Mrs Mobina Sayani

# St Paul's Residential Home

## Inspection report

127 Stroud Road
Gloucester
Gloucestershire
GL1 5JL

Tel: 01452505485

Date of inspection visit:
28 September 2022
29 September 2022

Date of publication:
15 November 2022

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
St Paul's Residential Home is a residential care home providing care and support for up to 32 older people across four adapted buildings.

People's experience of using this service and what we found
Care plans and risk assessments were not in place for all people. Some people's care plans, and risk assessments had not always been reviewed and contained inaccurate or conflicting information.

People were not always protected from the risks of their environment as effective maintenance had not always been carried out. The provider had not undertaken effective measures to ensure that service users would be protected from risks associated with fire safety and legionella.

Systems to monitor and improve quality and safety of the service were not always effective. Records to support management of the service had not always been maintained. In response to our last inspection the provider sent us an action plan which stated they would meet the regulations in full by the end of August 2022. At this inspection we found the provider had not fulfilled all the actions outlined and remained in breach of the relevant regulations.

People and their relatives felt the provider was approachable, however had raised issues regarding communication. The provider was aware of these concerns and were aiming to improve communication with relatives and healthcare professionals by reviewing their governance systems and management structure.

Staff told us they felt supported and enjoyed working at St Paul's Residential Home. We observed people being treated with dignity and respect.

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 (5 July 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of these regulations.

At our last inspection we recommended the provider consider current guidance related to legionella risk management and take action to update their practice accordingly. Risks relating to the management of legionella had not improved since our last inspection.

At our last inspection we also recommended that the provider strengthen the systems in place to gather and

communicate how feedback has led to improvements. At this inspection we found the provider had not made the necessary improvements to strengthen their system.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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 remained the same.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Paul's Residential 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, good governance and reporting incidents 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 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?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# St Paul's Residential Home

**Detailed findings**

## Background to this inspection

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

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

Inspection team
The inspection was carried out by two Inspectors 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 Paul's Residential 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 Paul's Residential 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 was also the registered manager for the service. Throughout the report we will refer to the 'provider'. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We used the information the provider sent us in their latest 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 the provider, deputy manager, one visiting professional, four people who use the service, two senior staff and four care staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures and quality assurance records. We gathered feedback from five professionals who visit the service, and 10 relatives.

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 requires improvement. The rating for 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.

Assessing risk, safety monitoring and management; Using medicines safely; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

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.

We asked the provider to take action. They sent us an action plan which stated they would meet the regulations in full by the end of August 2022. At this inspection we found the provider was still in breach of regulation 12.

● People were not always protected from the risks of their environment. Environmental concerns identified at our last inspection had not fully been addressed. Fire exits were not always clear or free from obstruction. Areas where combustible items should not be stored were not always kept clear.
● The environment and systems in relation to fire had not been addressed since the last inspection. Action required by the fire-service, requested before our last inspection, had not yet been met. Fire checks had not been completed in line with recognised guidance and records were not reliably completed. People's Personal Emergency Evacuation Plans were not up-to-date and contained incomplete and inaccurate information which increased the risk to people in the event of a fire.
● The environment of the home had not always been maintained, which placed people at risk. Worn carpeting posed a tripping hazard and, in one corridor, exposed metal protruding from the wall put people at risk of injury. The provider told us they were taking steps to address the environmental concerns but had found it difficult to source contractors to complete the work in a timely fashion.
● Staff supporting people who experienced behaviours of distress, did not have clear guidelines to follow to ensure the safety of them and those around them. Staff told us they were given information at handovers and were trying their best to support people who could become anxious.
● Medicines were not always stored correctly and safely in accordance with the providers policy and manufacturers guidance. Topical creams had not always been labelled and were seen loose in people's bedrooms and a communal bathroom during the inspection.
● People did not always have an accurate and up-to-date plan of care to guide staff in managing risks to them safely. Where we saw concerns relating to skin integrity, records and our discussions with staff did not clearly show how the risk had been mitigated. For some people there were no care plan or risk assessments in place to direct staff to care for them safely and in accordance with their preferences.
● The provider had not appropriately monitored the risk of Legionella to protect people who use their

service from Legionnaires disease. The provider's risk assessment did not cover all required areas, and effective monitoring processes were not in place to minimise the risk of potential exposure to legionella bacteria by checking water temperatures throughout the service.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the records related to people's medicines were not always complete. This placed people at risk of harm. This was a breach of regulation 17 (2.3) (2.4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to take action. They sent us an action plan which stated they would meet the regulations in full by the end of August 2022. At this inspection we found the provider had made improvements in relation to people's medicines administration records. However, they were not meeting the regulation in full which we have reported on in the 'Is the service well led' section of this report.

● Staff completed medication administration records (MAR) charts electronically following the administration of medicines. The online system meant that management had real time oversight of medicines administration.
● We observed staff assisting people with their prescribed medicines in a dignified and person centred manner.

