Carecall Services Limited

St Luke's Care Home

Inspection report

35 Main Street
Scothern
Lincoln
Lincolnshire
LN2 2UJ

Tel: 01673862264

Date of inspection visit:
01 February 2023
22 February 2023
06 March 2023

Date of publication:
25 May 2023

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 Luke's Care Home is a residential care home providing the regulated activities of accommodation and personal care for up to 32 people. At the time of our inspection there were 25 people using the service.

People's experience of using this service and what we found
The risks to people's safety were not always well managed. Identified measures to reduce the risk of falls, fire safety and skin damage were not always in place for people. People's medicines were not well managed, staff did not follow best practice when administering and recording people's medicines. Incidents were not always investigated or reported to both the local safeguarding teams or CQC.

Staff supporting people did not always have the necessary training for their roles. People were supported by large numbers of agency staff, some of whom only stayed at the service for one to two weeks. People did not receive consistent person-centred care.

Staff recruitment processes were not robust. Management of agency staff employed was poor. There was a lack of records to show the provider had assured themselves these staff had the necessary employment checks and training to ensure they were safe to support the people in their care.

There was a lack of robust and consistent quality monitoring systems to maintain good standards of care for people. There was a lack of effective provider oversight of the service. This had resulted in a deterioration of people's care.

Staff were not always supported by the management team and people and their relatives were not asked for their opinions about the quality of the service.

Infection prevention and control practices were safe, and people were able to see their families and friends when they wished.

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.

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 10 August 2022). At this inspection we found the provider remained in breach of regulations.

Why we inspected

We undertook this focused inspection to check they met their warning notice 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 changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

We carried out an unannounced comprehensive inspection of this service on 14 and 16 June 2022. Breaches of legal requirements were found. We issued a warning notice to the provider.

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.

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

Enforcement
We have identified breaches in relation to regulations 12, 17,18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to manage the risks to people's safety in relation to their medicines, personal safety, falls and skin damage. There was a lack of consistent training for staff employed at the service. The provider had failed to have recruitment processes established to ensure fit and proper persons were employed and failed to provide effective governance 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.

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 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 time-frame, 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 of the provider's 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?

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 Luke's 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 prevention and control 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 an Expert by Experience who undertook telephone calls to relatives following the inspection. 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 Luke's Care Home, 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 Luke's 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

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 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 3 people who used the service about their experience of the care provided. We spoke with members of staff including the registered manager, who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the home manager, who was in charge of the day to day running of the service, and 8 members of care staff. We also spoke with a health professional visiting the service. Following our visit, we continued to review records and seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke by telephone with 9 relatives about their experience of the service.

We reviewed a range of records. This included 9 people's care records and multiple medication records. We looked at 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.

Inadequate

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. At this inspection the rating has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12

Assessing risk, safety monitoring and management;

- The risks to people's safety were not well managed. Information in people's care plans was contradictory and where people had been assessed as requiring measures to reduce the risks to their safety, these had not always been implemented.
- At our last inspection there had been concerns over poor fitting bed rails putting people at risk of entrapment. At this inspection we found one person who had been assessed as requiring bed rails with bumpers to reduce the risk of entrapment. They did not have bed bumpers in place on the first day of our inspection on 2 February 2023. The home manager told us they had put bed bumpers in place following the first day of the inspection, on the third day of our inspection, 6 March 2023, we saw the bed bumpers were not in place. This put the person at continued risk of entrapment and injury.
- Where people were at risk of falls, assessed measures to reduce the risks of falls had not always been put in place. One person's falls risk assessment stated they required a sensor mat by their bed. However, on the second day of our inspection the sensor mat was not in place. When we asked staff, they told us it should be in place but did not know why it wasn't in the person's room. Following our visit, the home manager emailed us to tell us the sensor mat had been found and put in place.
- Measures to support people following a fall were not always robust. Two incident forms showed people had sustained head injuries following a fall. There was a lack of post injury observations in place for these people. We asked for a copy of the provider's protocol following a person sustaining a fall with a head injury. The document sent was a standard NHS guidance document designed for the general public. The document gave no clear guidance on staff's responsibilities should a person sustain a head injury in their care. This lack of guidance for staff put people at risk of not receiving safe care and treatment following a fall.
- People's personal emergency evacuation profiles (PEEP's) did not always give staff consistent and relevant information about people's needs. One person who lived on the first floor of the building stayed in their room throughout the day, was reluctant to leave their room, and sometimes locked their door. Their care plan gave conflicting information about whether they could safely access the stairs or used the lift if they left their room. This information was not in the person's PEEP. This put them at risk of not receiving the support they needed should they require evacuating from the service in an emergency.
- There was conflicting information in people's care plans on their repositioning needs to ensure they

