Prime Life Limited

Meadow View

Inspection report

Meadow View Close
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17 March 2023

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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
Meadow View is registered to provide accommodation and personal care for up to 42 people, including people living with dementia. At the time of our inspection visit there were 31 people living at the home. The home is split into a large main building which provides care to people on a permanent basis. There is a separate building known as 'The Poppies' which provides respite care. Respite care is planned or emergency temporary care. Some people living at the home were living with dementia. People have use of a communal lounge and dining area, as well as occasional seating throughout corridors. People's bedrooms are ensuite and there are further communal bathroom facilities located around the home. People can access outside spaces.

People's experience of using this service and what we found
Known risks relating to people's health and welfare and environmental risks were not managed safely. In some cases, when quality assurance checks were completed, improvement actions were not made, or insufficient actions failed to keep people safe.

We checked examples of people's care plans and found these were not always accurate or they held conflicting information. Some risk assessments although completed, needed additional information to ensure the risks and actions people needed, were fully documented. This meant staff did not have accurate information to manage people's risks safely.

Fire safety needed improvement. People were at risk because fire safety checks that identified potential issues in November 2022, mainly went without action. Fire doors to people's bedrooms and communal areas did not always close, some closed to fast or were defective so any potential risks to control the spread of fire, or to stop people being harmed, were ineffective.

Risks associated with people's health and welfare were not always considered, reviewed or reflected a person's current needs. Records and actions that were required to be completed, were not always recorded, so we were not confident risks were managed safely. Oversight and scrutiny of those records through effective checks, went unchecked.

Infection, prevention and control practices required improvement. During our visit, some people in the home had tested positive for COVID-19. The management systems to keep people and staff safe, were not aligned with latest government guidelines. On both inspection days, we saw the registered manager and care staff, not wearing face masks. In some cases, we saw staff grouped together, some not wearing their masks. People were not always isolated or protected from others, so cross infection was not managed robustly.

The provider's quality assurance systems were regularly completed, however they failed to identify the issues we found. Overall, the provider failed to operate and manage a robust and effective quality assurance

system. Where similar issues had been identified at inspections across the providers other homes, there was limited evidence lessons had been learnt.

The provider had sufficiently trained and suitable staff on shift to meet people's needs. However, some staff told us, it was not uncommon for shifts to run lower than planned numbers. The registered manager supported staff when required and the registered manager covered for the cook, 3 days a week. The registered manager told us this situation had been like this since August 2022 which could explain why, there was limited oversight of the service.

People received their medicines from trained staff. Medicines were stored safely and securely. People were assessed and protocols were in place for medication prescribed to be taken on an 'as required basis.' Time critical medicines were administered in line with their prescribed instructions. However, some medicines required to help manage people's anxieties, were not always given as directed and in some cases, without other distraction techniques being adopted.

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 good (published 29 October 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the standards of care, a lack of management oversight and infection control when supporting people during an outbreak of COVID-19. A decision was made for us to inspect and examine those risks.

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

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.

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 good to inadequate based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadow View on our website at www.cqc.org.uk.

Enforcement
Following our visit, we asked the provider to respond to the immediate concerns we found at our visit. We continued to seek their updates and assurances they had mitigated the immediate risks to people.

We have identified a breach in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance).

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

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 from 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 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 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 always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not always well led.

Details are in our well led findings below.

Meadow View

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 visit was completed by 1 inspector on the first day of our visit. The following day, 2 inspectors returned.

Service and service type
Meadow View is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Meadow View is a care home without nursing care. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection visit was unannounced. We announced our return for the second day.

Inspection activity started on 16 March 2023 and ended on 23 March 2023. We visited the location's service on 16 March 2023 and 17 March 2023.
Following our visit, we requested further information from the provider so we could be assured, immediate risks were being managed safely.

What we did before inspection
We reviewed the information we held about the service, such as feedback from people and their relatives, statutory notifications, as well as any information shared with us by the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who received a service to get their experiences about the quality of care received. We spoke with 5 members of care staff and a housekeeper. We spoke with the registered manager and a regional manager. Following our visit, we spoke with an external occupational therapist.

We reviewed a range of records. This included examples of 4 people's care records, samples of medicine records and associated records of people's care. We looked at records that related to the management and quality assurance of the service and risk management. We reviewed 2 staff recruitment files.

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 good. At this inspection this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;

