Elizabeth Peters Care Homes Limited

St Jude's House

Inspection report

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Date of inspection visit:
24 April 2018
26 April 2018

Date of publication:
11 June 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this unannounced inspection on 24 and 26 April 2018. At our last inspection in March 2016 we rated this service 'good'.

St Jude's House is a care home. People in care homes receive accommodation and nursing or personal care as 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 provides accommodation and support to people with mental health needs. At the time of our inspection there were 9 people using the service one of whom was in hospital at the time of our inspection.

The building consisted of 10 bedrooms, a large lounge and dining area, launderette, indoor smoking area and a garden with an outdoor smoking area. The staff office was positioned next to the main communal area.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were measures in place to address risks to people using the service, however in one high risk situation these were not applied appropriately. Appropriate actions were taken when incidents had taken place. People were safeguarded from abuse by care workers who had a good understanding of the possible signs of abuse. Where money was held on behalf of people this was stored safely but not regularly checked to prevent loss or theft.

Staffing levels were suitable to meet people's needs safely, but safer recruitment measures were not always followed to check that care workers were suitable for their roles. Staff received appropriate training and supervision to carry out their roles and told us they were well supported by managers.

The provider carried out regular checks of the safety of the property but there was not a suitable fire risk assessment in place. People received their medicines safely, but appropriate records were not always kept of this and sometimes errors in recording were not detected by audits. Managers had good systems of handover and communication in place. The provider was not meeting requirements to display their ratings and to inform us of significant events that had taken place.

People had choice and control over their care as the provider took appropriate steps to obtain consent to care. People's care plans were reviewed regularly to make sure people's care met their needs, and the service was responsive when people's mental health had deteriorated. Information was not presented to people in line with Accessible Information Standards; we have made a recommendation about this. People

were supported to maintain good health and the provider worked well with other professionals involved in people's care. People were encouraged to eat well and to have varied diets.

People's views were sought through keyworking and residents meetings, although these meetings did not always take place regularly. We observed positive and respectful interactions between people using the service and care workers, and people appeared comfortable approaching care workers for support.

We found breaches of regulations regarding safe care and treatment and notifying the Care Quality Commission of significant incidents. You can see what action we told the provider to take at the back of the full version of this report.

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 safe in all respects.

The provider had risk management measures in place, however these had not been followed where a person was at high risk.

There were suitable staffing levels to meet people's needs. However, safer recruitment measures were not always followed to ensure care workers were suitable for their roles.

Care workers carried out checks of the building to ensure it was safe but there was not a suitable fire risk assessment in place.

People received their medicines safely, however at times discrepancies were present in recording which were not detected by audits.

Is the service effective?

Good

The service was effective.

People's needs were assessed before they started to use the service. People received the right support to eat well and improve their health.

Care workers received the right training and supervision to carry out their roles.

People had consented to their care and did not have undue restrictions placed on their liberty.

Is the service caring?

Good

The service was caring.

People told us they were treated well by staff and we observed positive interactions.

Keyworking sessions were used to obtain people's views about the service and to meet people's wishes.

Residents meetings were taking place to obtain people's views

but these were infrequent.

Is the service responsive?

Good

The service was responsive.

People had care plans designed to meet their daily needs and meet identified goals, which were reviewed regularly.
People received care in line with their plans.

The provider did not routinely assess people's needs to ensure that information was presented in an accessible way.

People were supported to access meaningful activities in the community and within the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was evidence of good joint working with other professionals. There were strong systems of communication and handover in place.

Managers made sure that audits were carried out regularly but in some areas these were not always effective.

The provider was not meeting their responsibility to inform the Care Quality Commission of certain events or to display the ratings from their previous inspection.

St Jude's House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a routine inspection as we had rated the service 'good' two years ago. We were not aware of any serious incidents or concerns about the service.

This inspection took place on 24 and 26 April and was unannounced on the first day. The provider knew we would be returning on the second day. The inspection was carried out by an adult social care inspector and an expert by experience who was present on the first day only. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to carrying out this inspection we asked the provider to complete a provider information return (PIR). This is a form which asks providers to tell us what they think the service is doing well and their plans to improve the service. We reviewed records we held about the service such as notifications of incidents the provider is required to tell us about. We also spoke with a contracts manager from the local authority.

