Care First Class (UK) Limited

St Joseph

Inspection report

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27 August 2020

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
St Joseph is a residential care home providing personal and nursing care to 12 people aged 65 and over at the time of the inspection. The service accommodates people in one adapted building and can support up to 15 people.

People's experience of using this service and what we found
The provider remained in breach of the regulations due to poor risk management in relation to the safety of the premises, infection control concerning COVID-19, fire safety and failing to ensure risks related to people's needs and incidents at the home were always effectively assessed. The provider did not adequately review incidents to look for potential themes and to ensure all necessary action was taken to keep people safe. People and relatives felt the service was safe and staff we spoke with knew how to respond to safeguarding concerns, although not all staff had received training in this area and other areas related to the safety of the service. Feedback indicated there were not always enough staff to support people safely. Processes for staffing levels and recruitment were not robust. Medicines audits had helped promote safe practice although we identified some further improvements needed. Improvements were underway to the safety of the premises yet we identified further hazards which we asked the provider to address.

The provider remained in breach of another regulation because systems and processes failed to ensure the quality and safety of the service. We needed to prompt the provider to address shortfalls in the safety of the service, some of which they had identified but not addressed. Systems had also failed to ensure risks were adequately assessed and that records in relation to risks were accurately maintained. We identified the provider was in breach of a third regulation because CQC had not been notified as required about specific incidents and events concerning three people living at the home.

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 Inadequate (published 27 June 2020) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating and to follow up on breaches identified at the last inspection in March 2020.

We carried out an unannounced comprehensive inspection of this service on 11 March 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance systems.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains as 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 Joseph 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 continued breaches in relation to safe care and treatment and good governance at this inspection. We also identified a third breach in relation to the provider's requirement to notify CQC about specific incidents and events at the service.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
After our inspection we made a referral to West Midlands Fire Service and informed the local authority of our inspection findings. We will continue to work with partner agencies and we will continue to monitor information we receive about the service until we 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 therefore remains 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 Joseph

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.

Inspection team
The inspection was carried out by three inspectors. One inspector worked off site reviewing records and making phone calls to people's relatives and with staff employed at the service. Two inspectors visited the service on 27 August 2020.

Service and service type
St Joseph 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. The registered manager had left the service in August 2020 and the service was being managed by the area manager.

Notice of inspection
We gave a short period notice of the inspection because of the risks associated with COVID-19 and to ensure everyone remained safe during our inspection site visit.

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. 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
We spoke with two people living at the home, four relatives and a healthcare professional about their experience of the care provided. We spoke with six members of staff including senior care workers, care workers, a cleaner and chef.

We reviewed a range of records. This included four people's care records and three people's medication records and medication audits. We looked at four staff files in relation to recruitment. We also looked at training data and quality assurance records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

During the inspection, we met and spoke with the area manager who had taken over managing the service since the registered manager had left. The area manager is also the nominated individual for the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We will refer to this person as the area manager throughout the report.

After the inspection
We continued to seek clarification from the provider to validate evidence found and continued calls as part of our inspection.

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 Inadequate. At this inspection this key question has remained the same. 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; Preventing and controlling infection

