Chengun Care Homes Ltd

St Augustines Court Care Home

Inspection report

105-113 The Wells Road
Nottingham
Nottinghamshire
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Date of inspection visit:
14 October 2020
15 October 2020
27 October 2020

Date of publication:
14 December 2020

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
St Augustine's Court Care Home is a nursing home providing personal and nursing care for up to 40 people. On the first two days of inspection, 36 people lived at the care home. On the third day, 33 people were living in the care home. The service provides care to people, some of which are living with dementia. The service is a purpose-built property. Accommodation is split across two floors. There are several communal living areas, an accessible sensory garden, a cinema room and a sensory room.

People's experience of using this service and what we found
People did not have good outcomes. Restrictive practice was used at the service, including locking people in rooms and physically restraining them without staff training. One person reported staff being "rough with me". Another had bruising which supported a received allegation that the person had been restrained. These two concerns were reported to the management team, we returned 12 days later and were not provided with evidence that these allegations had been investigated. This left people at ongoing risk of neglectful care. We repeatedly observed staff not responding to people's obvious distress and need for support.

Medicines were not managed safely. Staff had received training, however this was assessed as ineffective when observing the service. Care plans were generic and did not provide sufficient guidance for staff to provide safe and person-centred care. There were insufficient staff to respond to people in a safe way. We also observed staff not attend people who required urgent support. Lessons were not learnt when things went wrong. This meant people were at risk of incidents repeating themselves.

Poor leadership and oversight of the service had impacted on the quality of care and treatment people received. Staff reported that the management team shouted at them. There was poor morale at the service. The service was inspected during the covid-19 pandemic. Staff were observed to wear personal protective equipment in line with government guidelines. People and staff were regularly tested for covid-19.
We communicated our concerns to the management team after the first two inspection days, they responded to our concerns stating that they would work to improve the service. We returned 12 days later and identified that minimal changes had occurred, this left people at ongoing risk of harm. We identified four breaches of regulation.

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

Rating at last inspection
The last rating for this service was requires improvement (Report published 23 October 2020).

Why we inspected
We last inspected this service on 8, 9, 10 and 17 September 2020. After our inspection, we received multiple

concerns about the quality of care provided. This included allegations of: low staffing, poor management of incidents, the use of restraint and neglectful care.

As a result of these concerns, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions 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.

Enforcement
The previous inspection found no breaches of the Health and Social Care Act 2008 (Regulated Activities).

At this inspection we identified breaches of regulation 12 (Safe care), 13 (Safeguarding), 18 (staffing) and 17 (Governance). These are requirements for the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the first inspection site visit, we urgently imposed conditions on the providers registration. These conditions prevented the provider from admitting new service user's without CQC permission. They also required a review of the safety of the service. The provider did not appeal this urgent enforcement action.

When we returned to the service, we identified that improvements had not been made and people were still at risk of harm. We therefore wrote a letter to the provider, proposing that we would cancel their registration with the CQC. Cancelling a provider's registration would prevent them from legally providing personal care support from the premises. The provider informed us that they did not intend to appeal this proposal. We have therefore taken action to cancel the provider's registration.

Follow up
We have cancelled the provider's registration. This provider is therefore not legally allowed to provide personal care support from these premises. If they apply to register another service, this will go through our usual registration assessment processes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

St Augustines Court 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.

This was a focussed inspection to check whether the provider had met the requirements for the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection team consisted of two inspectors and two assistant inspectors.

Service and service type
St Augustine's Court 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We checked the COVID-19 status of people on site, when we were in the building.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and health care commissioners who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections

We used all of this information to plan our inspection.

During the inspection
In the late evening of 14 October 2020, we attended the service unannounced. We reviewed the safety of people using the service. We spoke to two people that evening about their experiences of the care provided. After our site visit, we required further information and assurances. We therefore decided to return to the service. The management team were unaware that we intended to return, therefore the second site visit on 15 October 2020 was also unannounced.

On 15 October 2020 we spoke to six people about their experiences of using the service. The inspection team also spoke to five care staff, one nurse, the registered manager and the nominated individual. An office based assistant inspector phoned seven other staff to gather their feedback. An external nurse attended the service with us, they supported the inspection team to review people's health and medical needs.

We reviewed a range of records. This included the relevant parts of eight people's care records and multiple medicines records. We looked at incident records. We looked at three staff files in relation to their recruitment and supervision. A variety of records relating to the management of the service, including audits and policies were reviewed.

We found multiple concerns during the inspection visits on 14 and 15 October 2020. We sent a letter to the provider outlining our most serious concerns and requested a response detailing what action they would take. We were provided with assurances that these concerns would be rectified. We decided to return to the service on 27 October 2020 to review if effective changes had been made to the service. This visit was completed by two inspectors and an assistant inspector. The inspection team focused on reviewing concerns identified previously. This third day was also unannounced.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested further documents to support our evidence.

Inadequate

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.

