Colleycare Limited

St Andrews Care Home

Inspection report

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16 September 2020
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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 Andrews Care Home is a purpose-built residential care home providing personal care to 57 people at the time of the inspection. The service can support up to 70 people.

People's experience of using this service and what we found
People were exposed to the risk of harm due to a lack of robust risk management by the management of the service. People's care plans and risk assessments were not up to date and lacked guidance for staff. Where care plans identified action was to be taken by staff to minimise the risk of harm to people, these were not always completed.

People had experienced unexplained injuries and bruising, these were not consistently investigated. Potential safeguarding concerns had not been referred to the local authority.

Incidents and accidents reported by staff were not reviewed or analysed by management or the provider. There was a lack of assurance that lessons were learnt, and action taken to minimise the risk of these types of events happening again.

We were not assured the provider was doing all that was needed to ensure COVID-19 outbreaks would be prevented at St Andrews Care Home. The service was not consistently following Government guidance, about how to operate safely during the COVID-19 pandemic, in areas such as the wearing of personal protective equipment (PPE) and actions required when people were isolating.

The provider had failed to act to rectify shortfalls found at previous inspections. This is the third consecutive inspection where the service has been rated requires improvement, and is now inadequate, in the Well Led domain with a breach of the regulations.

Management had failed to use the care planning, risk assessment and monitoring systems in place effectively to ensure that people were safe. Action had not been taken where identified by the care planning alert system. Concerns relating to the health, safety and well-being of people were not responded to in a timely manner.

The provider had failed to ensure the service was consistently well-managed with effective oversight and governance.

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 8 February 2020) and there was a breach in 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 received concerns in relation to wound management, pressure care, incidents and management oversight. As a result, 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.

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 coronavirus and other infection outbreaks effectively.

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 St Andrews Care Home on our website at www.cqc.org.uk.

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 of risks to people's health and well-being, safeguarding people from harm and management oversight at this inspection.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

Special Measures
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?

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 Andrews 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
The inspection team comprised of four inspectors.

Service and service type
St Andrews 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, however they were no longer in post at the time of our inspection. The provider had appointed a peripatetic manager. This means that the provider is 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.

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 professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with seven members of staff including the regional manager, peripatetic manager and care workers.

We reviewed a range of records. This included nine people's care records and associated risk assessments. A variety of records relating to the management of the service, including audits and resulting action plans.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at meeting minutes, handover records and quality assurance records.

We spoke with six members of staff including senior care workers and care workers. We also contacted relatives to gain their experiences of the care provided at the service. We received written feedback from ten relatives.

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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- At this inspection we found systems for assessing and managing the risks to people's safety had deteriorated.
- People's care plans were not up to date. Where care plans had been created and risks to people's health, welfare and safety had been identified, there was a lack of guidance for staff to protect people from harm.
- Where care planning identified there was action to be taken by care staff to manage risks to people, this was not consistently carried out by staff.
- Staff we spoke will all stated that they referred to care plans to understand the needs of the people living at the service. This meant that people were at risk of not receiving care that met their needs as staff were provided with inaccurate and out of date information via the care planning system.
- We were told by the local authority, that visiting health professionals had raised concerns regarding a high number of people presenting with wounds, skin integrity concerns and weight loss. People's care records confirmed these issues were present at the time of the inspection.
- Following incidents where people sustained injuries from falls, care plans and risk assessments were not updated. We were not assured the provider had taken action to fully explore incidents in order to protect people.

Preventing and controlling infection

- A review of the infection control and prevention measures found shortfalls in steps taken to protect people from acquiring COVID-19.
- We were not assured that staff were using PPE effectively and safely. We observed staff wearing masks around their necks during break times. When asked about the use of PPE one member of staff told us, "I feel there is a really blasé attitude. I had to remind the senior on my floor that she wasn't wearing her mask properly, it was around her chin."
- We saw, where people were isolating in their rooms, doors had been left open and there was no PPE available outside the rooms or disposal units within rooms for staff to don and doff PPE.
- Signs on people's doors to indicate isolation periods were out of date.
- We observed a member of staff walk into a person's room who was required to isolate for 14 days and provide support without additional PPE. The member of staff then entered a further two people's bedrooms without washing their hands, using alcohol hand gel or donning and doffing PPE.

Using medicines safely

- Medicines were not managed safely. We found multiple gaps in people's records relating to medicines,

topical creams and nutritional drinks.
● Staff meeting minutes referred to a medicines action plan in place to address concerns, however it was clear that improvement was still required.
● We saw records relating to people refusing their medicines were not completed in a timely manner. This meant that there was a delay in the sharing of this information. For example, we saw one person had refused their lunch time medication, however their administration record was not completed for four hours after the refusal.

