St. Quentin Residential Home Limited

St Quentin Senior Living, Residential & Nursing Homes

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 Quentin Senior Living, Residential & Nursing Homes is a collection of three individual buildings providing personal and nursing care to up to 73 people. The buildings are located next to each other and are called, St Quentin's, The Hawthorns and Langley House. The service provides support to older people who may be living with dementia or those with a physical or sensory disability. At the time of our inspection there were 71 people using the service. Each building had its own care manager. The registered managers worked across all three buildings.

People's experience of using this service and what we found
Medicines were generally managed safely; however, some improvements were needed. People were protected from risks, however there was a range of levels of detail in some care plans and risk assessments. Some people had detailed information available; however, others did not always contain sufficient detail. Quality assurance systems in place did not always consistently identify and improve the quality and safety of the service. We received mixed feedback about whether people and relatives felt engaged and involved in the service, although we saw evidence of attempts to engage with relatives.

People were protected from the risk of cross infection. Work was ongoing to improve the physical environment to ensure it could be kept hygienically clean. People were protected from the risk of abuse by staff who had received training and understood their responsibilities. People were supported by enough safely recruited staff and did not have to wait long for support. Lessons had been learned when things had gone wrong. Registered managers understood their duty of candour. The home embraced working in partnership with other organisations and worked to continuously improve.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, we received feedback that one person was not having their needs met and professionals were taking action about this.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

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 2 December 2021) and there were

breaches of regulation. 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 a regulation.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 29 September and 1 October 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and governance processes. This inspection was also, in part, prompted due to some concerns raised to us about alleged poor care. This inspection also examined those risks, as well as reviewing the previous breaches.

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 requires improvement following this inspection.

You can see what action we have asked the provider to take at the end of this full report.

We also looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Quentin Senior Living, Residential & Nursing Homes on our website at www.cqc.org.uk.

Enforcement
We have identified a breach in relation to the quality assurance systems in place not always being effective at identifying areas for improvement. We issued a warning notice in response to this breach.

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.

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 Quentin Senior Living, Residential & Nursing Homes

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 2 inspectors and 2 Experts 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 Quentin Senior Living, Residential & Nursing Homes 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 Quentin Senior Living, Residential & Nursing Homes is a care home with 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 were 2 registered managers in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who shared details of information they'd received about the service. We asked Healthwatch for their feedback; they did not have any to share. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 15 people who used the service and 8 relatives, during the inspection. We also spoke with 11 staff including care assistants, nursing assistants, nurses and each home manager. We also spoke with both registered managers. We also spoke or received written feedback as part of the inspection from 3 professionals who worked with the service. We made observations in communal areas to observe interactions between people and staff and the care and support offered.

We reviewed a range of records. We looked at 7 people's care records and multiple medicines and daily care records. We looked at 4 staff files and some agency staff profiles to check recruitment processes. A variety of records relating to the management of the service, including policies and procedures, building safety records and audits were also reviewed.

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 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.

At our last inspection the provider had failed to ensure risks to people were assessed or mitigated to protect them from the risk of harm and medicines were not always managed safely. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12, although some further improvements were needed to medicines management.

Using medicines safely

- Medicines management needed improving.
- Eye drops were not always safely managed in 1 building (The Hawthorns). Two people's eye drops did not have an opening date on which could put them at risk of having them administered after the recommended maximum time they should be in use for. Two people had eye drops being stored in the fridge, open and past the recommended maximum time they should be open for – these did not appear to have been administered to either person as there were in-date bottles of eye drops available, but there was an increased risk of error as these had not been disposed of.
- Some people needed to be given their medicines hidden in food and drinks, known as covert medicines. There had been consideration of this with relevant health professionals and guidance was in place. However, one person's prescription had changed since the agreements and guidance were put in place, so required a review to ensure all medicines being administered were included in these records.
- Oxygen cylinders were not always stored safely in 1 of the buildings. They should be stored away from combustible materials. Following our feedback, the home agreed to review and rectify storage arrangements for oxygen.
- Despite this, people told us they received their medicines. One person said, "They bring me it [medicine] every day." Medicines stock levels matched records, so we could see people were having their medicines as prescribed. Medicine Administration Records (MARs) were clear and well completed.
- We were told people had regular medicine reviews by the GP to ensure the medicine they were on remained appropriate. One relative said, "The staff have been very supportive with my relative's medication. My relative had a review. The nurses here spoke to the GP. Now my relative is much more engaged and alert."
- People had instructions in place for 'when required' to help staff identify when it was needed.

Assessing risk, safety monitoring and management

- People were protected from risks, however there was a range of levels of detail in some care plans and risk assessments.

● Some people had detailed information available such as people's mobility and those who may communicate in physical ways, as well as verbally.
● However, others did not always contain sufficient detail. For example, one person had 2 health conditions which may need a response from staff should they display symptoms. Their plans in relation to these conditions lacked some basic information. Despite this, staff knew people well.
● Another person needed their fluids monitoring due to their health conditions and medicines they were taking. Their records referred to multiple different targets, so it was not clear what staff should be aiming for.
● Environmental concerns identified at the last inspection, such as lack of appropriate window restrictors, had been rectified. At this inspection we found 1 window which did not had a restrictor on, but this was rectified immediately.
● We found exposed pipework in 1 communal toilet and in some bedrooms with their own bathrooms. Following our feedback these were made safe by the provider. The provider also provided evidence a risk assessment had been put in place following our inspection.
● Other checks were made on the safety of the building to ensure it remained safe for people to use it, such as on gas, electrics, and fire safety.

