

Reed Care Homes Limited

St Andrews Lodge

Inspection report

184 St Andrews Avenue
Colchester
Essex
CO4 3AG

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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 Andrews Lodge is a residential care home providing regulated activity accommodation and personal care to up to 8 people. The service provides support to people who have a mental health condition or a learning disability. At the time of our inspection there were 8 people using the service, 3 out of 8 people were receiving the regulated activity personal care.

People's experience of the service and what we found:

People we spoke with were satisfied with the service.

The service was not well led. The provider did not have adequate oversight of the service and lacked a recognition and understanding of risk. Governance systems were not robust or used effectively and were failing to consistently assess, check and improve quality and safety of the service, and care delivered.

There were risks associated with fire safety, health and safety and incidents triggered by people's mental state. Incidents were not being investigated properly, and there was a lack of effective learning from incidents, complaints, and safeguarding incidents to reduce risks to people from reoccurring.

Right Support: People did not receive the right support to maximise their choice, control, and independence and staff did not support them in the least restrictive way possible, and in their best interests. This meant people did not lead fulfilling and meaningful everyday lives that promoted their wellbeing. Limited information was available about people's aspirations and goals and how staff could support them to achieve these. People did not receive an interactive and stimulating service that ensured they led inclusive and empowered lives.

Right Care: There were no clear management systems followed in practice to support staff learning and development. Gaps in staff training, supervision and competency checks did not ensure people were cared for by staff with the necessary skills, knowledge, and ability to deliver the right care and support, and protect them and others from harm.

Right Culture: The culture of the service did not empower people to lead their best life. Care delivered was not person centred and did not always promote people's dignity, independence and safety.

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

Rating at last inspection and update

The last rating for this service was Requires Improvement, published 29 March 2019.

At this inspection we found the provider remained in breach of regulations and the service is rated inadequate.

Why we inspected

This inspection was prompted by a review of the information we held about this service.

We undertook a focused inspection to review the key questions of safe and well-led only. For those key question not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for St Andrews Lodge website at www.cqc.org.uk.

Enforcement

We have identified continued breaches in relation to management and governance and risk management, and a new breach in staffing support and training.

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 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.

Special Measures

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.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

<p>Is the service safe?</p> <p>The service was not safe.</p> <p>Details are in our safe findings below.</p>	<p>Inadequate ●</p>
<p>Is the service well-led?</p> <p>The service was not well led.</p> <p>Details are in our well-led findings below.</p>	<p>Inadequate ●</p>

St Andrews Lodge

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 team consisted of 1 inspector on 6 November 2023 and 2 inspectors on 7 November 2023.

Service and service type

St Andrews Lodge 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 Andrews Lodge is a care home without nursing care.

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. The registered manager was also a director of the company providing the service.

Notice of inspection

The inspection was unannounced.

What we did before the inspection

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority safeguarding and quality team, and professionals who work with the service. We used all this information to plan our inspection.

During the inspection

We spoke with 4 people who used the service, however they declined to speak with us at length. We used informal observation to evaluate people's experiences and to help us assess how their needs were being met. We also observed how staff interacted with people.

We looked at records in relation to 4 people's care.

We also spoke with the registered manager also a director of the company, 4 staff members and 3 agency staff. We looked at records relating to staffing, recruitment, training and development of staff, management of the service and systems for checking the quality and safety of the service.

After the inspection

We continued to seek clarification from the provider to validate evidence found.

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 has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvements and the service remained in breach of the regulation.

Assessing risk, safety monitoring and management

- People were not consistently kept safe because the provider did not take action to mitigate known risks.
- At our last 2 inspections we found hot water exceeded safe temperature of 43 degrees and people were at risk of scalding. At this inspection the registered manager/director told us thermostat mixer valves (TMV) had since been fitted to sinks and showers to regulate the water temperature. We found the hot water was still very hot to the touch. The registered manager/director was unable to find and produce evidence during or after our inspection to show the valves had been fitted and were checked annually.
- A health and safety audit dated 4 July 2023 showed a lot of gaps where areas needed addressing and no actions had been taken to improve safety in the service. For example, the kitchen and laundry flooring were damaged and posed a significant trip hazard, wardrobes were unsecure and posed a risk of injury if they toppled over, portable appliance testing (PAT), the examination of electrical appliances and equipment by a qualified person to ensure they are safe was last carried out in 2021 and remained overdue. Trailing wires and overloaded sockets in the office posed a risk of injury. We found these areas had not been addressed and posed a risk of harm to people.
- Fire safety arrangements were poor. A bedroom fire door was held open with a fridge and therefore unable to close automatically if the fire alarm was activated.
- The fire evacuation grab case used to hold essential information for staff, and others in an emergency, held documents that were no longer current or correct. For example, a list of people using the service and their room numbers was out of date and incorrect. There were 8 people using the service but there were only 6 personal emergency evacuation plans (PEEPS) and one related to a person no longer using the service. This meant staff may not have immediate access to information needed to support everyone safely in an evacuation.
- Risk assessments did not identify risks to people clearly or how they were to be mitigated.