- Risk management was not effective to keep people safe and protected. This included risk to people's health and welfare, fire safety and effective management of infection prevention and control.
- One person was at risk of consuming fluids that could cause them severe harm. Pre assessment information showed this person had consumed chemical liquids (not for ingestion) shortly before moving into Meadow View. One month later, this person consumed 2 bottles of liquid soap. The incident was recorded, but no other action was taken or considered to limit the risk. We looked in this person's room and found a half full litre bottle of liquid soap. Management or staff failed to consider the risks this posed. We shared our concerns immediately with management who took action to minimise the risks.
- Risks supporting people's anxiety and mental health were not managed in accordance with people's individual needs. One person's anxieties had increased over time. Strategies to support and manage this person's anxieties were not personalised to them. There was no information to tell staff what to do to reduce those anxieties, how to diffuse or redirect the person. Common practice was to administer medicines.
- This persons' care plan required staff to complete charts to monitor all incidents of increased behaviours. Since 1 March 2023 to 17 March 2023, medicine records recorded 48 examples of increased anxiety and agitation. In these cases, medicines were given to support this person. However, charts to monitor those behaviours recorded only 13 incidents. This meant it was not clear, why incidents had escalated and what methods were used to de-escalate before medicines were given.
- Staff told us it was difficult at times to meet this person's needs. Mental Health teams were involved however, the care records and daily records do not offer a complete picture of how this person's mental health had presented.
- Another person was assessed as being high risk of weight loss on their malnutrition universal screening tool (MUST). This person's care plan stated staff should complete a food and fluid diary and prompt the person to eat and drink.
- We observed this person sat with their breakfast for over 1 hour with no prompting from staff. The unfinished breakfast was removed by a member of staff with no alternative foods offered.
- We checked this person's daily food diary which failed to accurately record what was consumed. Food and fluid records were not detailed enough, nor did they provide important information to other health professionals to support this person's nutritional intake.
- We spoke with staff about nutritional risk management. Staff told us non care staff completed food diaries for people at breakfast and those staff could not with certain ty, if that individual had eaten or drunk what they were offered.
- Risks promoting people's health and welfare were not always considered. One person was cared for in bed, some staff said this person could be hoisted if they wanted to get out of bed. Staff couldn't remember

the last time this person was out of bed. One staff member said, [Person] has been in bed for years, never moved or hoisted out of bed and I have been here years." External referrals and engagement were not made when they should be. Staff did not know how and when they should refer concerns. People may be harmed as a result.

● Following our visit, we raised our concerns with an occupational therapist. The occupational therapist confirmed this person's care plan contained inconsistencies and inaccuracies. From speaking with staff and reviewing this person's care plan with an occupational therapist, there was no clear message why this person remained in bed. The occupational therapist confirmed the provider had not sought any occupational therapy advice to support this person.

● Environmental risk measures went without prompt actions. Fire safety checks were completed; however, we found a number of fire safety checks known in November 2022, continued to require action to make safe. We checked some fire doors and found they either did not close properly, or, shut to quickly which could put people at risk of injury. Following our visit, we shared our concerns with the fire authority.

Preventing and controlling infection

● At the time of our visit, the home was in a COVID-19 outbreak. Effective measures to manage and limit the spread of infection was not sufficient. In some cases, government guidelines were not followed.

●We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. For people who self-isolated, staff wore the required personal protective equipment (PPE) and disposed of it in the person's room, in a bag, on the persons bathroom floor. This was unsafe because clinical bins were not being used. We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. One person did not self-isolate and was not always supported, not to enter other people's rooms. We saw staff hug this person, then go and support other people who had not tested positive for COVID-19.

● We were not assured that the provider was using PPE effectively and safely. Staff were seen on both days of our visit, not to wear or wear masks incorrectly. PPE in some cases, was not disposed of safely.

Using medicines safely

● Risk assessments and protocols were in place for medication prescribed to be taken on an 'as required basis.' (PRN). However, for 1 person we found 2 separate occasions where their dose had exceeded the maximum number of doses. It was not clear from reviewing the PRN history and the medication administration record (MAR), why this had happened.

We found no evidence people had been harmed however, the provider failed to robustly assess all necessary risks relating to the health safety and welfare of people. This placed people at 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.

Following our visit, the provider assured us, arrangements had been made to address the issues for fire safety and limiting risks to people.

● Staff had training in medicines before they were able to administer medicines. There were policies and procedures to ensure that people received their medicines safely.

● Medicines were stored safely and securely.

● People had assessments around medicines to assess the level of support they needed to ensure they had their medicines safely.

● Where people required time critical medicines these were administered in line with their prescribed instructions.

We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
At the time of our visit, the home had an outbreak of COVID-19. Families had been made aware and were encouraged not to visit until the home was out of outbreak. When we and other health professionals arrived, we were told of the outbreak. If anyone was at end of life, visits for those people were supported to take place safely. When visiting restrictions were in place, telephone and internet calls were encouraged and supported so families could maintain contact.

Learning lessons when things go wrong
● Lessons learnt did not always improve the quality of care. Reportable and notifiable incidents were not always reviewed or reported to us. The provider did not gather, monitor, or include all safety-related information to look for themes and trends. In some examples, the provider does not learn from incidents and adverse events.
● Similar concerns identified at this inspection had been found at other provider locations. Yet there was no learning from those other CQC inspections to ensure good and safe standards and practices were maintained.

Systems and processes to safeguard people from the risk of abuse
● People we spoke with told us they were happy with their care and support and that they felt safe when staff supported them.
● Staff understood what to look out for and how to safeguard people. One staff member said, "I would report it to the management."
● From reviewing people's records and incident reports, we found some incidents had been responded to, but the local authority or CQC had not always been informed about incidents that should have been safeguarded. The registered manager told us this was an oversight. We recommended to them they completed retrospective notifications to us.