- Processes to assess, monitor and improve the safety of the service were poor. We identified hazards on the premises that could cause harm to people, for example, one person's prescribed thickener was left unattended in the lounge, which can be a potentially fatal risk if consumed. We also saw the garden had discarded paving stones and mattresses and missing fence panels allowing access into a private garden.
- The provider's systems had identified, but not addressed, that some water temperatures were very high and put people at risk of scalding. We had to prompt for this to be addressed because no action had been taken to ensure people were kept safe.
- Fire safety risks were not assessed and managed to ensure people could be safely supported in the event of a fire. Fire drills were not regularly carried out, and there was not clear, appropriate guidance in place to allow staff to fully understand fire safety procedures.
- Regular checks had deemed a fire escape route unsatisfactory to use in the event of a fire. This had not been recognised as a risk and immediately addressed. As at our last inspection in March 2020, we made a referral to the West Midlands Fire Service given these concerns.
- The provider did not adequately monitor safety-related information to look for themes and trends. Records showed incidents were responded to at the time, for example, to support a person to access health support after a fall. However, such incidents were not analysed and reviewed for potential themes and how to reduce similar risks to people in future, and to ensure all safeguarding matters were appropriately escalated.
- The provider failed to ensure national guidance in relation to infection control was met. Infection prevention and control procedures in relation to COVID-19 were not adequate and this placed people and staff at risk. For example, we saw only two hand sanitizers throughout the home and the personal protective equipment (PPE) station in use, did not promote safe practice.
- Staff did not have adequate guidance and training about how to correctly use PPE and we saw staff did not use, take off or discard of PPE in line with current good guidance. A relative told us, "On window visit from what I've seen wearing the masks is not consistent."
- People's identified risks were not always effectively assessed and to ensure staff had clear and consistent guidance about how to support people safely. For example, records showed, and staff used inconsistent language in relation to how one person's foods and drinks should be prepared to safely manage the person's swallowing risks.
- People's individual needs and risks regarding COVID-19 had not been assessed, for example, those who might be at higher risk due to COVID-19 due to their protected characteristics.

Failure to assess and mitigate risks including in relation to health and safety of the service is a breach of

Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Two people we spoke with told us they felt safe at the home and happy with their care. A relative told us, "I feel it's okay. They seem to really care and [person] seems happy there."
● One person told us, "It is very clean, nice and clean". Although the home was visibly clean, there were significant shortfalls in infection control practices and procedures concerning COVID-19.
● Relatives confirmed, and we saw, some improvements to the safety of the environment had been made and were underway since the last inspection, for example new fire doors had been fitted. One relative told us new equipment had been purchased for one person and, "Staff tell me it's much better for [person]."

Staffing and recruitment
● Staff we spoke with told us they had undergone recruitment checks including through the Disclosure and Barring Service (DBS) before they started their roles. However, four recruitment records we sampled at random, did not contain recruitment decisions or evidence that DBS checks had been completed. The area manager was able to provide this evidence for two of those four staff members.
● Risk assessments and recruitment decisions were not completed where required and based on DBS findings. These poor systems put people at risk of being supported by staff who were unsuitable.
● Most relatives we spoke with told us they felt more staff were needed to support people well. One relative said, "It's impossible… if they are supporting someone to go upstairs, the other residents are left." One staff member confirmed there were not enough staff to safely support others and to meet the needs of more dependent people at the same time.
● There was not a system in place to ensure there were enough staff based on people's individual needs including to respond in the event of an emergency and we prompted the regional manager to address this.
● Most staff felt staffing levels were good apart from during nights. One person told us, "They are very good. Only got to ask and they help you." During our visit, we saw staff were often on hand to respond promptly to people's needs.
● Staff were not all up-to-date with safety related training, for example, health and safety, First Aid, fire safety, risk management and training to support people safely with equipment and medicines.

Systems and processes to safeguard people from the risk of abuse
● Our inspection identified two incidents of alleged abuse concerning three people living at the home. Neither incident had been reviewed or escalated as required, to relevant partner agencies such as the police, CQC and local authority. This failed to ensure people could always be protected from abuse. We ensured these safeguarding concerns were reported to the local authority for further investigation.
● Staff were not all up to date with safeguarding training. Records showed half of the staff group had received recent safeguarding training; others had received some training in 2019 or none.
● One person told us they felt very safe and that there were people they could raise concerns to if needed. Staff we spoke with had knowledge of how to identify and report any suspicions of abuse.

Using medicines safely
● One person told us they were happy with their medicines support. Medicines records we looked at were appropriately completed and correctly reflected the medicines left in stock.
● Medicines audits were in place to help ensure people were supported safely, for example one person was referred to the doctor following review of their medicines. However, audits had not identified some areas to address in relation to people's 'as and when needed' (PRN) medicines.
● One person had regularly taken their PRN pain relief each day in August 2020 yet this had not been identified and raised with their doctor to explore further with this person.

