Care Quality Commission

Mr Andrew Burgess and Miss Marian Lloyd

Priory Paddocks Nursing Home

Inspection report

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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
Priory Paddocks Nursing Home is a nursing home providing personal and nursing care to 30 people at the time of the inspection, some people were living with dementia. The service can support up to 40 people in one adapted building.

People's experience of using this service and what we found
The provider had a good history of meeting standards and regulations, however, since our last inspection there had been a deterioration in the service and standards of care provided to people.

We were not provided with all the information requested during our inspection. No records relating to the governance systems and health and safety were received. Therefore, we could not be assured that the provider and registered manager's oversight and systems to monitor the service to identify and address shortfalls were either in place or robust.

Incidents of abuse had not always been reported to the local authority who were responsible for investigating concerns of abuse.

We were not assured there were effective systems to keep people safe from harm. Risks in people's daily lives and in the care environment were not always being assessed and there was a lack of written guidance provided to staff in how any risks were to be mitigated. We saw no evidence or received any information which demonstrated learning from incidents, and monitoring and analysis of incidents and accidents.

People's care plans were not person centred and did not detail the needs people required to meet their specific requirements. Records relating to the care provided to people were not always complete and accurate. This was a risk of people receiving unsafe and inappropriate care.

There had been no staff training or care staff meetings since the start of the pandemic. This meant new and existing staff were not being provided with support and guidance to keep people safe and provide good quality care.

The registered manager told us about the issues they had with recruiting new staff. The provider had taken the decision to not admit any new people into the service until the staffing levels had increased. We were not assured that people's emotional and social needs were always being met, due to the staff being busy supporting people with their personal care needs.

Medicines were being stored safely and nursing staff were able to explain the systems in place to ensure people received their medicines when they needed them. However, not all medicine administration records showed people received their medicines as prescribed.

The registered manager and staff were proud that no one using the service had contracted COVID-19. However, we found infection control processes were not robust. There were systems to support people to have visitors and a programme to test staff and people using the service.

We were told by staff about some taps, baths and showers not working in the service. Staff were, at times, transporting hot water in bowls and buckets to support people to bath and/or wash, which was not safe.

We received feedback that the call bell system to alert staff if a person needed help worked intermittently and could not be heard throughout the building. This was a risk that people may not receive the care and support they needed in a timely way.

Despite our findings we received positive feedback from people using the service, relatives and two health care professionals. All feedback received commented on the caring nature of the staff.

Feedback from staff demonstrated they were committed to providing people with good care, but were concerned about the lack of training and staffing levels. Staff were complimentary about the registered manager and their caring nature, however, some staff told us there was a lack of leadership and they did not feel listened to or supported to raise concerns about the service to the registered manager.

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 13 November 2018).

Why we inspected
We received concerns in relation to the management of the service, the safety of people using the service and medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. The inspection was prompted in part by intelligence received of a specific incident. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

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 inadequate. This is based on the findings 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 COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. 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 Priory Paddocks Nursing 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 safe care and treatment, safeguarding people from abuse, the provision of staff training, and the systems to monitor the service, at this inspection.

Please see the action we have told the provider to take at the end of this report. We have added conditions to the provider's registration, these conditions ask the provider to undertake actions to provide assurances of improvement and safety. Please see the enforcement action we have taken at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the 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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Care Quality Commission

Priory Paddocks Nursing 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
Two inspectors visited the service on 26 October 2021. Following our visit, one inspector concluded the inspection remotely, this included reviewing records and gaining feedback from relatives of people using the service, staff and health professionals.

Service and service type
Priory Paddocks Nursing 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. The registered manager is also one of the providers.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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.

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 all of this information to plan our inspection.

During the inspection
During our inspection visit on 26 October 2021 we spoke with five people who used the service about their experience of the care provided. We spoke with five members of staff including the registered manager, deputy manager, nurse and care staff.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision.

Following our site visit, we asked the registered manager to send us records which we could review remotely. This included a variety of records relating to the management of the service, including policies and procedures and records relating to people's care including medicines, repositioning charts, food and fluid charts. We did not receive all the records requested, including staff training records, environmental risk assessments and checks and records which showed how the management audited and monitored the service people received.

We received electronic and telephone feedback from two health care professionals, 10 relatives of people using the service and 16 staff members, including nursing, care and domestic staff.

We gave feedback our findings of the inspection on 8 November 2021 to the registered manager, deputy manager and clinical lead nurse.

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

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
● Action was not always taken to safeguard people from harm. Prior to our inspection, two safeguarding referrals were made to the local authority safeguarding team, who are responsible for investigating any concerns of abuse. However, we found there were other incidents which had not been reported to safeguarding or to CQC. We raised a safeguarding referral regarding these incidents.
● One person's records identified safeguarding incidents which were not reported. The records did not include information to show risks had been fully assessed and mitigated and there were no follow up actions to reduce future incidents. This put people at risk of abuse and avoidable harm.
● We were not assured staff received training and guidance to keep people safe from abuse. Feedback from staff showed they had not all received safeguarding training. This was confirmed in three staff records reviewed, two staff had not received the training and the third in December 2019, therefore it was out of date. The registered manager told us this training would be delivered in the new year.

