Moorings Care Home Ltd

# Moorings Nursing Home

## Inspection report

167 Thorney Bay Road
Canvey Island
Essex
SS8 0HN

Date of inspection visit:
03 December 2020
04 December 2020

Date of publication:
16 February 2021

## 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
Moorings Nursing Home is registered to provide care and accommodation with nursing care for up to 39 people some of whom may be living with dementia and/or mental health conditions. When we inspected there were 17 people living in the service.

People's experience of using this service and what we found
During the inspection we identified serious concerns about Infection Prevention and Control (IPC). This included concerns about the cleanliness of the service and poor practice in the use of Personal Protective Equipment (PPE), which placed people at the risk of infection. We met with the provider setting out the urgent nature of our concerns and asked them how they would address this.

The service had a manager registered with the Care Quality Commission at the time of inspection, however they had not been in charge of the day to day running of the service and failed to have oversight.

We found the provider's governance and oversight system were not robust and did not identify areas of concern in order to effectively mitigate the risks identified on inspection.

The provider failed to act where harm had been identified, to keep people safe. This included failing to raise safeguarding referrals with the local authority. The service had also failed to notify the CQC of safeguarding concerns, which is a legal obligation for providers so CQC can monitor the safety and quality of care.

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 30 November 2017).

Why we inspected
We received concerns in relation to infection prevention and control. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. 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.

Enforcement
We have identified breaches in relation to infection prevention control, the environment and good governance of 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.

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.

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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Details are in our safe findings below.

### Is the service well-led?

**Inadequate**

The service was not well led.

Details are in our well led findings below.

# Moorings 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
The inspection team was made up of one inspector

Service and service type
Moorings 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. However, at the time of the inspection, they were not in the service and did not have day to day control of what was taking place.

Notice of inspection
We gave a short period notice of the inspection because some of the people using it could not consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

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. 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

We used all of this information to plan our inspection.

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

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.

Preventing and controlling infection

- The provider's hygiene practices failed to promote people's safety. We found areas which were visibly dirty and stained, and some communal spaces which were unclean, including stairwells and lounge areas.
- We found poor hygiene practices in communal toilets and bathrooms. A stained urine bottle had been left out and was found with flies alive inside. There were also multiple toilet brushes which continued to hold faecal matter. One bathroom had large stains on the floor that had not been cleaned for a period of time due to the extensive staining.
- We were not assured that the provider was using PPE effectively and safely. We found PPE being stored out of its original packaging in inappropriate areas including a dirty sink in the ground floor sluice room and on a chair in a ground floor shower room. This did not keep it clean or reduce the risk of contamination prior to its use. Our observations showed staff were actively using this PPE to support service users. This placed both service users and staff at increased risk of contracting COVID-19 or other infections through cross infection.
- A staff kitchen area on the first floor was being used as both a "clean" and "dirty" area to change into and out of PPE as well as an area for staff to take breaks. This placed both service users and staff at increased risk of cross infection, and potential spread of COVID-19 or other infections.
- Hazardous waste bins were not available to staff, people or visitors within the service to safely dispose of used PPE. This included people's bedrooms where people were COVID-19 positive. This meant any used and contaminated PPE would need to be disposed of in other bins around the service, increasing the risk of cross contamination.
- The service's policy and procedures for COVID-19 did not reflect national guidance or explain how the provider planned to protect and mitigate risks to service users. This includes no information about the expectation, including escalation and reporting from your registered manager and/or senior leadership team including those responsible for quality and safety oversight. There was no information about what action needs to be taken if staff or people that used the service tested positive for COVID-19 and how that might impact on the continuity of the service.
- Staff and management within the service were unable to demonstrate their understanding of both national and local policies and procedures relating to infection prevention and control.

The above issues were a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks in relation to people's care were not assessed or managed appropriately.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Processes and procedures were in place for staff to report concerns. However, staff did not always

recognise potential abuse. For example, records showed safeguarding concerns had not been reported by the provider or staff to the local authority for further investigation. This meant we were not assured potential abuse was being identified and raised by staff.

