Elizabeth Peters Care Homes Limited

St Jude's House

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

At our last comprehensive inspection in April 2018 breaches of regulations were found. This was because the provider was not managing risks appropriately or notifying us when serious incidents had occurred.

We carried out this unannounced focussed inspection of 'St Jude's House' on 15 January 2019. This was to check that improvements to meet these legal requirements had been made. The team inspected the service against two of the five questions we ask about services: Is the service safe and well led?

No risks, concerns or significant improvements were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

This service 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 is registered to provide accommodation for up to 10 people. At the time of this inspection there were nine people using the service.

At our last inspection we found the provider was not doing all they should to mitigate risks from a person's behaviour. At this inspection we found the provider was now doing this, but improvements were still required with regards to updating risk assessments and promoting positive risk taking.

The provider had addressed fire risks by arranging for an appropriate fire risk assessment. However, aspects of the premises were unsafe and food hygiene and storage was not always safe. Staff lacked training in food safety.

There were suitable processes to safeguard people from abuse. However, the provider did not monitor incidents and accidents to look for trends and how they could learn when incidents had occurred.

The provider followed safer recruitment processes and people told us they thought there were enough staff to support them safely. Medicines were safely stored and managed.

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.

Managers did not always ensure that people could speak up. Keyworking sessions and tenants' meetings did not take place regularly. Systems for recording information were sometimes complex and difficult to manage. The provider submitted notifications of significant events as required. The rating of the previous

inspection was displayed in the service but not on the provider's website.

We found breaches of regulations relating to food safety and display of ratings. You can see what action we told the provider to take at the back of the full version of this report. We will return to the service within 12 months of the previous comprehensive inspection 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

Aspects of the service were not safe.

Risks to people's safety were assessed, but there were some improvements required regarding managing risks. People were safeguarded from abuse.

There were poor standards of food hygiene and care workers had not received training in this area. Some areas of the premises were not well maintained.

There were enough staff to meet people's needs and safer recruitment processes were followed.

Medicines were safely managed and checks were carried out on these.

Is the service well-led?

Requires Improvement

Aspects of the service were not well led.

Systems for obtaining people's views were not consistently followed. Audits did not always pick up on issues of concern.

Recording systems were difficult to manage and were not always complete.

The provider was meeting requirements to inform us of significant events that had occurred at the service, but did not always display their ratings from their last inspection as required.

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.

Why we inspected- we found a breach of regulations at our previous inspection in April 2018. This focussed inspection was carried out to check improvements to meet these legal requirements had been made. We were not aware of any further concerns about the service.

The inspection took place on 15 January 2019 and was unannounced. This inspection was carried out by one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In carrying out this inspection we spoke with the deputy manager, two senior support workers and a support worker. We looked at records of care and support for three people and records of recruitment for six care workers. We also looked at records of audits, staff training and consultation with people who used the service. We spoke with six people who used the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found the provider was not meeting regulations relating to safe care. This was because there were not always appropriate steps taken to mitigate risks to staff and people using the service.

At this inspection we found the provider was meeting this regulation as people were no longer at risk. However, practice still needed to improve with regard to how risks were assessed and managed. In April 2018 a person using the service displayed behaviour which was a high risk to people using the service and staff. As a result the provider had agreed with a multidisciplinary team to conduct room searches with the person, but this had not been taking place. Following the inspection in April 2018 the provider gave us a copy of a revised risk assessment and evidence that room searches had been taking place.

At this inspection we found that the person was no longer displaying the behaviour of concern. Room searches had continued sporadically, and both the person and the staff team felt that this was now unnecessarily intrusive. However, the provider had not revised this risk assessment or considered more positive ways to mitigate this risk. Following our inspection the provider updated the risk assessment for this person to address these concerns.

Other risk assessments were in place where people were at risk of avoidable harm. This included behaviour of concern and when people may be at risk in the community, and there was monitoring in place to minimise these risks.

The service did not ensure people were protected from infections as food hygiene practices were not satisfactory. Parts of the kitchen were unclean and some surfaces were chipped and worn, including where medicine cups had been left to dry. Chopping boards were colour coded to prevent cross infection but these were also damaged and worn. Staff kept records of the fridge temperatures but lacked guidance on what constituted a safe temperature. Records showed that the fridge temperature was regularly between seven and nine degrees centigrade, but the Food Standards Agency advises that a safe temperature is below five degrees and should not be above eight degrees. Care workers had not received training in food hygiene even though their roles involved preparing food for people.