Systems were either not in place or robust enough to demonstrate people were protected from abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● People's records did not always have risk assessments to guide staff in how risks associated with their daily living were to be reduced. One person had an incident of choking, but no risk assessment had been completed. We told the management team what we had found during our visit and were told at feedback the risk assessment was now in place.
● We saw items left unsecured which could cause a person harm if ingested, such as shampoos and thickener used for fluids for people at risk of choking. No risk assessments were provided to us or seen.
● We were not assured risks were assessed and reduced in the environment and in practice, such as the use of a bar at windows to reduce the risk of people climbing out of them and staff transporting buckets and bowls of hot water to assist people to bath and wash. The information was requested but not provided.
● We were not provided with evidence to show equipment and the environment was safe, in relation to gas, electrical, legionella and fire safety. We saw hoists had stickers to show they had been serviced in June 2021.

●The registered manager told us there were no personal evacuation plans for people using the service, but these would be completed. This meant information was not available for emergency services should the service need to be evacuated, putting people at risk.
● Staff told us the system to alert staff when people needed assistance such as call bells and pressure mats, intermittently worked and could not be heard in all areas of the home. The registered manager told us

batteries needed to be regularly replaced, which did not always happen, which put people at risk of harm.

Learning lessons when things go wrong
● We were not assured there were robust systems in place to learn lessons and prevent incidents from reoccurring to reduce the risks of avoidable harm.
● Accident and incident forms did not always include review to show actions taken to reduce similar incidents from happening in the future.
● We asked the registered manager to send us information of how they analysed and monitored incidents and accidents, such as falls, none were received. Therefore, we could not be assured they were in place.

Systems were either not in place or robust enough to demonstrate safety was effectively mitigated and lessons were learned to prevent future incidents. 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.

Staffing and recruitment
● People were at risk of receiving unsafe and inappropriate care from staff who were not trained to meet their needs safely. Staff told us training had not been kept up to date and no training had been provided since the start of the pandemic. Some staff had not received any training, other than moving and handling.
● The registered manager told us they had a plan to provide staff with training in fire safety in November 2021. We were not assured this plan considered the seriousness of ensuring all staff were trained to meet people's needs safely.

People were supported by staff who were not receiving training to ensure they were supported by staff who were skilled and trained to meet their needs. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us how they had problems with finding staff to work in the service, despite their attempts to do so. A regular agency staff member had recently been sourced and an interview was planned for a staff member who had previously left. The registered manager had taken the decision not to take any new people into the service until more staff were recruited.
● Staff told us staffing levels impacted on the quality of care provided to people, including not having time to spend time with people and provide activities to meet their emotional and social needs. One relative said their family member was becoming bored and isolated and there were no activities to stimulate them.
● People told us they felt they were supported by staff when they needed them, although they were busy. One person said, "They come when I call, and someone is always around if you need anything." We observed staff working hard to ensure people's requests for assistance were responded to.
● The deputy manager started working in the service in September 2021 and supported nursing staff to access online training to keep their knowledge and continuous professional development updated. This had not been provided by the registered manager prior.
● We reviewed three staff recruitment files which showed checks had been made to reduce the risks of people being cared for by staff who were unsuitable to work in this type of service.

Preventing and controlling infection
● We were concerned regarding the infection control processes in the service. Taps in bathrooms and the first floor kitchenette had limescale on them which prevented thorough cleaning, some plugholes were not clean, and a toilet had limescale build up under the rim. The deputy manager told us this was addressed following our visit.

● The service had recently received a 1* rating for a local authority food hygiene inspection, the lowest rating is 0* and the highest is 5*. Two staff members told us improvements had been made and they were waiting for a follow up visit. We were not provided of evidence to show actions had been taken.
● The registered manager did not provide us with their infection control audits. Therefore, we could not be assured this area was being monitored and any shortfalls being identified and addressed.
● The registered manager did not provide us with their most up to date training records. Staff told us there had been no training relating to infection control since the onset of the pandemic. Therefore, we were not assured staff were given the training to effectively practice good infection control processes.
● We saw staff were wearing PPE throughout our visit. However, a used glove was disposed of in a bin with no lid in one person's bedroom, which was a risk of cross contamination.

Systems were either not in place or robust enough to demonstrate effective infection control processes were in place. 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.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. However, relatives told us they needed to call the service at 9am to make an appointment for a visit that day, which was not always convenient.
● 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 accessing testing for people using the service and staff.

Using medicines safely
● Medicine administration records showed not all medicines had been signed to say people had received them, including codes to indicate they were out of stock. We were not provided with audits to show the discrepancies had been picked up by the service and acted on. Therefore, we could not be assured people always received their medicines when they needed them.
● During our visit we observed part of the lunch time medicines round, this was done safely by the member of staff responsible. Medicines were stored safely and medicines which required specific storage and recording was managed appropriately.
● Prior to our inspection we had received concerns regarding medicines being left in pots with people and staff signing the say they had been given and late administration of some medicines. We were told this was addressed.