Systems and processes to safeguard people from the risk of abuse

- There was a culture of restrictive practice at the service. Staff explained how they used physical restraint to provide personal care. However, staff had not been trained on how to restrain people safely and there was insufficient guidance for this in care plans. There was also a poor-quality physical intervention policy in place. Restraint should only be used as a last resort and by skilled staff, this restraint practice was unsafe and put people at risk of injury. Less restrictive measures had not been explored.
- We had received concerns that one person was roughly held by staff. We identified bruising on the person's arm. The registered manager was informed, but when we returned 12 days later they did not provide evidence that they had investigated this concern.
- One person described staff as being "rough with me", they added "They just push me and pull me around to get it done. They aren't gentle here." The person added that this rough handling had previously caused them bruising. They explained that they had reported this and it had not been investigated. We reported this concern to the management team. When we returned 12 days later they did not provide evidence that they had investigated this concern.
- We observed that one person was locked in their bedroom. They were heard shouting for support to go to the toilet and staff repeatedly walked past their room and did not respond. The person did not have a call bell to assist them to call for help. The locking of this person in their room and not responding to their requests for help, is an infringement on their human rights and neglectful care. We highlighted this to the registered manager and provider. When we returned 12 days later, we identified a person very distressed and calling for support. We observed eight staff not support the person or provide reassurance. The culture of neglectful care had not been rectified despite us highlighting it to the registered manager
- On the first two days of inspection, we found there were insufficient staff at the service. This meant people were left for long periods without being responded to. People who required one to one care were left unattended, this put them and others at risk from these people's behaviour. Insufficient staffing put people at risk of serious harm. We raised this as a concern, and additional staff were put in place. However, on the third day of inspection we found these additional staff still did not respond to people's needs promptly. We observed neglectful care that could put people at risk of harm

People were not kept safe from abuse and neglectful care. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staff told us there were not enough staff and this impacted the quality of care provided to people.
- We observed staff providing one to one care repeatedly left the person to care for others. This meant the

person was left alone and unsafe. We raised this with the provider who said they would talk to staff. When we returned 12 days later, staff were unaware of our concerns. We again observed a person receiving one to one support being left unattended while staff supported another person. This unsafe practice had not changed which put people at ongoing risk of harm.

● Staff were not safely deployed around the home. On the first two days of inspection, we observed three people shouting in distress but staff were not around to respond to them. We were informed staff numbers would increase. On the third day of inspection, we reviewed the impact of this. We observed one person shouting in distress. Eight staff walked by and did not offer support. The additional staffing did not resolve the neglectful culture at the service.

● Staff had received training. However, we observed ineffective staff support for people at the service. We are therefore not assured by the quality of staff training. We requested the provider assesses staff skills and competency, when we reviewed this we found this assessment was poor quality. Staff told us it was a verbal discussion of their skills for less than ten minutes, without observation of their practice.

There were insufficient staff to support people safely. Staff were unskilled. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Staff did not have adequate care plan guidance to support people's behavioural needs safely. People displayed behaviour that could challenge staff, however guidance was generic and did not guide staff on how to support the person in a person-centred way. Staff advised that they would hold people to allow other staff to care for them. There was no guidance to try other less restrictive care methods. For example, one person had received professional advice that direct eye contact would reduce their agitation. However, this guidance was not recorded in the care plan for staff to follow, instead between four and six staff provided personal care.

● One person used a catheter. They were shouting in pain and requesting an ambulance. A staff member and registered manager was alerted to this but did not take action to review the person's health. The following day, we requested a visiting nurse review the person's catheter. They identified the catheter had not been attached to the person's leg safely. This could have contributed to their pain. A staff member told us they had requested catheter training but this had not been provided. We requested this person's care was reviewed, when we returned 12 days later, we found only nursing staff had received catheter training. The person's care plan remained poor quality which risked poor care from untrained staff. The failure to act on this concern, put the person at risk of ongoing ill health.

Using medicines safely

● Medicines were not managed safely.

● Three people were prescribed thyroid medications, they should have blood testing for this prescription. There were no records to suggest staff were arranging these required blood tests with professionals. This can have a significant impact on a person's health.

● One person required 'as needed' medicine. There was conflicting guidance to give this up to six times a day. However, the prescription was for up to four times a day. This incorrect guidance could risk overdose.

● One person was prescribed both paracetamol and co-codamol. Co-codamol contains paracetamol and taking it at the same time as paracetamol can risk overdose. There was no guidance to prevent taking these two medicines together. This put the person at risk of having an overdose.

Learning lessons when things go wrong

● Records of incidents relating to challenging behaviour did not include reflective analysis and learning. Entries made by staff in incident forms showed incidents of physical aggression between service users was

accepted as the norm. One incident record stated, 'No lessons learned all staff is aware [service users] behaviour is unpredictable'.

● Care plans and risk assessments were not reviewed and updated following incidents of challenging behaviour and falls. The poor-quality learning at the service, meant people were at risk of repeated incidents.

● We highlighted our concerns to the provider, however when we returned 12 days later we identified that incidents had still not been reviewed. Multiple incidents had occurred which may have been preventable. There was a failure to respond to the risks identified and improve the quality of the care

Risk's associated with people's mental and physical needs were not safely managed. Medicines were not safely managed. Incidents had not been effectively reviewed to improve the care provided. These concerns were 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

● We observed staff wearing suitable PPE during our inspection

● No people in the care home had COVID-19 diagnosis. Regular testing had been arranged for people and staff to monitor this.