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.
● However, we received mixed feedback from professionals about this. We received feedback that one person was not having their needs met and there were concerns about the care in relation to their restrictions. However, another professional commented how well staff seemed to know the person they were there to visit. Action was being taken for the person who was not having their needs met, by the professionals involved.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home appeared generally clean; however, some areas would benefit from refurbishment to ensure they could be cleaned effectively and kept hygienically clean. Such as areas with chipped varnish and paint and missing tiles in one bathroom. Some soft furnishings would have benefitted from a clean and we were told this had already been booked in for completion. The registered manager told us there had already been many improvements and a plan was in place to continue with these.
● 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 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
● There were no restrictions on visiting.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse.
● People told us they felt safe. One person said, "I feel safe here, I don't worry about anything." One relative told us, "I feel my relative is safe here. I feel comfortable with them being here. We're not worried about my relative's safety at all."
● Staff understood their safeguarding responsibilities. Staff were able to answer our questions and all knew how to recognise and report concerns. Records confirmed staff had received training.
● There was evidence referrals had been made to the local safeguarding authority, when needed.

Staffing and recruitment
● There were enough staff to support people and staff were recruited safely.
● One person said, "I think there's plenty of staff, they always come quickly even in the night." Another person told us, "Yes, I think there is enough staff. I can buzz them, and they do come quickly." A relative commented, "I think there's enough staff here. You don't have to go looking for them, there's always somebody here."
● The provider had a dependency tool in use to calculate the required staffing levels. We observed people did not have to wait long for support.
● There was a reliance on agency staff, generally to support those people who had 1-1 care. The provider attempted to block book agency staff for consistency.
● Checks were made on the suitability of staff to support people who used the service. This included checks on employment history, identification, references and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● Lessons had been learned when things had gone wrong.
● The registered managers had introduced an audit to monitor the use of certain medicines to ensure they were not being overused and to check if there was a pattern in which staff resorted to these medicines.
● There were also reviews of safeguarding incidents and accidents and incidents to ensure learning was identified.

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 requires improvement. The rating for this key question has remained 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.

At our last inspection the provider had failed to ensure people and relatives were engaged and involved in the service and systems were either not in place or robust enough to demonstrate effective management of risk. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, systems were still not robust to ensure the effective oversight to ensure areas for improvement were identified and rectified so the provider was remained in breach of this regulation.

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

- The registered managers were clear about their roles and responsibilities. However, quality assurance systems in place had not always identified and addressed areas for improvement.
- Systems in place for medicines had been effective at managing and monitoring stock levels to ensure people received their medicines as prescribed. However, they had failed to identify omissions in the management of eye drops, storage of oxygen and reviews of documentation being needed for some of those on covert medicines.
- The storage of medicines was now being regularly monitored, whereas this was not being consistently done at the last inspection. The provider had employed a medicine compliance officer since the last inspection to manage medicines across all 3 buildings. However, records showed the medicine fridge and medicine room were going above the maximum recommended temperature. This had not been identified, despite there being notices and instructions stating action needed to be taken. Following our feedback, the registered manager acted to resolve the issues.
- Some omissions in care records had not been identified, such as lack of detail for one person and conflicting fluid targets for another person. This had not been identified through audits by registered managers or through regular reviews by staff.
- The monitoring of some people's bowel movements was not always effective as there was not a consistent way of recording this. There was a mixture of a chart in their daily records, handover records and the electronic recording system. One person had not had a recorded bowel movement for 10 days. There was no impact as the person had since been to the toilet, but this issue had not been identified.
- Repositioning charts, for people who may be at risk in relation to their skin integrity, were not always clearly completed and did not always demonstrate people were being supported to move regularly enough. We did not find anyone had come to harm as a result of this, however records were not clear.

Systems were not always effective at identifying and addressing areas for improvement. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a range of other audits in place to monitor the service, such as mattress and pressure cushion checks, health and safety checks, the monitoring of staff training compliance, accidents and incidents and laundry audits.

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

● We received mixed feedback about whether people and relatives felt engaged and involved in the service. One person said, "They don't ask my opinions." Another person told us, "They don't ask me any questions about my opinions." Another person commented, "They don't ask my opinions about living here or about my care. If something was bothering me though I would tell the nurses."

● Despite these comments, people still told us they felt positive about the home and would recommend it to others.

● One person told us, "I would recommend it here. They are very friendly, very careful and they do anything you ask them to. I think the staff here are wonderful." Other comments included, "I would tell them if I thought something could be improved though. It doesn't and I'm happy with everything. I would definitely recommend it here" and, "I'm happy with everything, nothing could be better."

● We saw evidence of attempts to engage with relatives and staff through surveys, but there had not been many responses received. If feedback had been received, this was acted on. There was also a tracker to tracker when relatives had been asked about reviewing people's care plans or when a copy had been shared with them.

● There was recurring feedback from people that they were not always able to understand some staff who had English as their second language. The registered managers explained if there were concerns about staff communication, permanent staff would feed this back to address.

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 registered managers were aware of their duty of candour. One registered manager said, "It's being open and honest."

● One relative said, "Any concerns that I had have been dealt with."

Continuous learning and improving care; Working in partnership with others

● The home embraced working in partnership with other organisations and worked to continuously improve.

● The local authority had carried out monitoring visits and the home had responded to feedback.

● The registered manager was active in local and national groups about social care and aimed to share learning and best practice within the sector.

● The registered manager gave an example where they had identified a theme from feedback there had been an issue with ensuring people's laundry was also returned to the correct person. They had acted to reduce the risk of this occurring.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not always effective at identifying areas for improvement and addressing these.

The enforcement action we took:

Warning notice