maintained skin integrity. One person had been assessed as very high risk of skin breakdown. Their care plan stated they required 2 hourly repositioning. However, their records showed this was not always achieved. Repositioning record charts showed there were times when the person had stayed in the same position for between 4 and 8 hours. This put the person at increased risk of skin tissue breakdown and deterioration of their health.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People were not always protected from the risk of abuse as the home manager did not always investigate or report incidents to the local safeguarding teams.

● There had been an incident of unexplained bruising reported to the home manager by staff. This incident had not been reported to the safeguarding team. We asked the home manager for records of any investigation undertaken but they were unable to provide this. The failure to investigate safeguarding concerns put service users at risk of further harm.

● Staff we spoke with were not always able to tell us what their responsibilities were in safeguarding people from abuse. Several staff had not been recorded as receiving safeguarding training. This put people at risk of harm as potential incidents of abuse may not be reported and effectively managed to reduce the risks of abuse.

Using medicines safely

● People's medicines were not managed safely. Staff did not always follow safe administration practices.

● Staff did not always check people had taken their medicines when administering them. We saw one person's medicines on the flat roof outside their bedroom, a staff member told us the person was known to throw their medicines out of their window. This was not documented in their care plan. The home manager told us the person only did this when their mental health deteriorated, and staff would contact the mental health team. However, there was no evidence this had been undertaken. This lack of information and action put the person at risk of not receiving the medicines they required to manage their health needs.

● On the first day of our inspection, we witnessed staff did not follow best practice when administering controlled drugs (CDs). A staff member took the CD record book, and a controlled medicine in a medicine pot, and checked the medicine against the details in the CD record book while in the dining room with a second member of staff. This meant both members of staff had not counted the medicines to ensure the count was correct. The member of staff went on their own to administer the medicine to the person using the service. This meant staff did not follow NICE guidance on managing medicines and put people at risk of unsafe care.

● The medicine administration records we viewed showed there was a lack of signatures against medicines people should have been given. There were discrepancies with medicines counts. This included controlled drugs. This poor management of medicines put people at risk of not receiving essential medicines to manage their health needs.

● There was a lack of consistent audits to monitor medicines, so when errors occurred they were not identified, and no action was taken to reduce the risk of further errors.

The provider had failed to manage the risks to people's safety in relation to their medicines, personal safety, falls and skin damage. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

● One person was prescribed transdermal patches, there was a patch application record used to ensure the site of application of the patch was rotated to prevent skin damage. However, handwritten medicine instructions were not always signed by 2 staff members to show they had been checked for accuracy of transcription.

At our last inspection the provider was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was not always enough staff to meet people's needs.

Not enough improvement had been made at this inspection and the provider was now also in breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People were not always supported by staff who knew their needs and had received the appropriate training for their roles.
● The training matrix we were sent showed large numbers of staff had not received essential training for their roles since starting work at the service. This included, Fire safety, Moving and Handling, and Safeguarding adults training. This included two agency staff who had completed shifts at the service. One member of staff who had worked night duty at the service since November 2022 had only completed one training module since starting at the service. This lack of training, coupled with the high use of agency staff, put people at risk of harm as staff may not have had the necessary skills to support them.
● Between November 2022 and February 2023, the duty rosters we viewed showed there had been 60 different agency staff undertaking shifts at the service. There was a lack of evidence to show these staff had received a proper induction to the service. This put people at increased risk of receiving care which didn't meet their needs.
●There was also a high turnover of staff employed by the provider. Some relatives we spoke with were concerned about the changes in staffing. One relative said, "They have lots of different staff attending to my [relatives] and they seem to rely on agency staff. They have 2 or 3 agency people on (duty each day) and it confuses [name] because they have dementia. They are bed bound now and not as aware of things, so they need to see the same people (staff)."