In carrying out this inspection we spoke with two people using the service and two relatives of people using the service. We spoke with two senior care workers and a care worker. The registered manager was not available and we spoke with them by telephone following this inspection. We looked at records of care and support and medicines management for three people using the service. We looked at records of recruitment and supervision for three care workers. We also looked at records of incidents and accidents, internal audits, and staff training and meetings.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from harm as the provider's risk management plans were not followed in all cases.

Risk management plans were in place in most cases and reviewed regularly. This included identifying areas of possible concern and recording steps which were in place to mitigate these. People had signed these to indicate their agreement. Plans included a relevant history of the risk, self-management plans and other control measures which could mitigate the risk. Plans routinely considered people's views, and covered areas such as self-neglect, deterioration of a person's mental health and where appropriate, a falls management plan.

However, in one instance we noted a person had a history of behaviour which may pose a risk to care workers and others. This person's risk management plan was discussed in the minutes of a care plan approach meeting with a multidisciplinary team. This included random searches of their room. However, care workers told us that in reality searches were not as comprehensive as suggested in the meeting and were not documented, and described other measures that they took to mitigate this risk. The provider had not carried out their own risk assessment which described the steps they took.

Following the inspection, at our request the provider completed a satisfactory risk assessment and provided us with this and evidence of the steps they had taken to mitigate this risk.

The provider had also not carried out or reviewed a suitable fire risk assessment. An assessment had been carried out in 2015 by the registered manager, and this had not been reviewed since this time. This considered whether the building was provided with reasonable means of escape. However, there was not a fire risk assessment carried out by a suitably qualified individual who could consider the wider risks of fire in the property. The provider told us that they had such a risk assessment scheduled to take place next month and that they would send us a copy when this was completed.

The above issues constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had systems in place to record when incidents and accidents had occurred. This included details of what had happened, who had been involved in the incident and the managers recorded what action had been taken to prevent a recurrence. There was also a missing person's profile in place for each person, including a description of the person, a recent photograph and a summary of the person's health needs which would be useful for police. However, these lacked an agreed timescale for when the person should be reported missing. The provider had a suitable safeguarding policy in place to protect people from abuse. The provider's records showed there had been no recent safeguarding concerns and we did not see any incidents which could constitute potential abuse. Care workers had received training in safeguarding adults and were able to describe the signs that a person may be at risk of abuse and understood their responsibilities to report this.

Where money was kept on behalf of people this was securely stored and people signed for their transactions; staff told us they carried out daily balance checks but these were only signed for irregularly. This was usually monthly but there were occasions when these weren't completed for two months. This meant there was a risk of errors or theft not being detected. Staff told us that they did check balances every morning but didn't keep a record of this. The registered manager told us they would attach a note to finance books to state that the balance would be recorded on a daily basis in future.

Staffing levels were suitable to safely meet people's needs. Staffing levels were consistent and as described by the provider. This included having three staff on duty in the morning and two in the afternoon, and there was a waking member of staff and a sleep-in staff member at night. Staff also had access to a 24 hour on call service and were equipped with a mobile phone with an app which enabled them to call for help when working alone. There was also a call bell system in each person's room which enabled people to call for help when needed. Staff we spoke with told us they felt there were enough staff on duty, and that managers arranged extra cover when required, for example to support people to attend appointments. One person told us "The main office is very close, they come and support us."

The provider had obtained a work history, satisfactory references and proof of identification before they started work. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. However, in one instance we saw that a staff member had started their induction before their DBS check was received. The provider told us that they believed this was reasonable as the person was not working alone, but had not documented the reasons why the person needed to start work before proper checks had been carried out, or carried out a risk assessment of this.

There were measures in place to promote a safe environment, this included carrying out regular checks of fire extinguishers and testing emergency lighting. Staff carried out weekly audits of the health and safety of the premises, including checking fire safety equipment, exit routes and fire doors. Staff recorded the actions that they had taken following these audits, such as booking an electrician and taking action to ensure rubbish did not accumulate. However, fire alarm call points were not included in the provider's regular health and safety checks and had only been tested twice in the previous year. Floors were kept clean with no trip hazards, and we observed care workers using warning signs when floors were wet.