There had been some improvements to the premises but we found areas which remained unsafe. For example, a lock had been changed on the back door which meant people no longer needed to use the staff room as a fire escape. Several bathrooms had been updated with improved tiling and fittings. However, the main office was poorly laid out with many trailing wires and extension cords. Portable Appliance Testing had been carried out, but one extension cable was clearly charred from previous overloading and this had not been replaced. We pointed this out to the provider who agreed to replace it. The provider told us that the kitchen was routinely kept locked to restrict access to knives, but we found this unlocked several times during the course of our inspection.

The provider carried out annual health and safety checks and had completed a workplace risk assessment

but these did not address these issues of concern. We also informed the local authority of our concerns in this area.

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

At our last inspection the provider did not have a fire risk assessment carried out by a suitably qualified person. This had since been carried out, and priority actions had been identified and addressed, and the fire risk assessment now considered the risks tolerable. Fire equipment, including the fire alarm had been checked to ensure it was safe to use.

Care workers had received training in safeguarding adults and there were suitable procedures for reporting suspected abuse. Most people we spoke with told us they felt safe using the service and that staff were kind, but one person expressed concern about the safety of the premises.

People told us they thought there were enough staff in the service and that staff came when they needed help. There were enough staff to support people, and this included having a waking night and a staff member sleeping in.

The provider operated safer recruitment. This included obtaining proof of people's identification and their right to work in the UK. Prior to starting employment the provider obtained a full work history, evidence of satisfactory conduct in previous employment and carried out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

The storage of medicine cups was not safe due to these being left to dry on an unclean surface. However, other aspects of medicines management were safe, but there were sometimes flaws in how these were checked. Medicines were kept locked in the staff office and care workers completed a medicines administration recording (MAR) chart when they administered people's medicines. Recent charts were correctly completed, but one chart in November had a number of gaps. Although an audit recorded that there were "some gaps" on this chart, it did not detail what these were or what actions had been taken to verify the person had safely received their medicines.

The provider kept records of when incidents had taken place, but sometimes these records were incomplete. The provider did not routinely monitor trends of low level incidents or identify ways in which these could be learnt from.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found a breach of regulations, as the provider had not notified us of significant events that had occurred in the service. At this inspection we found the provider was now meeting this regulation. One incident had occurred where the police had been called to the premises, and the provider had notified us of this.

The provider was displaying their ratings from the previous inspection in the registered premises. However, these were not displayed on the provider's website, which constituted a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service were unsure about who the manager of the service was, and in practice the registered manager was not based full time at this location.

People told us that they did not feel they were asked for their views or that they had a say in the running of the service. Comments from people including "They do not ask me for my views" and "I don't have say, I wish I did." There were systems in place for obtaining people's views about the service, but these were not consistently applied. For example, tenants' meetings had not taken place since June 2018. There was a questionnaire to obtain people's views, but this had not been done since June 2017. People had keyworking sessions, but these did not take place regularly. One person only had two keyworking sessions in 2018.

Other systems of audit were inconsistently applied. For example, the provider told us they carried out weekly medicines checks, however only seven of these had been carried out since August 2018. A team meeting had taken place in December 2018 and was used to discuss expectations in areas such as keyworking and medicines management. However, this was the first team meeting since July 2018.

Care workers told us they were well supported by managers. There were suitable systems for ensuring information was handed over between shifts.

Systems in the service were difficult to navigate. Many forms, including daily logs and summaries, were now completed in the office using a computer. However, paper systems were also maintained, and in many cases care workers then had to print off forms to keep manual filing systems up to date and staff did not always complete this. Some information completed in the service could subsequently only be obtained by head office. A care worker told us "A lot of things need to be completed."

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 Care was not provided in a safe way as the registered person did not ensure the premises were safe for use in their intended purpose or used in a safe way and did not control the spread of infections 12(2)(d)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments A website maintained by or on behalf of the service provided did not show the most recent rating by the Commission of the service provider's overall performance 20A(2)(c)