

Saint Jude Residential Care Home Limited

Saint Jude Care Home

Inspection report

6 Warren Road
Blundellsands
Liverpool
Merseyside
L23 6UB

Tel: 01519248427

Date of inspection visit:
21 October 2021
25 October 2021

Date of publication:
10 December 2021

Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

About the service

Saint Jude Care Home is a residential care home providing personal care to 17 people aged 65 and over at the time of the inspection, including people living with dementia. The service can support up to 22 people. The service is a domestic style property and accommodation is over three floors.

People's experience of using this service and what we found

There were significant concerns with health and safety which put people at risk of harm. We found multiple fire doors that did not close, no fire evacuation drills, no record of checks on emergency lighting and missing radiator covers. We raised concerns with the local fire service and the provider responded immediately to address these.

Risks to people were not always appropriately assessed or managed. Care plans did not contain enough information to support people safely. The manager had identified this concern when they started in August 2021 and had plans to review care records.

Medicines were not always safely managed. There was no appropriate medicines policy to support the safe management of medicines. Not all staff administering medicines had been assessed as competent. There was a lack of guidance for staff on administering as and when needed medication (PRN) to people. This meant people were at risk of not receiving medicines when they needed them.

There were no systems in place to effectively and consistently analyse incidents to ensure learning could be implemented at the earliest opportunity to prevent reoccurrence.

People were at risk of being supported by staff that had not been recruited safely. There were not enough staff to meet people's needs. There were ineffective systems to determine staffing levels and not all staff had completed training necessary for their role.

People were not always admitted to the home safely following current COVID-19 guidance. Infection and prevention control policies were not updated to reflect the current guidance to ensure this was managed safely.

There was a lack of leadership, oversight and governance in the home. There had been changes in the management team since the last inspection with no effective handover completed with the manager.

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 8th January 2021) and there were multiple 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 enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

We carried out an unannounced focused inspection of this service on 8th January 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 good governance and fit and proper persons employed.

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.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

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.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the assessment, management and mitigation of risk, recruitment processes, staffing and governance and oversight of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate ●

Saint Jude 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 Care Act 2014.

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

On day one the inspection was carried out by two inspectors. On the second day it was carried out by one inspector.

Service and service type

Saint Jude Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 did not have a manager registered with the Care Quality Commission. This means the provider was legally responsible for how the service is run and for the quality and safety of the care provided. There was a manager in post at the time of the inspection who was in the process of registering with the CQC.

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 and professionals who work with the service. We used all of this information to plan our inspection.

The provider was not able to complete a Provider Information Return. 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.

During the inspection

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 spoke with three people who use the service and four relatives about their experience of the care provided. We spoke with eight members of staff including the manager, provider, senior care workers and care workers.

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

After the inspection

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

We made a referral to the local fire service to raise concerns with fire safety at the home.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection the provider had failed to ensure safe recruitment processes were followed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation.

- Recruitment processes were not safe, and people were at risk of being supported by unsuitable staff. Full employment histories were not always recorded or corroborated and appropriate references were not always in place. We asked the manager to follow this up immediately.
- When background checks on staff identified concerns, these were not appropriately risk assessed. The manager completed this before the end of the inspection.
- When information was missing from application forms, the manager failed to follow this up appropriately.

The provider had failed to ensure recruitment processes were appropriate and safe. This was a continued breach of regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to review recruitment processes to ensure staff were recruited safely.

- There were not enough suitably qualified staff to support people. During the inspection we observed multiple people shouting staff for help but having to wait as staff were unavailable.
- Staff told us staffing levels were unsafe. One staff member said, "Staffing levels are too low. People are at risk."
- There were not always staff available who were trained to administer medicines. People who required a medicine of a night were not always able to have this administered. The manager was in the process of training other care staff to administer medicines to ensure cover was available of a night.
- When care staff were covering other duties, such as cleaning and kitchen duties, there was no extra cover to ensure people were supported with their care needs.
- Staff administering medicines were interrupted multiple times as there were not enough staff to support with tasks. During day one of the inspection, we saw a senior care worker have to stop medicines to support someone in distress and answer the door and phone to other professionals.

There were not enough suitably qualified, skilled and experienced staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to review staffing levels in light of the concerns raised.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At our last inspection the provider had failed to ensure risks relating to the health, safety and welfare of people were assessed, monitored and mitigated. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

- Risks within the environment were not consistently assessed, monitored and managed. Although checks were in place to monitor health and safety in the service, these were not robust. Health and safety checks, such as fire doors, hot water temperature checks and window restrictors were not always completed or recorded. This concern was noted at the last inspection.
- Incidents that occurred in the home were not always recorded. There was also no analysis of incidents which meant opportunities for learning and reducing the risk of recurrence were missed.

