St Cecilia Care Home Limited

St Cecilia Care Home

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 Cecilia Care Home is a residential care home providing care and accommodation for up to 17 people in one adapted building. At the time of our inspection there were 11 people living in the home

People's experience of using this service and what we found
The service did not have robust systems in place to monitor the quality and safety of the service. Systems that were in place were not effective and had not identified the improvements that were required. The provider visited the home regularly, but no formal audits had been completed to identify any shortfalls and to monitor any actions identified.

The service did not have a way of assessing the staff numbers it needed to keep people safe. We have made a recommendation about staffing.

Staff followed infection prevention and control measures. Medicines were managed safely. Staff knew how to recognise, and report abuse.

The provider had appropriate recruitment procedures in place to ensure staff employed by the service were safe to work with vulnerable adults.

Relatives told us communication was good with the service and they were satisfied with the support their relatives received.

People and relatives told us people felt safe with the care and support they or their relative received. People and staff were positive about the registered manager.

The service worked in partnership with health and social care professionals.

People were supported to have 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.

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

Rating at the last inspection
The last rating for this service was good (published 21 May 2018).

Why we inspected
This inspection was prompted by a review of the information we held. This was a focused unannounced inspection covering the key questions of Safe and Well Led. This report only covers our findings in relation to

the Key Questions Safe and Well-led.

We 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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection. We found evidence the provider needs to make improvements. Please see the Safe and Well Led sections of this report. The provider took action during the inspection to mitigate the risks.

Enforcement and Recommendations
We have identified breaches in relation to assessing, monitoring and managing risks to people, governance and quality assurance systems at this inspection. We have made a recommendation about staffing levels.

Please see the action we have told the provider to take at the end of this report

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Cecilia Care Home on our website at www.cqc.org.uk

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 Cecilia Care 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 3 inspectors over 2 days and was supported by an Expert by Experience for 1 day. 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 Cecilia Care Home is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. St Cecilia Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post.

Notice of inspection

The inspection took place on 11 and 12 January 2023 , it was unannounced on the first day and announced on the second day.

What we did before the inspection
We reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is legally required to tell us about. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 3 relatives. We spoke with 7 staff, which included the registered manager, the provider, 1 senior care staff, 2 carer's and 3 domiciliary staff. We undertook observations of people receiving care to help us understand their experiences. We reviewed a range of records. This included 4 people's care records and 2 medicine records. We looked at 2 recruitment files and 1 agency profile. A variety of records relating to the management of the service were reviewed including, accident and incident records and audits. We sought feedback from professionals who work with the care home.

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.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Lessons Learned

- The provider did not always follow their system to assess risks to people before undertaking their care and support. Risks were not always fully assessed, monitored and managed to keep people safe.
- Records of incidents, accidents and falls were recorded, although there was no system in place to look for trends, identify any learning, and reduce the risk of an incident happening again. For example, where a person had several unwitnessed falls over a period there was no analysis of the falls to protect the person in the future.
- People were not always protected from the risks of unsafe care because care planning was not always completed. The provider had not completed a care a plan and risk assessment for one person, the person sustained an injury at the care home resulting in a hospital stay. We identified there was no care plan and assessment of risk for the person upon their return to the care home putting them at risk of it happening again.
- People were at risk due to risks from legionella not being effectively managed. There were not regular checks on sentinel points and hot water tanks.

A failure to assess, monitor and manage risks within the service placed people at increased risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- During the inspection, the registered manager responded to the concerns identified and provided action plans on how some of the concerns would be addressed.

- Despite the concerns identified, we received positive feedback from health professionals we contacted who told us they felt the service was a safe environment.
- Checks were in place relating to the safety of the building, such as fire equipment checks, PAT testing (portable appliance testing), gas and electrics, and water temperature checks.
- Systems were in place to assess and monitor fire safety. There was a recent fire risk assessment in place. Personal Emergency Evacuation Plans (PEEPs) assessed the level of support people required to evacuate safely. PEEPs contained a picture of the person which support emergency services in identifying people.

Staffing and recruitment

- Feedback about staffing levels was mixed. A relative told us, "Mealtimes, I find the atmosphere difficult, not very inviting all a bit rushed and hectic and not enjoyable, the dining room is stark."

