made in a timely manner.
● We found the provider very responsive and keen to learn from any mistakes and keen to learn from

incidents to ensure improvements.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Our inspection was prompted by whistleblowing and stakeholder concerns sent to us. Our inspection identified some of these allegations were accurate and had not been effectively identified and addressed by the provider.
- There were systems and processes to monitor the quality and safety of the service in place, but these were not effective and had not addressed the issues we found during inspection. A lack of provider oversight has meant that the quality and effectiveness of the management oversight were not reviewed.
- We were not assured the current governance arrangements and oversight of the service were robust or effective in identifying and following up actions needed. Particularly with regard to people's personal care and risk management.
- Systems and process to monitor the quality and safety of the service were in place but not effective and had not identified or addressed the issues we found during the inspection. Particularly in regard to medicines management, personal care and managing risk.
- Where audits had taken place, there were no actions completed, which meant improvements had not been made.

The provider had failed to assess, monitor, and improve the service. The provider had failed to assess, monitor, and mitigate risks to people. The provider had failed to maintain accurate, complete, and contemporaneous records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We discussed the issues we found during the inspection with the provider. They were open and transparent and responded immediately to ensure actions were competed during our inspection and in the time following. We were given assurances that immediate action had already been commenced to make the required improvements. Following the inspection, the provider took a voluntary suspension on any new admissions into St Peter's House to enable them to focus on making the improvements needed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had arrangements in place to seek people's feedback and views about the service. At the

time of the inspection an electronic system gave visitors the opportunity to provide feedback following every visit. The provider showed us multiple examples of positive feedback being left by relatives and visitors praising and complimenting the service.

● Many people and their relatives described to us a difficult atmosphere at times at the care home. One relative said, "Only positive feedback is welcomed and constructive criticism is avoided or dismissed. As soon as you walk into St Peter's House now, you can sense a bad atmosphere and the frustration and unhappiness of the staff."

● Many staff expressed concerns about the culture at the service. A staff member told us, "I feel that morale has been low in the home as of recent as [registered manager] can be very unapproachable. I think the feel in the home is we don't feel very appreciated for the work we do by [registered manager]." Another staff member said "The [registered] manager does not address concerns from staff. The deputy manager and assistant manager are visible at all times, the [registered] manager is not visible."

● We recognised that the service had been through a challenging period. We received overwhelmingly strong feedback that the management arrangements at the home were not effective or conducive to a professional working relationship. We fed this back to the provider, along with examples of the feedback we had received, and they took immediate action to review the management arrangements.

● The provider demonstrated an open and transparent approach and understood their responsibilities under the duty of candour.

● The provider was aware of their obligations for submitting notifications to CQC, as required by law.

● The provider understood their responsibility to provide honest information and suitable support and to apply duty of candour where appropriate.

Working in partnership with others

● We saw evidence the provider was working in partnership with community professionals and organisations to meet people's needs. The registered manager had failed to ensure appropriate and prompt healthcare referrals were made, however at the time of our inspection this was being rectified.

● A visiting health care professional told us they worked closely with staff at the home to provide effective care for people.

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 12 HSCA RA Regulations 2014 Safe care and treatment Arrangements were not robust to manage and mitigate risk for people using the service and improvements were required to the management or medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff deployed. This put people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.