We could not improve the rating for Safe from Inadequate because not enough improvement had been made which meant people were not safe and were at risk of avoidable harm. We will check this during our next planned comprehensive inspection.

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 Inadequate. At this inspection this key question has remained the same. 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.

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

- Systems to review and analysis of incidents and safeguarding matters were not used effectively, to help identify potential themes and reduce risks to people. We saw two examples of safeguarding incidents which had not been appropriately escalated to relevant partner agencies including CQC, the police and the local authority.

Failure to notify the Commission of any abuse or allegation of abuse in relation to a service user is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

- Systems to ensure the safety of the service were not robust. Although regular checks had identified concerns about high water temperatures and an unsatisfactory fire evacuation point, no action had been taken to resolve this and we had to prompt the area manager to immediately address these concerns.
- Although the provider was making improvements to the safety of the premises, systems had not identified additional hazards and concerns found at this inspection. For example, systems had failed to ensure consistently safe infection practices and processes to reduce risks to people associated with COVID-19.
- The provider's recent review of staffing levels was not effective because it had failed to assess people's individual support needs to inform safe staffing levels. We received mixed feedback as to whether there were always enough staff.
- The provider was not able to demonstrate adequate recruitment checks had been carried out for all staff employed.
- The area manager told us enhanced cleaning was undertaken in response to risks associated with COVID-19. However, staff feedback indicated this did not happen and records did not demonstrate this took place as recommended in current good practice guidelines. We saw management failed to lead by example to address inconsistencies and shortfalls in PPE use.
- The provider had submitted action plans to CQC detailing their improvement plans based on the last inspection. We saw the majority of planned actions had been carried out however the provider's own oversight had failed to identify additional areas of improvement required.
- Records were not always accurately maintained and did not demonstrate people's risks were always adequately assessed, for example, in response to incidents, in the event of a fire or in response to the COVID-19 pandemic.

Failure to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The majority of staff interactions with people were positive however we saw occasions where people's choices and views were not considered and promoted as far as possible and some staff used task-based language when describing how they supported people which did not represent a person-centred culture. A health professional commented that moving and handling support could be improved by involving and talking to the person more during this support.

● A new electronic system had been introduced which would help to support care planning and to monitor how people's needs were responded to.

● Feedback we received from a relative indicated the provider had not been transparent about their last inspection findings. We found another relative's concerns had not been appropriately responded to.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● 'Residents' meetings' took place where people had discussed activities and we saw one staff member encouraged two people to chat and let one person know the other person was greeting them. We saw a lack of activities during our visit however and some relatives' feedback reflected this. One relative told us, "I think they need more activities… staff do try and they do bingo but there needs to be more activities."

● Some people had been supported to keep in touch with loved ones over the phone and a text and voice messaging app while the home was on lockdown during the COVID-19 pandemic.

● Staff told us they felt they could raise any concerns or issues they had. Most staff told us they were well supported and management were approachable. One relative told us, "They used to send out a questionnaire but they don't anymore," regarding a person's choices and the home.

● People were supported to access healthcare services when needed. A relative told us one person was supported with their symptoms as needed and, "When [symptoms] deteriorate, they call in the district nurses."

● Records showed not all had staff had received the provider's mandatory training. A range of training had been provided to small groups of staff at a time during the pandemic.

● The provider submitted regular, though not daily updates to the local authority about the impact of COVID-19. Providers are asked to submit this daily information so that local, regional and national support can be mobilised. The area manager told us they would raise contact the local authority, CQC and Public Health England if they had new concerns about COVID-19.

● The registered manager had recently left the service and so the area manager had become responsible for direct management of the service as well as overseeing the quality monitoring in their role as area manager. The area manager did not always demonstrate robust oversight of quality and safety issues including in relation to staffing and recruitment issues.

We could not improve the rating for Well-Led from Inadequate because not enough improvement had been made and there remained widespread and significant shortfalls in service leadership. We will check this during our next planned comprehensive inspection.

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 The provider failed to assess and mitigate risks including in relation to health and safety of the service.

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 failed to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

Regulation 17 Warning Notice served