We found no evidence that people had been harmed, however, systems and processes were not consistently implemented to ensure risk related to the health and safety of people was assessed, monitored and mitigated at all times. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We found multiple and significant concerns with fire safety. No fire evacuation drills had taken place and staff we spoke with were not aware of the evacuation process. There was also no equipment to support people in the event of an emergency evacuation. Due to concerns we found we made a referral to Merseyside Fire and Rescue who completed follow up checks with the service to ensure people were protected from harm in the event of an emergency.
- Multiple radiator covers were missing from people's bedrooms and communal areas. No appropriate risk assessments had been completed to ensure people were not at risk of burning from the hot surfaces.
- People were exposed to risk of harm due to a lack of person-centred risk assessment. Risk assessments were either not completed, not accurate or reflective of people's current needs, or detailed enough to guide staff on safely supporting people.
- Where people were supported with bedrails, there were no risk assessments in place to ensure risks to people had been assessed and managed. Bed rails checks were not always completed to make sure they were safe.

The provider had failed to robustly assess risks relating to the health, safety and welfare of people. This placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to the risks to people from radiators and fire by addressing concerns with the fire doors, fire evacuation procedures and radiator covers.

Using medicines safely

At our last inspection we recommended the provider consider current guidance on administering medicines and act to update their practice. At this inspection the provider had not made enough improvement and was in breach of regulation.

- Care staff who administered medicines did not always have appropriate competency checks to ensure their practice was safe.
- Medicines were not always administered as prescribed. One person was prescribed warfarin. We checked the stock of this medicine and there were three tablets in stock that should have been administered. We asked the manager to seek clinical advice regarding this person's missed medicines.
- There was not always enough information to guide staff on when to administer when required medicines. One person was prescribed a medicine as and when needed up to twice a day, but this had been administered every morning. A senior care worker told us the person had a health condition that meant they needed the medicine every day and a healthcare professional had advised to do this. However, there was no information recorded to evidence this and the prescribing instructions did not reflect this.

The provider had failed to ensure the safe management of medicines. This placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- On arrival at the home we found used COVID-19 tests discarded on the front desk. These were discarded immediately when we raised the concern with the manager.
- Regular COVID-19 testing for staff and residents had not taken place in line with national guidance. However, the manager had implemented this recently.
- New admissions to the home were not always admitted following national guidance. One person recently admitted should have been in isolation but was mixing with others in communal areas. There was no risk assessment in place to show how the risk of cross infection was being reduced. We asked the manager to complete a risk assessment immediately.
- There were no cleaning schedules to show regular cleaning of high touch point areas, such as handrails. There wasn't always domestic staff on shift to ensure regular cleaning took place.

The provider had failed to ensure the risks of the spread of infection were safely managed. This was a breach of regulation 12 (Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Systems and processes to safeguard people from the risk of abuse

- Staff told us they completed training in this subject and knew what actions to take if they needed to.
- People and their relatives told us they were safe at the home. Comments included, "I feel safe absolutely. I had a problem with my finger and the staff sorted it straight away for me" and "Yes, I feel safe. Carers are very good and kind to me. If you ask, they [carers] will do it."

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure systems and processes were in place to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation.

- Systems and processes to assess and monitor the safety and quality of the service were ineffective. Not all the concerns found at this inspection had been identified by the managers or provider's monitoring processes.
- Checks on the safety of the building were not always recorded and there was no evidence these had been completed regularly. We found significant concerns with health and safety at the home which put people at risk of harm. The provider took immediate action to address these concerns.
- Oversight and governance at the home was inconsistent. The lack of leadership since the last inspection was evident in records, audits and the planning of people's care.
- Records were not of good enough quality to guide staff on how to meet people's needs safely in a person-centred way. This meant there was a risk care and support provided may be unsafe.
- Systems were not robust enough to ensure learning from incidents was implemented to further reduce risk to people.
- People were at risk of receiving poor care because risks to their safety and well-being were not mitigated or managed appropriately to protect them from harm.
- There was a lack of appropriate guidance to guide staff in supporting people safely. Policies were not reviewed regularly and did not always reflect best practice guidance.

The provider had failed to effectively assess, monitor and improve the quality and safety of the service provided. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and provider were receptive to feedback during the inspection and implemented some

immediate improvements to reduce the risk of harm to people.

- There had been an issue with notifications being submitted to CQC, however this was discussed with the provider before the inspection and notifications were submitted in line with legal requirements.
- The ratings from the last inspection were not displayed in the home as required. We raised this with the provider during the inspection and this was addressed immediately.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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

- Staff told us they had been asked for feedback but this wasn't listened to or acted on.
- Some staff felt there was a lack of support from the provider and previous manager and this impacted staff morale. One staff member said, "There's a lack of support for staff. We [staff] are overworked. It's causing tension with staff and causing them to leave. Staff turnover is horrendous." Most staff acknowledged that morale was starting to improve with the new manager.
- Relatives told us communication with the home and involvement in their loved one's care had improved since the manager started.
- Managers and staff understood their legal responsibility to be open and honest with people.

Working in partnership with others

- Referral to healthcare professionals were made when required. However, advice given was not always reflected in people's care records.
- The provider worked with other services to ensure the safety and wellbeing of people were promoted. However, when recommendations were made these were not always acted upon in a timely manner.

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 The provider failed to ensure care and treatment was provided in safe way.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effective systems and processes to ensure risks were assessed, monitored and mitigated. The quality and safety of the service was not effectively monitored and improvements were not made in timely way.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to establish and operate safe recruitment procedures.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

The enforcement action we took:

Warning notice