● During our inspection we observed one person trying to stand and move without their frame. Once a member of staff was present the person stood safely and moved with their frame to another seat. We also observed a person with an unattended skin tear walking about the home.
● Records showed some people were having regular unwitnessed falls in their rooms and in communal areas. The provider did not have an effective system, such as a staff dependency tool to assess staffing levels were sufficient at the right times to keep people safe.

We have made a recommendation to the provider to ensure they can satisfy themselves they have the right staffing levels to meet the needs of the people all of the time.

● Recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
● Relatives were positive about the care people received. 1 relative said, "came for respite and when she came home, she was talking again. That's when we decided she needed to live here." Another relative said, "I feel she is safe, was [previously] living by a main road, now has 24-hour care."
● Staff received training in safeguarding adults. Staff we spoke with reported they would feel confident and able to report concerns to the registered manager, or the provider if they needed to. Policies and procedures were in place to protect people from abuse.
● There were positive comments from relatives who said family members were well cared for and safe. 1 relative told us, "The staff are lovely; they will come up and have coffee with her."

Using Medicines Safely
● Medicines were managed safely. Staff who administered medicines received training in safe medicine administration and the provider checked they were competent to do so.
● Medicines were stored securely in a locked room and temperatures were taken to ensure medicines were kept at the correct temperature. A relative told us, "They manage her medicines, no issues." A person said, "Staff do medication and I get it [prescribed medicines]."

Preventing and controlling Infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service appeared clean and was well maintained.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visits for people living in the home in accordance with the current 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 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).

- The provider had followed the principles of the MCA. Where people lacked capacity to make a specific decision, a mental capacity assessment had been undertaken and a best interests process followed.
- Deprivation of Liberty applications had been made where required.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

●The service did not have a robust system in place to monitor the quality and safety of the service. Audits were in place, however there was insufficient auditing in some areas to identify or address the issues we found during the inspection. For example, care plans and falls auditing.

● The provider did not ensure risks to people were always assessed, monitored and managed to keep them safe. This placed people at risk of harm. One person who had sustained a serious injury did not have a care plan or risk assessment in place.

● The provider did not have a system in place to assess if it had enough staff on duty and to monitor whether people's needs were being met in a timely and safe way.

● The provider told us they visited the home once a week and kept in contact with the manager by phone. The provider told us when they visited, they walked around the home and checked some records. However, they confirmed they did not conduct formal quality monitoring of the home or maintain records from visits. This meant there was not an effective system for the provider to have oversight of service delivery or to identify and monitor the shortfalls within the home to make required improvements.

Systems were either not in place or robust enough to demonstrate that there was adequate oversight of the service. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● During and following the inspection, the management team acted promptly on our feedback and provided assurances the concerns identified would be addressed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

● People knew who the registered manager was and felt able to approach them. A relative told us, "[Name of registered manager] is easy to speak to and always responds to messages but I would talk to carers, they can always tell me what is happening, and they look in their books."

● Staff told us the registered manager was visible and had an open-door policy. Staff said meetings were held regularly. The registered manager recently sent out a staff questionnaire and were still collecting responses at the time of the inspection.

● The registered manager told us people raised concerns or issues on a one to one basis if required. Meetings of people who used the services were held every 6 months. Staff told us they involved people by

having informal conversations with them in between.
● Staff were happy in their jobs which created a friendly atmosphere for people. People were cared for by staff who felt well supported by their colleagues and the management at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
● Communication systems were in place to help promote effective discussions between staff and the registered manager. This included daily handover reports and written daily records.

Continuous learning and improving care; Working in partnership with others
● The registered manager told us they were part of the local 'Dementia Action Alliance Group' which worked towards raising dementia awareness and inclusivity with local business and the community.
● The service worked in partnership with external agencies such as GP's, local authorities and other health and care professionals. A GP told us the home was, "Thorough and pro-active, trying all reasonable steps before contacting the GP." A local community nurse said, "The staff are always keen to develop existing skills to aid patient care and deliver excellent quality care to all the residents of the home."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to safely monitor and manage risk to people. Regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems were in place or robust enough to demonstrate that there was adequate oversight of the service. This placed people at risk of harm. Regulation 17.