The providers failure to provide care and treatment in a safe way including recognising and mitigating risk placed people at risk of receiving unsafe care and support. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

People were supported to receive their medicines in a way that was not always safe.

- Our last inspection found protocols for medicines prescribed 'as and when required' (PRN) had limited detail to guide staff on when to administer the medicines. This inspection found not enough improvement had been made to ensure PRN medicines were safely administered as they should be. Protocols for medicines prescribed PRN to reduce anxiety did not clearly include at what point the medicine should be administered or any alternative support methods that should be tried first, nor did they address monitoring and review. This posed a risk of over use of PRN medicines.
- Medicines storage arrangements were not safe. They were stored in a small unventilated room which also accommodated the washing dryer which increased the temperature of the room when used. Although room temperatures were checked, it was unclear when they were checked or if they were checked when the dryer was in use. The records did not show any action was taken when temperatures exceeded the recommended temperature for the safe storage of medicines. Incorrect temperatures could reduce the effectiveness of medication putting people at risk.
- Medicine audits needed further development to include oversight of all medicine management processes to ensure they are safe, including PRN protocols and storage and temperature. Currently they only focused on stock control.

The providers failure to provide care and treatment in a safe way including recognising and mitigating risk in medicine management placed people at risk of receiving unsafe care and support. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Administration of medicines was generally well managed. Records showed people were receiving their medicines as prescribed. A sample check of people's medicines was carried out and found to be correct.
- Staff had completed e-Learning relating to the management of medicines but there was no evidence to demonstrate staff competency had been assessed to ensure they understood and were competent to undertake this task safely.

Preventing and controlling infection

- Overall communal areas appeared clean. However, observation of 3 people's rooms found the en-suite facilities were unhygienic with long term build-up of limescale and mould around taps and sealant, and toilet pans were heavily stained, increasing the risk of infection.
- The cleanliness and infection control section of last managers audit carried out in July 2023 identified the condition of shower cubicles and toilets in all bedrooms, but no action had been taken to address this.
- There were no cleaning schedules or regular environmental checks to ensure robust infection prevention and control to keep people safe from harm.
- Staff had not completed infection prevention and control training.

The providers failure to provide care and treatment in a safe way including infection control and prevention, placed people at risk of receiving unsafe care and support. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting

- People were able to receive visitors at the service without restriction.

Staffing and recruitment

- The provider did not always ensure there were sufficient numbers of suitable staff.
- The level of staffing and shift patterns were not linked and decided by people's support needs. Staff survey

results of June 2023 raised consistent themes about not having enough staff with the right skill mix. The registered manager told us staff numbers had been increased but was unable to show how they calculated staffing numbers according to people's needs.

- The registered manager did not have oversight of the staffing for the service. They could not find the duty rotas for us because they were managed by a staff member at the sister service. They were unable to show us how they were reviewing staffing levels and mix of skills to make sure staff were able to respond to people's changing needs.
- Staff induction, training, supervision, and appraisal were not robust to ensure staff had the right competence, knowledge, qualifications, skills and experience to carry out their roles.
- The induction of new staff was no more than a checklist and was not aligned to the Care Certificate standards.
- Not all staff had completed or refreshed e-Learning in core subjects needed to do their job.
- There was no evidence to show a structured support and supervision system was in place or that robust probationary reviews were consistently carried out during an induction and probationary period.
- Agency staff were employed to support people with complex needs on a one-to-one basis. Reviews of their understanding, skills and competence had not been completed to ensure they could meet people's needs safely and effectively.

The providers failure to fully support and develop staff, placed people at risk of receiving unsafe and inappropriate care and support. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not always operate safe recruitment processes.

- The provider's recruitment processes were generally robust with the required documentation obtained to ensure right staff were recruited to support people. However, we found 2 new staff had started work 3 months before their disclosure and barring scheme (DBS) check had been completed, and a risk assessment had not been carried out.