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 were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection
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.

We asked the provider to take action. They sent us an action plan which stated they would meet the regulations in full by the end of August 2022. The provider had taken action to ensure staff were wearing PPE as required. As of 31 August 2022, government guidance relating to asymptomatic testing had been paused.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections.

● We were somewhat 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 somewhat assured that the provider was responding effectively to risks and signs of infection.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.

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

The provider enabled people to have visitors in line with local and national policy. During our inspection we saw people receiving visits from relatives and making use of private and communal space in accordance with their preferences.

Staffing and recruitment
● Staff had been recruited safely. Records showed that pre-employment checks had been completed to ensure staff were suitable. However, further evidence of the provider's decisions to employ some staff was needed when there was limited information about their previous employment histories and character.
● Staff had Disclosure and Barring Service (DBS) checks completed prior to starting their employment. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● There was a diverse staff team at the service. One professional said, "They have a good mix of multicultural staff who are able to speak in different languages."

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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; 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; Continuous learning and improving care

At our last inspection the provider did not always have oversight of the quality assurance systems. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to take action. They sent us an action plan which stated they would meet the regulations in full by the end of August 2022. At this inspection we found quality and safety monitoring systems had not improved sufficiently and the provider was still in breach of the regulation.

● Systems and processes were not established and operated effectively in relation to shortfalls we identified at this inspection. Concerns in relation to fire safety processes, topical creams, care plans and legionella risks had not been identified and addressed by the provider. The provider told us they had found it difficult to keep on top of the governance associated with their management responsibilities. They were now looking to appoint a manager so they could solely focus on their provider responsibilities.
● The provider delegated tasks related to the quality monitoring of the service to staff members but had no system to check the accuracy or completeness of the monitoring tasks staff carried out. Audits had not always been scrutinised to monitor progress on improvement actions, or to ensure shortfalls would not impact people whilst improvements were being made. Incomplete fire safety and maintenance auditing meant risks to people we found had not been identified or mitigated.
● Some care records and documents were not complete, current or accurate to clarify and reduce associated risks to people. For example, records relating to people's Personal Emergency Evacuation Plans were not complete or accurate. The provider and staff were not aware of this concern.
● Effective processes to learn and improve from incidents had not been established. Incident reports and complaints were not always documented and actioned, therefore improvements were not always made and the potential for repeating mistakes was increased.
● The provider had not acted on guidance and requirements from other professionals in a timely manner. The provider told us work required by the fire and rescue service in May 2022 would be completed in October 2022.
● This is the second consecutive rated inspection where the provider has failed to meet regulations and

achieve a good rating as a minimum standard. This demonstrated governance systems were ineffective in addressing and sustaining improvements.

The provider had failed to establish and operate effective governance systems to assess, monitor and mitigate the risks to people's health, safety and welfare. Some records were not accurate or complete. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Statutory notifications had not been made in line with current legislation to allow the Care Quality Commission to monitor the service. All services registered with the Commission must notify us about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

The provider failed to send statutory notifications about notifiable events to the CQC. This was a breach of Regulation 18 (Notifications) of the Care Quality Commission (Registration) Regulations 2009.

● The service had implemented a system to monitor DOLS (Deprivation of Liberty Safeguards) applications, accidents and incidents and equipment. However, due to staff changes more time was needed to embed the system and ensure it was fit for purpose.
● Despite the governance concerns we identified on inspection; the provider was committed to providing high quality care to people. They acknowledged their ability to do this with the resources available was limited. One staff member said, "There is not always 100% support, but the manager is trying [their] best."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Relatives told us there were no newsletters, relatives' meetings or surveys to be able to gather their feedback. However, they all told us the manager was visible, approachable and pleasant.
● We received mixed feedback from professionals about the quality of engagement they received from the service. Some told us that communication from staff had been limited and, at times, contradictory. Whilst others spoke more positively. One professional said, "I have personally always received timely responses to phone calls or emails, and access to care records provided."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff generally told us they were happy working at St Paul's Residential Home and received support from management.
● We observed staff supporting people in a dignified and caring way. One person said, "The staff are excellent and I'm happy here."

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider failed to send statutory notifications about notifiable events to the CQC this was a breach of Regulation 18 (Notifications) of the Care Quality Commission (Registration) Regulations 2009 |

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<br><br>Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. |

**The enforcement action we took:**

The Care Quality Commission (CQC) has issued a warning notice for breach of Regulation 12 in relation to the care provided at St Paul's Residential Home.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to establish and operate effective governance systems to assess, monitor and mitigate the risks to people's health, safety and welfare. Some records were not accurate or complete |

**The enforcement action we took:**

The Care Quality Commission (CQC) has issued a warning notice for breach of Regulation 17 in relation to the care provided at St Paul's Residential Home.