There were daily checks carried out of fridge temperatures and monthly checks of hot water temperatures to protect people from the risk of scalding, where temperatures were too high staff took action to address this. Care workers we spoke with did not know what was a safe temperature for bathing and there were not guidelines for water temperatures in place. There were up to date checks of gas and electrical equipment. CCTV was in use around the front and back doors with clear warning signs to inform people of this.

People were protected from the risk of infection. The building was kept clean and floors and surfaces were regularly washed and disinfected. There were specific sinks used for washing hands, these were equipped with suitable hand wash liquid and instructions for how to do this thoroughly. We observed that care workers wore gloves at particular times such as when administering medicines. Care workers received a detailed explanation of infection control processes during their inductions.

Medicines were not always managed correctly as records were sometimes incomplete. People had care plans in place for their medicines which included information about past events which could affect their concordance with medicines and details on the support they required. We observed people receiving their medicines in a suitable setting with the support of two staff members. Where people took homely remedies such as paracetamol, there was a list of this in place for each person which was agreed with the person's GP.

We also saw that when medicines were taken as needed there were protocols in place for when these should be offered to people.

There was no evidence of missed doses or medicines errors having taken place. Accurate tallies were kept of stocks of medicines. The provider used medicines administration recording (MAR) charts which were provided by the pharmacy. In some cases these charts had overlapped. For one person care workers had signed for medicines on both charts for a five day period, and for another person this was for a three day period. However, as medicines were provided in blisters an error had not taken place. In two cases MAR charts contained gaps, for one person this was for one day and for another person this had taken place on three occasions. Tallies showed that these medicines had been administered as planned. Weekly audits were carried out of medicines, however they had not detected these errors in accounting for medicines.

We recommend the provider seek advice from a reputable source about how to carry out effective medicines audits.

Good

Is the service effective?

Our findings

People's needs and choices were assessed before they started to use the service. The provider carried out detailed assessments of people's needs. This included assessing people's current presentation and mental status, their views on the service and their likes and dislikes. The assessment also included a comprehensive psychiatric and forensic history, information on the person's diagnosis and any already identified risk factors and the support people needed to mitigate these risks.

Care workers received the right training and supervision to carry out their roles. Comments from people included "Staff know what they are doing" and "Staff seem to be adequate, they have experience."

Care workers had obtained an NVQ level two or three in health and social care. The NVQ is a work based qualification which recognises the skills and knowledge a person needs to do a job. In addition to this the provider had assessed the training needs of care workers and had a plan in place to ensure staff received the necessary training and development. This included safeguarding adults, first aid and several different mental health awareness courses, including psychosis, anxiety, self-harm and how respiratory health relates to mental health. Care workers received these courses yearly; some care workers were a month overdue for some of these courses but had dates scheduled to address this. Care workers were also booked on external courses around recovery, behaviour, activities, dual diagnosis, physical health and medicines. A staff member told us "I've had all my trainings and we have a plan."

New members of staff underwent a detailed 18 part induction plan which they carried out in the service. This included days devoted to polices, fire, food safety, cleaning, infection control, promoting choices, mental health awareness, medicines and internal recording.

Care workers received quarterly supervisions. These were used to discuss the staff member's wellbeing, any issues affecting their work, and any concerns relating to people who use the service. Training and development needs were discussed and an agreed action plan was put in place.

People received support to eat healthily. The service provided meals three times per day, and we observed that fresh vegetables and fruit were made available. Care workers recorded the food people ate and records indicated people ate varied diets. Care workers we spoke with were aware of people's preferred options and encouraged people to try different food. People's weights were recorded regularly and changes to these were noted, which helped care workers monitor people for significant changes in weight at an early stage. When a person was in crisis, care workers had recorded extensive support to encourage the person to eat regularly and closely monitored the person's intake of food.

People received support from care workers to meet their health needs and to access the pathways of care. People's files recorded regular appointments to health screening and check-ups. The provider monitored people's attendance at routine appointments such as foot care, opticians and dentistry. Where people had a diagnosis of diabetes they received support to monitor their blood sugar levels and attend regular check-ups and screening. Where a person had had an unstable blood sugar level staff told us of some of the steps

they had taken to support the person to control their diabetes; subsequent records of the person's blood sugar showed that these measures had been effective. There were suitable risk management plans in place to monitor the risks associated with long-term health conditions such as diabetes.