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 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- We found significant deterioration in standards with multiple breaches of regulation. This was attributed to the lack of management and provider oversight. Where the registered manager had been made aware of shortfalls by staff, prompt action had not been taken to address them.
- Staff did not feel the service was well-led, did not feel confident in reporting any concerns and did not feel listened to. Some staff felt the registered manager was resistant to change.
- We were not assured there was a robust quality assurance system in place to drive improvement. Despite us asking on four occasions, the registered manager failed to provide any evidence of their governance systems and how care and safety was being monitored to assist them to identify and address any shortfalls.
- Staff told us that not all taps, showers and baths were working and/or provided hot water. We asked the registered manager to tell us what actions were being taken to address this. This was not provided.
- The registered manager told us the issues we had been told about by staff regarding the call bells not always working had not happened recently. However, two other staff present said it had, the day and two days before. This demonstrated a lack of oversight of what was happening in the service.
- People's care plans were not person centred and did not have enough detail to guide staff on how their specific needs and preferences were to be met. At the time of our visit there were five people who had no care plans. This was a risk of people not having their needs met. We were not provided with evidence to show the care records were being monitored.
- Records relating to the care people received were not always complete and accurate, specifically food, drink and weight records. No evidence was provided to show this was being monitored.
- There was a risk of people receiving unsafe care due to the lack of training, guidance in care plans and oversight of the registered manager.

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

- We did not receive the requested information to show people using the service and relatives were asked for feedback about the service and how this was used to drive improvement. Therefore, we could not be assured it was in place.
- People's relatives told us they were kept updated regarding their family member's wellbeing by staff and consulted about the care provided but were not being asked about their views of the service. One relative told us they had emailed the registered manager for information and they received no response.

● The registered manager had not engaged the staff team in listening to their views about the service and to provide feedback. There had been no staff meetings, except for a weekly office meeting. We were told by staff they had not had one to one supervisions and clinical supervisions for nursing staff for, "A couple of years," but these had recently started with the arrival of the new deputy manager.
● We reviewed three staff files, two for staff recently employed in 2021. There were no records of how their performance was monitored during their probation.

Systems were either not in place or robust enough to demonstrate safety and the care provision was effectively managed, monitored and assessed. This placed people at risk of harm. Systems were either not in place or robust enough to demonstrate the views of staff, relatives and people using the service were sought and used to drive improvement. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings we received positive feedback from people using the service. People commented on the very caring nature of the staff, including the registered manager. People told us they were happy and felt they were cared for. One person said, "I couldn't say anything bad about it here. Everyone is so nice and friendly to me. They [staff] care a lot and even though they're busy they always have a smile."
● We received positive feedback from relatives. Comments included, "[Family member] is happy and likes living there. I cannot fault Priory Paddocks… glad [family member] is there," and, "We are over the moon with the home, [family member] is settled and we have no worries about [family member] not being looked after, I cannot praise them enough glad to get [family member] in there, good reputation."
● The registered manager was open with us about their personal circumstances and recognised how standards had slipped. The registered manager told us they and the second provider were working night nurse shifts to fill a nurse vacancy.

Working in partnership with others
● We received positive feedback from two health care professionals who worked with the service. They told us the staff acted on any guidance and kept them updated with any concerns about people's wellbeing. One health care professional was complimentary about the nursing staff and said, "I trust their judgement." In addition, they told us they would have no hesitation moving into the service if they needed to.
● We saw meeting minutes, which showed the service had worked in a multi-disciplinary team to achieve good outcomes for a person.

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
● There was a duty of candour policy in place and this was understood. We asked the registered manager for evidence of how this had been used, none was provided.
● Feedback received from relatives, was they were kept updated of any incidents and received an explanation of what had happened and what was being done to support their family member. One relative said, "If there are any issues and they keep me updated what is happening [with family member], I just think it is an excellent nursing home could not ask for anything more."

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 18 HSCA RA Regulations 2014 Staffing People were supported by staff who were not receiving training to ensure they were supported by staff who were skilled and trained to meet their needs. Regulation 18 (1) (2) (a)

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 Systems were either not in place or robust enough to demonstrate safety was effectively assessed and mitigated. This placed people at risk of harm. Regulation 12 (1) (2) (a) (b) (d) (e)

The enforcement action we took:

Imposed conditions

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 were either not in place or robust enough to demonstrate people were protected from abuse. This placed people at risk of harm. Regulation 13 (1) (2) (3)

The enforcement action we took:

Imposed conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate safety and care provided to service users was effectively managed, monitored and assessed. This placed people at risk of harm. Regulation 17 (1) (2) (a) (b) (c) (d) (ii) (e) (f)

The enforcement action we took:

Imposed conditions