Inadequate

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 now 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.

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

- Care was not person-centred. Care records did not describe how to support people's differing needs. We observed staff turned lights on to people's bedrooms while they were asleep. A person told us this is usual practice. They added that staff choose clothes for them, and that the person's bedtime routines are arranged to suit staff routines.
- There were insufficient staff to provide responsive care. The registered manager had calculated the required staffing levels with a dependency tool, however we found this calculation was ineffective because we saw staff were not always available to support people. Staff that were available did not respond to people's distress. This led to a culture of neglectful practice at the service.
- People did not have good outcomes. Staff described the practice of physical intervention to complete personal care tasks. This was also in staff guidance. Physical intervention is a very restrictive practice, which should only be used as a last resort. Staff had not received training, which could increase the risk of injury to people.
- We identified concerns on our inspection which required a referral to the Local Authority safeguarding team to investigate. We raised these concerns with the management team and were not provided with evidence that expected referrals were made. These referrals were therefore made by ourselves. This is a failure of the provider to investigate allegations of abuse.
- The above points, led to a culture of neglectful care. People were not treated with dignity.

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

- Where incidents had occurred, there had been ineffective governance to review the incident and learn lessons. Care plans had not been reviewed to provide up to date guidance. The poor review of incidents would affect the provider's understanding of when things went wrong.
- One person explained that they had been bruised by 'rough' staff. They alleged that the registered manager had not investigated this. We reported this to the registered manager and provider, and 12 days later found they had not fully investigated this. This does not meet the duty of candour.

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

● People had poor quality personal evacuation plans. This meant staff would not be guided on how to safely evacuate people in the event of an emergency.
● Regulatory requirements were not met due to breaches of regulation 12, 13 and 18 (See the safe section). The failure to ensure that the service met regulatory expectations, was due to inadequate governance. We highlighted risks of: poor culture, restrictive practice, unsafe staffing levels and poor governance to the provider. When we returned 12 days later, we found sufficient action had not been taken to resolve these risks.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●Staff reported that the management team did not always listen to their feedback. Staff also reported the management team often shouted at them. One staff member advised they intended to leave without giving notice, shortly after our inspection we were advised another staff member had walked out of the building without giving notice. The poor staff morale could result in staff leaving and staffing levels being unsafe.
● Arrangements for relatives to visit their loved ones safely, while reducing risks from Covid-19 were in place.

● Records showed that relatives were kept up to date on changes in people's health

Working in partnership with others
● We identified concerns about people's care, that needed referral to the Local Authority Safeguarding Team. These referrals were not made by the management team as expected.
● We identified one person had a catheter strapped incorrectly, this could have contributed to their considerable pain levels. The person had had repeated treatment for related health conditions, but there was no evidence that catheter training had been arranged for nursing staff or that staff had approached other professionals for support
● One person had clear recommendations from health professionals, on how to support their behavioural needs. These recommendations had not been put in the persons care plan for staff to follow. Instead staff used restrictive practices to support the person.

Continuous learning and improving care
● There was ineffective governance of incidents that occurred at the service. Incident forms that had been completed, had not resulted in a change to people's care plans
● During the inspection we highlighted this risk to the management team. When we returned 12 days later, we were informed that historic incidents had not been reviewed. The registered manager told us that no incidents had occurred since our last visit. Records showed us multiple incidents had occurred in the last 12 days and would have benefited from management review. The failure to review incidents at the service, meant people were at risk of incidents repeating and causing harm.

The service was poorly managed. This resulted in poor outcomes for people. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk's associated with people's mental and physical needs were not safely managed. Medicines were not safely managed. Incidents had not been effectively reviewed to improve the care provided. These concerns were a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We urgently imposed conditions on the providers registration. These included not admitting new service users without CQC permission. Conditions also required the provider to review the safety of the service.

We also proposed to cancel the registration of the service. The provider did not appeal either of these enforcement actions. So we have made a decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not kept safe from abuse and neglectful care. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We urgently imposed conditions on the providers registration. These included not admitting new service users without CQC permission. Conditions also required the provider to review the safety of the service.

We also proposed to cancel the registration of the service. The provider did not appeal either of these enforcement actions. So we have made a decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was poorly managed. This resulted in

Treatment of disease, disorder or injury	poor outcomes for people. This is a breach of regulation 17 (governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We urgently imposed conditions on the providers registration. These included not admitting new service users without CQC permission. Conditions also required the provider to review the safety of the service.

We also proposed to cancel the registration of the service. The provider did not appeal either of these enforcement actions. So we have made a decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to support people safely. Staff were unskilled. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We urgently imposed conditions on the providers registration. These included not admitting new service users without CQC permission. Conditions also required the provider to review the safety of the service.

We also proposed to cancel the registration of the service. The provider did not appeal either of these enforcement actions. So we have made a decision to cancel the providers registration.