● The service failed to learn lessons when things went wrong. For example, following an incident in the home, the service failed to raise a safeguarding. The provider only raised the concern after being advised to do so by the local authority. Information provided to the commission by the local authority showed the service continually failed to notify them of safeguarding concerns.

The lack of robust systems and processes to safeguard people from abuse was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely

● The provider failed to assess risks to the health and safety of people using the service including assessing the risk of infection and preventing, detecting and controlling the spread of infection.

● The service could not demonstrate that medicines were administered to people safely and as prescribed by a healthcare professional. For example, one person was prescribed medicine five times a day to treat epilepsy. A copy of the Medicines Administration Record (MAR) provided showed that on 12 different days it was not recorded whether the person had been given one of the doses of their medicine. On two days it was not recorded whether, the person was given two doses of the five prescribed by a healthcare professional. The service could not demonstrate if the person had received these medicines or not. This meant there was a risk the person may have a seizure and become unwell.

● Another person was prescribed a fortifying yoghurt to support weight gain twice daily. The MAR record provided showed that between the 03 and 26 November 2020, the service failed to administer this due to awaiting pharmacy delivery. The service was unable to demonstrate how they supported this person during this time to maintain weight gain nor any action they had taken. This meant that this person was at increased risk of not maintaining or gaining weight which could be detrimental to their health.

Following our concerns with medicines, we raised a safeguarding referral to the Local Authority.

Staffing and recruitment

● At the last inspection, no concerns were highlighted about staff or recruitment within the service. At this inspection, no changes have been made to either so we did not look at this.

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.

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

- Systems for identifying risks and monitoring quality and safety were not effective and had failed to identify concerns at service. Systems and processes for managing health and safety and infection prevention and control were not robust and failed to highlight infection control concerns.
- The service does not have a registered manager in day to day charge of the service. During the inspection, the nominated individual confirmed to inspectors that there had been a lack of senior management at this service since the end of March 2020. They confirmed that they had only visited the service three times since then but had not identified any of the shortfalls we found during our inspection. The lack of oversight and monitoring led to a deterioration in the service placing people at risk of poor care.
- There was no formal system for overseeing the home in the registered manager's absence. The failure to ensure there was adequate leadership and that the systems and appropriate guidance was effective means that opportunities to improve safety and quality were missed.

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

- A member of staff confirmed to us on 11 December 2020 they had tested positive for COVID-19 after being tested at another registered premises on 08 December 2020. They also confirmed they had been to the service during this period, demonstrating they had not self-isolated in line with national guidelines, until the result was known. This shows a lack of understanding of the risks of cross infection and doing all that is reasonably practical to mitigate such risks.

The above concerns demonstrated this is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations.

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 Commission requires registered providers to report incidents to us in a timely way. We were informed by the local authority of incidents that warranted a safeguarding alert. These events are also notifiable to the Commission; however, notifications had not been sent. When incidents are not reported to the appropriate authorities, there is a risk that oversight of these incidents will be missed and support may not be provided.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notifications of other incidents.

Continuous learning and improving care; Working in partnership with others

- There were no arrangements for ensuring learning from incidents and for when things went wrong.
- Accidents and Incidents did not prompt learning to improve care. A lack of robust auditing and managerial oversight meant the service did not pick up on concerns. For example, risks around infection control had not been identified when they occurred meaning the provider did not learn or improve care for people. The provider did not escalate concerns to other professionals including notifying the relevant authorities of safeguarding concerns to ensure people were protected.

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 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had not notified CQC of all incidents that affect the health, safety and welfare of people who use services. |

| 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<br><br>The lack of robust systems and processes in place to safeguard people from abuse |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider failed to assessing the risk of preventing, detecting and controlling the spread of, infections, |

**The enforcement action we took:**

We have issued a warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The systems in place to assess monitor and improve the quality and safety of the service did not work effectively and failed to identify concerns |

**The enforcement action we took:**

We have issued a warning notice