Where a person had become unwell, this was recorded in their plan and the service had explored possible reasons for the person becoming unwell and steps that staff could take to prevent a recurrence, which we saw had taken place. We saw care workers offering support when a person appeared unwell.

Care workers also took regular measurements of people's blood pressure and pulse. We clarified with the registered manager what these were for. They told us that they provided this information to medical professionals when people were subject to ongoing health conditions and did not attempt to interpret it themselves, however care workers told us that they did not receive training in order to carry out these roles, but did this under the supervision of the registered manager.

The premises met the needs of people using the service. A smoking area was provided indoors with suitable ventilation in place, we saw that during the day people chose to smoke outside. Some people had en-suites and others used shared bathrooms, of which one had been adapted to a wet room. Nobody had mobility difficulties which would prevent them from accessing these facilities. We observed the building was kept clean and tidy throughout.

The provider was working in line with the Mental Capacity Act 2005 (MCA). The Act provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 had consented to their care plans and had made signed agreements regarding particular areas of their support.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One person was subject to restrictions on their liberty. There was an appropriate application made to the local authority to do so and the provider made sure that the existing order remained in date. People had cards which meant they could exit the building independently, but there was also an emergency release by the front door whereby people could exit in an emergency.

Good

Is the service caring?

Our findings

People and their relatives told us that the service was caring. Comments included "I am happy about the staff, they look after me", "It's pleasant and [my family member] is looked after well, the staff do their best" and "When [my family member] first came to this place they were very distressed, but the staff here gave a lot of care and now [he/she] is very happy." We observed pleasant interactions between people using the service and care workers.

People's plans included details of warning signs that a person may be becoming agitated and unwell and interventions that staff were to follow. This included diverting people's attention from intrusive thoughts and taking time to explain a person's issues and choices. People were confident in approaching care workers in the office when they needed reassurance or to discuss an issue of concern. We observed a person who complained of being distressed being asked if they wanted staff to do anything, and a member of the staff team suggested appropriate professionals who could come and help. We observed care workers protecting people's privacy and dignity, for example by closing doors before providing care, administering medicines or discussing confidential information.

Keyworking sessions were taking place regularly; this was intended to be weekly but in practice this was taking place twice monthly. People had allocated keyworkers. A care worker told us "we talk to people about their wellbeing and if they're happy with what we provide". Keyworking was used to record specific changes to the person's condition and particular events of note, including the information on what had gone well and what progress the person had made.

However, we noted certain phrases were used frequently that suggested that people's views were not always clearly recorded in this. For example, four consecutive keyworking documents contained exactly the same wording about a person's views regarding their care. Staff showed us instances of where they had had one to one meetings to discuss particular issues, such as items that people wanted support to buy including clothes and furniture. We observed people being offered choices on what to eat, and when people did not like what was being cooked that day they were asked what they wanted instead.

The provider carried out residents meetings to give people an opportunity to discuss issues which affected the household. These included people's food preferences, local groups and ideas for activities and house rules. However, in practice these were taking place irregularly. Two had taken place since November 2017, but before then meetings had not taken place for a year.

People had access to information about the service such as a service guide, information on how to make complaints and keyworking information..

Good

Is the service responsive?

Our findings

People told us that the service was responsive. Comments included "'They look after my [family member's] needs and I am happy' and ''I am involved in the care plan. They make sure that reviews are done".

People had agreed recovery plans and identified goals to work on, such as developing independent living skills. Care plans identified people's priorities for their care, such as developing a stable sleep pattern, and preventing social isolation. Plans were reviewed every six months, and covered areas such as physical health, mental health, food and drink, activities, behaviour support, finances and risk management issues. Care workers maintained daily records of the support people had received. These showed that people received care in line with their plans.

When people were new to the service the provider put a provisional care plan in place, which was developed as the service got to know people and their needs better. People received good support when they were unwell and in crisis. For example, where a person's mental health had deteriorated records showed that staff offered additional support and monitored the person's wellbeing, including maintaining contact with other professionals, and staff offered support such as to wash and eat even if this was declined.