Systems in place were not used to ensure risks at the service were effectively managed. The provider had failed to ensure people were protected from the risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People sustained bruising and injuries, often unexplained. The 'wound report' for the period of 1 August 2020 to 15 September 2020 had 37 entries relating to 23 people living at the service.
● Unexplained injuries were not consistently investigated or reported to safeguarding authorities.
● Staff we spoke with did not all know how to raise concerns external to the provider organisation.
● The provider had failed to complete any analysis about the high number of wounds, bruising and unexplained injuries that had occurred at the service.

Systems in place were not used effectively to protect people from harm and potential safeguarding incidents had not been reported to the local authority. The provider had failed to ensure people were protected from the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● We were not assured sufficient staff were available to meet people's needs at all times.
● Relatives told us that people experienced delays in receiving care. One relative told us, "[Relative] has told me, that there are not enough staff and that there is sometimes nobody there to serve their breakfast, they sometimes have to serve themselves, that they don't always get a drink at night-time and that they sometimes have to wait quite a while for someone to help them shower as the member of staff on duty has so many people to get round." Another relative commented, "No, there are not enough evening and night workers to help the residents."
● Staff told us that they did not feel there was enough staff on duty and the use of agency staff was high. One member of staff told us, "There is definitely a lack of staff. I know we always say that but it's true. You can't do everything we need to for people with the number of staff we have." Another member of staff told us, "We need more staff. Agency are good but we need permanent staff and more people on shift so we can get everything done."
● Visiting professionals also provided feedback with concerns regarding staffing levels. They shared with us a number of occasions where they had been unable to find a member of staff to assist them during visits to people and had found people wandering unsafely without staff support or observation.
● The provider visit completed in September 2020 identified that an assessment needed to be completed for staffing levels. However, the resulting action plan did not have a timescale for this action or who the action was to be completed by.

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.

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

At our last inspection the provider had failed to ensure that systems in place identified and addressed shortfalls. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider was still in breach of regulation. This is the third inspection where a breach of regulation 17 has been found.

● We could not be assured lessons had been learnt from previous inspections.
● We found continued shortfalls in the oversight of the service, which did not ensure the delivery of safe, quality care for the people living at St Andrews Care Home.
● There was a failure to use the care planning, risk assessment and monitoring systems which the provider had in place. This meant there was a lack of effective monitoring at the service by the management and provider. As a consequence, actions had not been taken to respond to failures in care delivery. The provider had failed to ensure the service was consistently well-managed with effective oversight and governance.
● Monitoring systems had not been used to ensure concerns about people's health, safety and wellbeing were responded to promptly. People had lost weight, developed pressure ulcers, experienced falls and unexplained injuries over a number of months, action had not been taken to address these issues in a timely manner.
● The provider and peripatetic manager had implemented an action plan at the service to address concerns found through their audits. However, these audits and the resulting action plan did not identify or include all of the concerns found during the inspection. In addition, there was a lack of detail regarding the action needed to be taken.
● As described in the 'Safe' section of this report, there was evidence to demonstrate a failure by the provider to ensure people using the service were safeguarded against the risk of harm.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Some relatives did not feel engaged with the service and did not feel that communication was open. One relative told us, "To date, I have still had no communication from the new manager, or the Director

overseeing things, or anyone at B&M Care, to let me know what is going on and what they are doing to improve standards. I was not informed by St. Andrews that they were imposing a 4-week lockdown in the middle of September, I only found out because I happened to ring up about something else."

● Staff we spoke with expressed concern about the management of the service and feeling involved. One member of staff told us, "There are staff that lack professionalism and just don't care about the job or the people. Management have not responded or done anything." Another member of staff told us, "I just don't feel listened to. It's been better since [Name of peripatetic manager] has been here, but I just don't know."

● Meetings minutes reviewed did not include set agenda items or include discussion topics from staff or feedback received. A recent provider audit stated that staff meetings should have a set agenda including safeguarding, incidents, lessons learnt and complaints, meeting minutes seen did not include these agenda items for discussion.

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 Systems in place were not used to ensure risks at the service were effectively managed. The provider had failed to ensure people were protected from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems in place were not used effectively to protect people from harm. Potential safeguarding incidents had not been reported to the local authority or the Care Quality Commission (CQC). The provider had failed to ensure people were protected from the risk of abuse.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that systems in place identified and addressed shortfalls. People had been placed at the risk of harm and abuse.

The enforcement action we took:

We imposed a condition on the providers registration.