

St Christopher's Homes

St Christopher's Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

St Christopher's Home is a residential care home providing personal care to 40 people aged 65 and over at the time of the inspection. The service can support up to 54 people.

People's experience of using this service and what we found

Systems and process in place to review and monitor the quality, effectiveness of the service required improvement.

Risks to people had not consistently been mitigated. Staff had not always followed the strategies in place and we found gaps in records for pressure care and food and fluids.

Records of injuries to people had not always been appropriately recorded.

Not everyone we spoke to felt there was enough staff on duty and staff did not always respond to people in a timely manner. Call bells were found to be unanswered for periods of time over 10 minutes on three separate occasions.

Medicine administration required improvements. We found gaps in the recording and best practice was not consistently followed.

Infection control measures were in place, however we found gaps in the cleaning records. The home appeared clean

People were supported by staff who had been recruited safely and who knew them well.

People were supported to stay in contact with their family during the pandemic via phone calls, video chats and outdoor visiting.

The registered manager and staff were open and transparent throughout the inspection and put actions into place after feedback.

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 Good (published 26 April 2018).

Why we inspected

We received concerns in relation to staffing levels and pressure sores. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

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 Good to Requires Improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Christopher's 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 monitor the service.

We have identified breaches in relation to risk management, medicine management and oversight at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Details are in our well led findings below.

Requires Improvement ●

St Christopher's 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 site visit was carried out by one inspector. Another inspector supported the inspection off site and an assistant inspector conducted telephone calls to staff and relatives remotely.

Service and service type

St Christopher's 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

The inspection was announced at short notice to assess COVID-19 risk.

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 were unable to speak to people who used the service due to COVID-19 risk. We spoke to six relatives about their experience of the care provided. We spoke with 11 members of staff including care staff, housekeeping staff, the deputy manager and the registered manager.

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

After the inspection

We continued to seek clarification from the provider to validate evidence found.

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 Good. At this inspection this key question has now deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely. Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse

- Risk assessments and care plans did not always detail the required information to keep people safe. For example, there was limited documentation in place for a person who had a diagnosis of epilepsy. This meant that staff did not have the required information to identify if the person was having a seizure and what action to take.
- Risk assessments were not always followed by staff. For example, one person with diabetes required their feet to be checked by staff. However, there were gaps in the recording and no evidence that checks had been completed as per risk assessment.
- Fluid charts had multiple gaps in the recording and did not contain all the relevant information such as the optimum amount. We found evidence that not all people reached their required daily amount of fluids. This put people at increased risk of dehydration.
- Repositioning charts did not detail how often people should be repositioned to relieve pressure on their skin. We also noted gaps in the recording. This put people at increased risk of developing pressure damage.
- During the inspection we observed people's call bells were not answered in a timely manner. Staff told us that people sometimes had to wait for their call bell to be answered. One staff said, "The call bells ring a little bit longer, but we always get to them, we are always busy. We try to get to them as soon as they can." A relative said "Occasionally they take a little bit of time to respond to a bell if [person] needs to go to the loo."
- Medicine Administration Records (MAR) required improvement. We identified gaps in recording and staff had not always followed best practice when transcribing a medicine. For example, two staff had not always signed or dated the changes made. Prescribed thickener for people's drinks had not been consistently signed as administered. This put people at risk of not receiving their medicines as prescribed.
- We saw no evidence of medicine stock being checked against the stock amount recorded on the MAR. This meant that staff were unable to identify any medicine errors or concerns.
- Unexplained bruises and injuries had not always been recorded on body maps. The registered manager agreed to investigate the injuries we found during the inspection that had not been recorded appropriately.

We found no evidence that people were harmed, however, the provider had failed to assess all risks to service users and to ensure the safe and proper management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had made safeguarding referrals to the local authority and conducted

investigations when required.

- Staff received training on safeguarding and understood how to recognise and report abuse. One staff member said "Any abuse towards to residents. Physical, emotional, financial I would report anything, and I know it would be taken seriously."

Preventing and controlling infection

- We were not assured that that the provider was promoting safety through the layout and hygiene practices of the premises. We found multiple gaps of recording on the cleaning schedules.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- 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 accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment

- Not all staff had up to date training, the training matrix evidenced only 20% of care staff had received dementia training, and nutrition training. However, due to COVID-19 the training of staff was limited. The registered manager was in the process of arranging training.
- Not all staff we spoke to felt there were enough staff on duty. One staff member told us, "It is very rushed, from first thing at morning and going to bed. Meal times are the worse." Another staff member said, "Due to the current climate of COVID, [staffing] causes a bit of concern with the numbers of staff, we are told if we have less staff and more poorly residents, to focus on the essential things, like foods and fluid, pressure relieving." However, we found no evidence of harm.
- Staff were recruited safely. The provider completed pre employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers.
- Where the service had used agency staff, checks were in place to ensure they were suitable working in the home, such as DBS clearance.

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 remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems and processes were not robust enough to identify the issues we found during the inspection. For example, care plan audits did not identify conflicting or missing information. We found a lack of recorded observations after a person had sustained an injury.
- The audit for medicines required improvement. It did not detail any actions identified or which records were checked as part of the audit. During the inspection, we identified concerns in relation to MAR records.
- There was no oversight in ensuring people had received adequate food and fluid intake. Staff shift handover records detailed that one person had 'good food and fluids' however, associated records identified that they had not reached their daily target.
- Audits of cleaning records did not identify the gaps in recording found during the inspection and no action had been taken to address this.

We found no evidence that people had been harmed however, systems and processes were not effective or robust enough to monitor the quality and safety of the service. This placed people at risk of harm. This was a breach of regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had completed spot checks to ensure staff were following good practice for PPE use and were promoting people's dignity and respect. The spot checks also ensured that staff understood people's care needs.

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

- People and their relatives spoke positively about the care their loved one received. One relative said, "When I call, they know who I am and who [person] is. They know [person's] personality." Another relative said, "Staff dance with [person]. That was one of the reasons I chose St Christopher's, through reputation. I knew they were kind people." One person told us, "Staff are wonderful, they support with the upmost care and generosity".
- People were supported to stay in contact with their family during the pandemic via phone calls, video chats and outdoor visiting.

- The registered manager had a good knowledge and understanding of the accessible information standards.

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

- We saw no evidence of any recent complaints made by people, relatives or staff. However, people told us that they would feel comfortable making a complaint should they need to. One person told us "I've never had to complain, as no cause of complaint. When something gone amiss it is dealt with promptly and effectively."
- The registered manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

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

- We saw no evidence of engagement with people who use the service to gain their feedback or suggestions. However one person told us, "I know I will be asked [for feedback], but haven't yet. We are in the middle of lockdown, not at the end of process. Once it has ended we can be reflective and will then be asked".
- Relatives told us that their feedback of the service had not been sought however, they told us that staff kept them up to date with information regarding their loved one.
- We saw no evidence of meetings with staff however, staff told us that they felt supported by the registered manager and information was shared during handover of each shift.
- We saw evidence of staff being offered and provided with additional support where required in order to effectively carry out their role.

Continuous learning and improving care. Working in partnership with others

- The registered manager was open to feedback and sent us evidence of improvements they made immediately after the inspection.
- We saw evidence of referrals being made to external healthcare professionals when required such as GP and District Nurse, who visited the service regularly.

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 had failed to assess all risks to service users and to ensure the safe and proper management of medicines.
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 systems and processes were effective to monitor the quality and safety of the service.