We found that the provider did not routinely assess people's needs with regards to receiving information in a format which was applicable for them, and care plans were not designed in a way which meant that they could be understood by people with limited reading skills or sensory loss. This meant that the provider was not meeting the Accessible Information Standard. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with the AIS. We recommend the provider take advice from a reputable source to ensure that they meet the AIS.

People were supported to have meaningful activities. This included working with local organisations such as colleges to provider appropriate courses for people to attend. There was also an in-house activity programme, such as arts and crafts and weekly cooking days, and the service told us they intended to start a gardening group from May. We saw examples of artwork that people had made displayed in communal areas. The service was running a visit to a local farm during the course of our inspection and had organised days out to the beach. An activities timetable was displayed in the communal area.

The provider had a complaints policy in place which people had access to, and carried out weekly checks of complaints records to address any issues. However, no recent complaints about the service had been received and nobody we spoke with had complained about the service. No one using the service was receiving end of life care, however people had been supported to express their wishes for the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

The provider was not always meeting their responsibilities to inform the Care Quality Commission of significant events. This included two occasions when the police had attended the service which we were not informed of. The provider had applied for and received an order to deprive a person of their liberty in line with the Deprivation of Liberty Safeguards (DoLS), but had not notified us of this application. The registered manager told us that they would do so in future.

This constituted a breach of regulation 18 of the Care Quality Commission (Registration Regulations) 2009.

The provider was also not displaying their ratings from the previous inspection, but this was rectified at the time of the inspection. We were unable to ascertain if the provider was displaying ratings on their website as they used an outdated content system which could not be displayed on some modern computers. The provider told us that they would speak with their web team in order to update this.

A senior care worker told us "The general aim of Elizabeth Peters is to make people feel cared for and valued." Care workers told us they felt well supported by managers. Comments included "We definitely get enough support, the office is just down the road" and "I enjoy working here. I have support from the other colleagues and the manager." Managers had devised a detailed induction procedure which promoted the values of the service and a training programme with a strong emphasis on areas of mental health awareness.

There were strong systems of communication. Care workers told us they received a handover from the previous shift verbally and that this was also recorded in the form of an email to the next shift. This contained detailed information about how people were, what they had done during the day and whether there were any issues of concern. All forms of communication and records were completed on a computer system which care workers appeared comfortable using; this meant that daily information could also be monitored from the provider's head office. This included updating and reviewing people's care plans, daily records of people's support and keyworking sessions.

Electronic systems were also used for systems of audit, which included health and safety audits, medicines audits and routine checks of the property, which were monitored by managers, but had not always detected some issues with balance checks and those relating to medicines recording. There was also a website app used for rostering which was easily accessed by care workers. Care workers we spoke with told us they were notified of their shifts through an app on their phone, which made it easier to keep track of their schedules.

There was good joint working with other professionals. People's records showed that care workers routinely supported people to their appointments and that they kept professionals such as social workers and psychiatrists updated with people's conditions. The local authority told us that they monitored people's care through six-monthly placement reviews and through regular visits by social workers and occupational therapists. We found that managers did not always make sure that residents meetings and keyworking sessions were taking place in line with the provider's requirements, and that records of these were of a

sufficient quality to reflect people's views.

Staff meetings were used to discuss people's needs and recent changes to their conditions, and to encourage staff to share their knowledge of signs that a person may be becoming unwell. Managers used meetings to reinforce policies and procedures, for example around the management of medicines and health and safety checks. Staff meetings were well attended with detailed minutes taken. The provider told us that these should be carried out bi-monthly, but in practice one had taken place in January and one was due for the day of our inspection, which was a gap of four months. There had been a period in early 2017 where no meetings had taken place for six months. The provider told us they would ensure that these were bi-monthly in future.

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 The registered person did not notify the commission without delay of incidents which were reported to the police or any request to a supervisory body made pursuant to Part 4 of Schedule A1 to the 2005 Mental Capacity Act and the outcome of the request 18(1)(2)(f)(4A)(4B)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way as the registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users or ensured that the premises were safe for their intended purpose and used in a safe way 12(2)(b)(d)