The lack of consistent training for staff employed at the service is a breach of Regulation 18(2) of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment processes were not robust.
● On 22 February 2023 we asked the registered manager to identify the 3 agency staff on shift. They were only able to identify 2 of the 3 agency staff. They had been expecting another agency staff member who was known to them. The home manager had not checked with the agency to verify the identity of the person or have a profile in place to ensure the person was a fit and proper person to provide care for people. Following our discussion, the home manager called the agency to verify the person's identity and obtain a profile showing their experience and training.
● Processes for Identification of agency staff working at the service were not safe. Agency staff names which appeared on the staff roster did not match the names on agency profiles we saw. Of the 60 agency staff employed at the service from November 2022 to February 2023, we were only able to see 9 profiles in the agency staff profiles folder and the home manager was unable to produce further evidence of them.
● One agency staff profile lacked a Disclosure and Barring Service (DBS) check. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● These poor practices meant the provider put people at risk as they did not have the required information to assure themselves fit and proper staff were employed to support people at the service.

Failing to ensure recruitment processes established for fit and proper persons were employed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

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.

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.
● 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
● People told us they were able to see their relatives on a regular basis. We saw visitors being welcomed into the service and following current national guidance on visiting in care homes.

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 our last inspection we rated this key question Requires Improvement. At this inspection the rating 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.

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

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The quality monitoring processes at the service were not robust and had failed to identify some of the issues we found and reported on in the safe section of this report. This had led to continued errors and poor practice affecting care for people at the service.
- There was a lack of consistent auditing processes to effectively monitor medicines at the service. Weekly medicines audits had not been completed since 26 January 2023. The audit from 26 January 2023 highlighted the lack of staff signatures on people's medicine administration records (MARs) to show whether they had received their medicines. There was no evidence to show the issues had been highlighted to staff or investigated.
- Monthly medicines audits from October 2022 to February 2023, recorded issues month on month, relating to lack of double signatures on handwritten prescription instructions, missing signatures on people's MARs, and medicines counts not correct. Although these issues had been highlighted there was a lack of recorded actions to show the concerns had been followed up. This had resulted in these errors, and staff's poor practice continuing and people not receiving their medicines in a safe way.
- The provider's quality monitoring systems showed there was a lack of provider oversight of the service. Some provider quality monitoring audits had not been completed since October 2022. These included reviews of medicines audits, care plan audits, home manager walk round audits, and monthly health and safety audits. This lack of provider oversight contributed to the failure in care we saw during our inspection.

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

- There was a lack of effective oversight of the staff working at the service. The training matrix showed staff were to receive 3 monthly supervisions and yearly appraisals. Twelve members of staff had not received any supervision, this included the home manager. One member of the night staff team who had also only undertaken one training module of moving and handling had also not received any supervision. This lack of

oversight and support for staff, combined with a lack of effective training, contributed to the provision of a poor standard of care for the people living at the service.
● The above issues, related to the oversight and governance, have been observed at the previous three CQC inspections. This demonstrated the provider had failed to install sustainable systems of effective governance. This resulted in a continued decline in the care people at the service have received.

This failure to provide effective governance of the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff we spoke with did not feel supported by the management team. They told us the home manager was not always easy to approach and talk to.
● Relatives we spoke with told us they had not been asked their opinion of the service via any questionnaires or surveys.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was not always a person-centred approach to people's care at the service. The majority of staff supporting people were agency staff, and there was a lack of consistent use of the same agency staff. The duty rosters we viewed showed some agency staff had only worked between one or two weeks at the service. The information in people's care plans was sometimes contradictory. These two factors meant people did not always receive care in a person-centred way.
● People and relatives told us while staff were not unkind to people, English was some staff's second language and people struggled to understand them. During the inspection we saw staff were not disrespectful towards people but there was a lack of engagement. At lunchtime on the first day of our inspection, one member of staff, whose grasp of the English language was poor, supported people without engaging verbally with them at all. This lack of engagement may contribute to a lack of person-centred care for people.

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 provider was not always open regarding events which happened at the service. As mentioned in the Safe section of this report (above) a safeguarding incident had not been reported to either the local safeguarding team or CQC. We discussed this with the home manager who acknowledged this should have been reported and would ensure moving forward they addressed this.