Staffing and recruitment
● The provider had policies to ensure staff were recruited safely and were suitable for their roles by conducting relevant pre-employment checks. We reviewed 2 staff recruitment files and saw appropriate references and the provider had completed Disclosure and Barring Service (DBS) checks.
● Staff told us there were enough staff to meet people's needs. One staff member said a recent COVID-19 outbreak meant some staff had gone off sick at short notice, which had impacted on staff numbers on a shift. The registered manager and management team told us they supported staff to help cover the shifts, to ensure people's needs continued to be met.
● However, during our visit, we found over both days, most staff took a break at the same time, and completed people's health records at the same time in the same location. This meant at times, parts of the home had no staff on hand to respond to people's calls for assistance. Not everyone had a call bell or was able to verbal call for health. The running of the shift required better management to ensure safe staffing levels met people's needs.

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 provider was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

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 good. At this inspection this key question has changed 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; Continuous learning and improving care

- The provider had systems to check and ensure the quality of service supported good outcomes for people. There were records of audits and checks completed but they failed to identify the issues we have reported on. This failure to operate an effective and robust system of quality assurance, exposed people to potential harm.
- The system to ensure fire safety checks were effective consisted of regular checks of the environment, including fire prevention measures. Completed checks failed to identify significant issues. For example, several fire doors (to people's bedrooms were identified in November 2022 as needing attention or repair. At our visit we saw actions had not been taken. We found a number of fire doors required repair and some fire doors did not shut or some fire doors closed to quickly, putting people at unnecessary risk of harm. These concerns had not been actioned in a timely manner.
- Infection control management practices were not implemented swiftly to minimise cross infection risks during an outbreak. We found clinical bin bags were left on people's bathroom floor because there were no clinical bins provided. When we told the registered manager, small metal bins were then used. By mid-day, used clinical waste was overflowing these bins. Staff did not wear face masks correctly. People who had tested positive to COVID-19, were not always encouraged to self-isolate which put others at risk.
- There was no follow up action or effective process to ensure those incidents were reviewed to identify any patterns or trends, or, if people needed further support or health interventions. For example, an incident that put someone at risk of harm in February 2023 had not been considered. We checked this incident and found there was no investigation or review of the person's daily records which recorded no incident had taken place. We looked at a number of daily records for people and found they were not descriptive enough or they were completed retrospective. We saw no evidence the quality of daily notes was reviewed or attempts to make them more personalised.
- We saw no process or system to ensure people's care information and risk information was known, reviewed and remained relevant. In Safe, we have referred to examples where risks were not considered or maintained, nor was external support considered to promote and support good care outcomes for those people.
- Systems were not effective to ensure people who needed strong medicines to manage anxieties, received them as required. We found one person had received additional medicines than required in a 24 hour period. We also found little information that demonstrated staff provided medicines as the last resort.
- Conversations with the registered manager showed us they spent time supporting staff on the floor, as well as covering kitchen duties 3 days a week. The registered manager said they had been doing this since

January 2023. This meant they were unable to have full oversight of the home because some of those actions we identified should have been known and actions taken to protect people.
● Systems to ensure staff training and refresher training in key areas remained updated, needed improvement. A high number of important refreshers in fire safety, moving and handling, care planning and first aid were required. A regional manager audit in January 2023 identified these topics needed completing. Following our visit, the director of elder services said training would be completed in April 2023.

A failure to assess and hold accurate records, complete reviews, take steps to drive improvements through effective governance and quality assurance was not possible. Checks were completed but a lack of effective actions put people at risk. The above issues demonstrate a breach of regulation 17 (Good governance) 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;
● We have reported examples that have not always focused on the individual or have strived to provide care that was person centred. Our observations on both days showed numerous times throughout the day, people were not involved or stimulated to pursue any interests or hobbies.
● People with dementia, were encouraged at times by staff to do something but at other times, there was no engagement. For some people, they may have preferred this, but for others, we found there was limited information or knowledge to understand why they were supported in the ways they were. It was clear from some of our conversations with people, they were not always content.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working with in partnership with others
● People and staff were not always given the information they needed to support and involve people. For example, having correct and up to date information to meet people's care needs. Staff were unaware of dismissive of what people who used the service thought of their care and
support. Some staff told us handover was not thorough enough to tell them who needed support.
● People received support from other health professionals. During our visit, a community nurse and a GP visited people to review their medicines and check on some people's health conditions. Neither of the professionals had concerns with people's care and treatment.

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 registered manager and regional manager responded positively to the concerns we raised on the day. Where possible, some actions were taken to address some of the fire safety risks and risks to people's health and welfare. For the examples we have reported on that had a direct impact on people, the registered manager apologised and agreed to improve the quality of care people received.
● The provider had met the legal requirements to display the service's latest CQC ratings on their website and in the home. However, we told the registered manager they must display a rating template rather than a copy of the rating report. This is because, where actions are required, the rating template provides any additional details.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not adequately assess and protect people against risks by doing all that was practicable to mitigate any such risks.

The enforcement action we took:

Issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured robust quality systems or processes were fully effective to monitor the service appropriately, including people's safety through good governance.

The enforcement action we took:

Issued a warning notice