Systems and processes to safeguard people from the risk of abuse and avoidable harm; Learning lessons when things go wrong

- People and others were not always kept safe from the risk of harm. Some staff at the service had previously been assaulted by a person using the service. Staff were not being given the training that enabled them to meet the needs of, and or effectively safeguard people. Staff were not equipped to manage people's distressed behaviours that posed a risk to themselves and others.
- Not all staff had received training in safeguarding people.

The lack of training in this area is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

- Incidents were not always recognised as safeguarding concerns and reported to the right authorities.
- Reviews of incidents and accidents needed further development to ensure objective investigation to find out what went wrong, and why, and learn lessons from them.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- For people who may lack capacity to make their own decisions the provider had not ensured their mental capacity was assessed and reviewed, in a way that met legal requirements, and demonstrate any decisions made were made within the legal framework, and in the persons best interest. People had one to one support staff seated in their bedroom while they were in bed.

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 has changed to Inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found management was not effective and governance systems were not operated well to ensure actions were being taken where issues had been identified. This was a breach of regulation 17(1) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvements and the service remained in breach of the regulation.

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

- The provider did not have an effective management structure and did not monitor the quality of care provided in order to drive improvements.
- There was no effective leadership to oversee and direct staff. Staff were unsure of the management arrangements for the service and told us the registered manager (also a director of the company) was not seen regularly at the service; a senior carer oversaw the running of it. The quality of care and support for people was not being checked to ensure it was right, safe, and followed best practice.
- The office was chaotic; the registered manager was disorganised, and IT systems did not function well. Relevant information for inspection could not be found and produced during or after our inspection, such as a current employers liability assurance certificate, current gas appliance safety certificate and a current 5-year electrical safety certificate. The lack of organisation presented risks to people and the service.
- Governance was poor. There was a lack of effective systems and processes to monitor and manage safety and quality of the service, and drive improvement. Whilst an action plan had been created to address identified shortfalls and drive improvement, the actions had not been carried out and/or sustained. For example, fire safety management, review and update of PEEPS, staff supervisions, staff training and care plans.
- Tools were in place to assess and monitor the service, but these were either out of date, incomplete or not used effectively to address and monitor shortfalls identified.
- The provider did not demonstrate that the staff employed and responsible for the care and welfare of people had access to accurate and relevant information they required, were competent in terms of their skills, or that they fully understood their roles and responsibilities.

The failure to have effective oversight and robust systems to proactively recognise and act on failings that affect the safety and quality of service provision is a breach of Regulation 17 (Good governance) of the

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 provider did not promote a positive person-centred culture and the service provided failed to achieve good outcomes for people.
- People's support plans did not include clear strategies to enhance their independence and did not evidence any future planning or consideration of the longer-term aspirations of each person. Goals and interests were not explored or developed.
- Staff were unable to deliver tailored and consistent support because there was not enough guidance in people's plans on how this was to be done. Agency staff employed to provide enhanced 2:1 and 1:1 support did not know how to effectively support the people they were supporting; they were seen either following the individual around the service or sitting outside their door. This meant people's recovery, well-being and best independence was not effectively promoted and sustained, and situations were not prevented from reaching crisis point.
- The provider was not assessing people's experience of care and support to see if they could be improved upon in any way. Resident meetings were not held regularly, and minutes did not show people were engaged or involved in a meaningful way.

The failure to have robust and effective systems to proactively maintain records necessary for the health, safety and welfare of people using the service and the failure to engage, seek and act on feedback to continually evaluate the service and drive improvement is a breach of Regulation 17 (Good governance) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The provider did not always work in partnership with others. There was no evidence to show the service had engaged in local and national forums or development groups to gather best practice knowledge in relation to mental health and learning disability to support service improvement.

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	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider was failing to fully support and develop staff placing people at risk of receiving unsafe and inappropriate care and support.</p> <p>This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider was failing to provide care and treatment in a safe way including risk management and mitigation, medicine management and infection control and prevention, placed people at risk of receiving unsafe care and support.</p> <p>This was a breach of Regulation 12(1)(2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider was failing to have effective oversight and robust systems to proactively recognise and act on failings that affect the safety and quality of service provision.</p> <p>The provider was failing to have robust and effective systems to proactively maintain records necessary for the health, safety and welfare of people using the service.</p> <p>The provider was failing to engage, seek and act on feedback to continually evaluate the service and drive improvement.</p> <p>This is a breach of Regulation 17(1)(2) (Good governance) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.</p>

The enforcement action we took:

warning notice